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BULLETIN

OF THE PARK RIDGE CENTER

Volume 4, Number 2

May 1989



THE PRESBYTERIAN HOSPITAL, FOURTH AVENUE, BETWEEN SEVENTIETH AND SEVENTY-FIRST STREETS, NEW YORK.
[PHOTOGRAPHED BY ROCKWOOD, NEW YORK.]

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Cover picture: From the November 16, 1872, issue of *Harper's Weekly*. A report on page 31 reviews the recent Park Ridge Center conference on the role and purpose of religiously sponsored institutions of care.

The small drawings below the "marginal information" are from various British magazines of the late Victorian era.

The *Bulletin of the Park Ridge Center* is published in January, May, and September and sent to all Center Associates. Its purpose is to present accessible, useful information in fields related to health, faith, and ethics, and to provide subscribers with a forum for interaction with each other. We welcome contributions in the form of letters to the editor, research suggestions, and manuscripts for review and possible publication in the *Bulletin* or in the Center journal, *Second Opinion*.

Additional copies and back issues of the *Bulletin* (if available) may be purchased for \$3.00 each, \$2.00 for Center subscribers. The editor of the *Bulletin* is Micah Marty; the copy editor is Sandy Pittman. Other contributors are Kathleen Cahalan, Martin Marty, Donna Ray, and James Wind. All material copyright 1989 by the Park Ridge Center.

Opinions expressed or implied in the *Bulletin* are not necessarily those of the Park Ridge Center or any organization with which it is affiliated. The *Bulletin* and *Second Opinion* are both published every four months (three times per year); subscribers will receive a publication every other month. Here is the publication schedule for the next two years:

May 1989—*Bulletin*, vol. 4, no. 2
July 1989—*Second Opinion*, vol. 11
September 1989—*Bulletin*, vol. 4, no. 3
November 1989—*Second Opinion*, vol. 12
January 1990—*Bulletin*, vol. 5, no. 1
March 1990—*Second Opinion*, vol. 13
May 1990—*Bulletin*, vol. 5, no. 2
July 1990—*Second Opinion*, vol. 14
September 1990—*Bulletin*, vol. 5, no. 3
November 1990—*Second Opinion*, vol. 15
January 1991—*Bulletin*, vol. 6, no. 3
March 1991—*Second Opinion*, vol. 16

The *Bulletin* and *Second Opinion* are sold together as a package for an annual subscription rate of \$35 (\$65 for two years, \$95 for three). In addition to the *Bulletin* and *Second Opinion*, subscribers receive discounts on Center books and periodicals; advance notice of forthcoming events and publications; and a greater opportunity to contribute to the Center's conversation on health, faith, and ethics.

All inquiries, including editorial correspondence, research suggestions, manuscripts, subscription orders, and requests for information should be sent to the Park Ridge Center, 676 N. St. Clair, Suite 450, Chicago, Illinois 60611. The phone number is 312/266-2222.

NEWS DIGEST

JANUARY

U.S. approves gene transplantation

The National Institutes of Health and the Food and Drug Administration approved the first federally sanctioned attempt to transplant genes into humans.

Scientists plan to transfer bacterial cells into white blood cells taken from advanced-stage cancer patients. The foreign genes are not intended to directly fight the cancer, but to serve as "markers" on the white blood cells to help gauge the effectiveness of the cancer treatment.

The ultimate end of such experiments is information about the efficacy of transplanting human genes, with an eye toward eventual "human gene therapy" (transplanting normal genes into patients who suffer from genetic defects). Gene therapy is in very early experimental stages and has not yet been approved; when two American scientists attempted the procedure in 1980, they were unsuccessful and were censured by the NIH and FDA for conducting the experiments without federal approval.

Catholic bishops address morale of priests

A new report published by the U.S. Bishops' Committee on Priestly Life and Ministry finds that many of the nation's 54,000 Roman Catholic priests have a "serious and substantial morale problem." "When the morale of priests is low," the report says, "the quality of ecclesial life diminishes and almost every area of church life suffers." The report is surprising in its candor, discussing problems such as loneliness, burnout, and sexuality—subjects that traditionally were not discussed before the public.

In "A Profile of the Problem," the report listed six major points:

1. "Role expectations among clergy leave many feeling trapped, overworked, frustrated, and with the sense of little or no time for themselves." Part of the problem, the report says, is the priest shortage (there are fewer than half as many priests in seminary as there were 20 years ago, while the number of U.S. Catholics continues to increase). How do priests deal with burnout? "A significant number have settled for a part-time presence to their priesthood," the report notes. "Many... elect to drop out quietly. . . . This is particularly true of those in the 45 to 60 age group who are willing to go through the necessary minimum of motions but whose hearts and minds are elsewhere."

2. "The declining number of active priests takes its toll at several levels, [including] present pastoral practice, clouded personal future, and solutions precluded from discussion." As fewer men enter the priesthood and more leave it, the strain on the remaining priests becomes greater, causing even more "dropouts." The report added that many priests are discouraged because "some possible avenues of relief are not to be considered or discussed." These include "ordination of married men, effective use of laicized priests, and expanded roles for women in ministry."

3. "Loneliness is often mentioned by priests as cause for anxiety and pain." The report says that the subject of loneliness, while a common experience—"particularly in the American male"—is brought up frequently by priests. The report calls for greater attention to "the need for intimacy, the distance sometimes created by the role of priest and the integrity demanded between priests' feelings and public life."

4. "The issues surrounding sexuality in culture and the church today introduce a goodly share of tension." The report says this includes both "personal" sexuality (e.g., celibacy) and "the politics of sexuality" (e.g., feminism, homosexuality). "Every study or commentary done on the priesthood and shortage of voca-

There are more than 27,000 medical articles published each month.

Source: *Edell Health Letter* 8(2):8



Doctors have been aware for some time that cancer patients can become nauseated upon mere sighting of their oncologists, because they associate the doctor with their nausea-inducing chemotherapy. In a recent letter to the *New England Journal of Medicine*, an oncologist recounted a shopping center encounter with a former patient he hadn't seen in three years: she threw up as soon as she recognized him. The doctor named the long-term conditioning syndrome after himself—but spelled his name backward so he wouldn't be identified as "the doctor who induces vomiting."

Source: *NEJM*, 320:189

tions mentions sexuality (and specifically mandatory celibacy) as a major reason a) for leaving the priesthood; b) for shortage of vocations; and c) for loneliness and personal unhappiness of those who stay."

5. "Differing perceived ecclesiologies seem to be a source of demoralization that has grown steadily." The report characterizes this to mean "vastly differing notions of faith, ecclesiology, law, and ministry. . . . within dioceses and parishes and . . . sometimes within the same rectory." The difference is often generational, according to the report, as priests must deal with those who do not accept the directives of Vatican II, or personal (many priests seek harmony but find conflict all around them). Priests are "caught in the middle" as they must pass on pastoral decisions formulated at the Vatican, "not fully endorsed" by their bishops, "personally questioned" by the priests, and "clearly disagreed [with]" by parishioners.

6. "The need for affirmation is particularly crucial today." Traditional systems of recognition for priests such as honorary titles and coveted appointments have largely disappeared, according to the report, and society and the media "less often deal with clergy or the church in an affirming or even kindly fashion."

What is to be done? The bishops' committee lists specific, practical matters that need to be addressed as well as more general instructions for "what bishops can do." Conceding that "priests' expectations of bishops could well be a major cause of stress in the life and ministry of bishops," the report urges bishops to talk to each other; conduct regional meetings for priests; support national organizations working on behalf of priests; and effectively use "documents on priestly life and ministry" from the National Conference of Catholic Bishops.

Surrogate motherhood-divorce custody case presents new legal dilemmas

An Ohio child custody case has dragged on for more than two years as several parties battle over a 4-year-old girl who was born to a surrogate mother and whose adoptive parents later divorced.

In January 1985, a married woman with three older children presented her day-old baby to a married couple who had agreed to pay her \$10,000 plus expenses for carrying the child. In 1986, however, the adoptive parents divorced, and a custody battle over the child ensued. The biological mother then filed a claim for the child

that she later withdrew but is now considering refiling. A couple on the East Coast has apparently added to the confusion by also asking to adopt the child, according to lawyers in the case.

The case is further complicated by the fact that although the surrogacy contract stipulated that the adoptive father would donate the sperm, he was found to be infertile after the contract was signed and a sperm donor was used to impregnate the biological mother. The child's birth certificate originally listed the surrogate mother's husband as the father and was later changed to say that the adoptive father was the biological father as well. In fact, a third party donated the sperm.

The final complication is that Ohio does not have a law regarding surrogate motherhood so there is no obvious legal direction for the case. Several of the parties involved have indicated that they can no longer afford the legal battle, but all parties agreed that for the good of the child they want to resolve the case as soon as possible. For now, the girl travels 100 miles twice a week between her two adoptive parents, who are temporarily sharing custody. She apparently is not aware of the legal disputes.

New death certificates ask about tobacco use

Following a recommendation by the American Medical Association, Oregon and Utah have become the first states to adopt death certificates asking the doctor whether tobacco use contributed to the death. "Some physicians are still reluctant to involve themselves in life style decisions of their patients," the director of Harvard's Institute for the Study of Smoking Behavior and Policy told the *New York Times*. "Maybe checking this box once or twice will make them take a more proactive role."

A spokesman for the Tobacco Institute was quick to criticize the new death certificates, which were introduced on January 1. "Absent an autopsy, you don't know what caused a person's death," Walker Merryman told the *New York Times*. "A death certificate is an estimate, a guess."

The new certificates were hailed, however, by the chairman of the Tobacco Products Liability Project, which encourages litigation against the tobacco industry. Richard A. Daynard said the death certificates could be used as evidence in such trials and "will be useful in recruiting plaintiffs."



As reported in the January *Bulletin* (pp. 8-9), many states are revising death certificates to provide more information about long-term causes of death rather than just the immediate physiological malfunction that proved fatal. In 1987, Oregon health officials sent out a letter to physicians asking whether smoking was a factor in the 3,000 deaths from lung cancer or pulmonary disease that year. Although only 2% of the 3,000 death certificates had cited tobacco use, almost 80% of the doctors queried said smoking was contributing factor—prompting the change in the death certificates.

In Utah, the *New York Times* reported, some health officials have expressed concern that the statistics “might be compromised by physicians under pressure from Mormon next of kin who did not want it to be known that the dead relative had smoked.”

Blacks underrepresented in medical research

A recent study published in the *Journal of the American Medical Association* claims that medical researchers often ignore racial variations when testing new drugs. Dr. Craig Svensson of Wayne State University claimed that in 35 of 50 reports on new drugs there was no racial breakdown or blacks were underrepresented.

Previous studies have shown clear differences in some aspects of the physiology of whites and blacks. For instance, blacks are usually more prone to hypertension (high blood pressure) and blacks with elevated fluid pressures in their eyes “are at greater risk of developing glaucoma than whites of the same age with the same malady.”

An editorial accompanying the study decried the “subtle economic racism” that has caused medical researchers to overlook the needs of blacks.

Cancer institute says FDA sluggish on drug approvals

In a surprising attack on a fellow federal agency, officials from the National Cancer Institute publicly charged that the Food and Drug Administration was moving too slowly in approving drugs for marketing.

The criticism came during a meeting at the National Institutes of Health, where officials are working to reduce the regulatory maze through which new products must travel before becoming available to the public. The debate over reg-

ulations and approval-related delays has become more heated with the AIDS epidemic and subsequent development of new drugs aimed at fighting the disease.

Much of the NCI-FDA argument was over scientific issues, such as medical definitions of “meaningful improvement” among test subjects. However, there is also a strong ethical and philosophical side to the debate with regard to such issues as the amount of risk experimental patients should be exposed to and the public’s right to a new drug versus the government’s duty to protect against dangerous or ineffective drugs.

The head of the deregulation review committee, Dr. Louis Lasagna, noted that the FDA probably errs on the side of caution because the agency is less likely to be criticized for delaying approval than for quickly approving a drug that later turns out to be dangerous. “I’d like to work without the threat of congressional investigations as to why [the FDA] let a drug on the market too soon,” Lasagna explained.

Issues of media expansion and mission divide Christian Scientists

Members of the First Church of Christ, Scientist, are embroiled in a bitter dispute over the mission of their church. At the heart of the controversy is a major move by the church into new forms of mass media, including a monthly magazine and a nightly news program on cable television.

Critics charge that the church is neglecting its original mission and spiritual agenda, barring any distinct religious content from the new media and even omitting the words “Christian Science” from their titles. In November 1987, the three top editors of the highly esteemed *Christian Science Monitor* newspaper resigned in protest over staff cuts and diversion of funds to the new *World Monitor* monthly magazine.

Defenders of the changes, however, claim that none of the public media outlets of the church have ever carried an overtly religious message (even the flagship *Monitor* carries only one article from a Christian Science perspective in each issue). These defenders say that the critics are merely “frightened of innovation” and suffer from “cloistered nostalgia.”

The debate was fueled by the Park Ridge Center book *Health and Medicine in the Christian Science Tradition*, by Robert Peel (Crossroad, 1988), which chides the church for not being true to its own traditions (*Bulletin*, vol. 3, no. 4,

Although 59% of American men say they are happy with the way they look in clothes, only 45% are happy with the way they look nude.

Source: *Gentlemen's Quarterly*



p. 1). The mother church sent out more than a thousand photocopies of the offending chapter to church employees, along with a memo noting church regulations against "incorrect" criticism.

Both sides in the controversy agree that the discussion is healthy if it revitalizes the church instead of dividing it. Although the church does not release specific figures, membership has been declining 7%–8% per decade for the last 50 years, and many remaining members are elderly. Moreover, according to the *New York Times*, there are only 3,500 church-licensed practitioners, compared to 8,300 less than 30 years ago.

Doctors unveil universal insurance plan

Declaring that "Our health care system denies access to many in need and is expensive, inefficient, and increasingly bureaucratic," a group of 1,200 physicians proposed new national health insurance plan that would cover every American citizen. The organization, Physicians for a National Health Program, designated the federal government as sole insurer and called for local boards to set fees for physicians, hospitals, and services. The proposal was outlined in the *New England Journal of Medicine*, accompanied by an editorial by editor Arnold Relman endorsing the general concept of universal health insurance.

The plan was quickly attacked by spokespersons for the American Hospital Association and the American Medical Association, who claimed that the plan would not be less expensive than the current system and would lead to long waits for routine forms of treatment.

Dr. Christine Cassel, of the University of Chicago, who helped write the proposed program, conceded that even though this specific plan may have little chance of success, it would pave the way for acceptance of a national health insurance system in the future. Experts estimate that approximately 37 million Americans have no health insurance.

Physician won't take on patients who smoke

A West Virginia physician who says he is still haunted by memories of his father's painful death from lung cancer has publicly announced that he does not want as new patients people who smoke cigarettes. Dr. John J. Cannell, of Beaver, West Virginia, staked out his position through a local newspaper ad, in which he pledged to nonetheless give emergency treatment to any needy patient. He said he would

not drop any current patients who already smoke, although he would continue trying to get them to quit.

Cannell, who was six years old when his father was "coughing up blood while dying in [his mother's] arms," has received both praise and criticism for his stance. Critics say that widespread adoption of Cannell's policy—especially if many physicians similarly excluded people who eat or drink too much—could lead to a society in which "no one would treat the rejected."

However, many fellow physicians have applauded Cannell's interpretation of Hippocrates' injunction to "do no harm." The family physician told reporter Larry Altman of the *New York Times* that he used to help severely ill patients to breathe again—and they would immediately resume smoking. "I just wanted to be consistent," Cannell explained, likening nicotine to other addictive substances. "Only a rare doctor would continue to treat a heroin or cocaine addict if the patient did not agree to enter a detoxification program." He said that he had struggled over the conflict for years and adopted the no-smoker policy after watching a 40-year-old mother of three die of lung cancer. Dr. John Burkhart of the AMA's council on ethics told the *New York Times* that he saw no ethical problems with Dr. Cannell's desire not to be a "co-conspirator" with patients who smoke.

Cannell says his goal is to get one person per week in Beaver to stop smoking; he claims that several dozen patients have quit since he instituted the new policy.

New York modifies free-needle program

New York City Health Department officials altered the goals of a needle-exchange program for drug addicts after the turnout was much lower than expected.

As reported in the January *Bulletin*, the city introduced the controversial new distribution program to prevent the sharing of hypodermic needles among heroin addicts, many of whom are infected with the AIDS virus. The goal had been to set up a test group of 400 regular visitors and through interviews to monitor addicts' drug and sexual habits. Only 8 addicts showed up the first week, however, and after two months fewer than 50 had participated in the program. Because of the low response, directors of the program modified it to concentrate on enrolling addicts in drug treatment and rehabilitation programs.

Medical service fees
(average, in U.S. dollars)
for an appendectomy in

Germany	\$81
Japan	\$185
New York	\$1135

Source: *NEJM* 319:1169
(figures from 1984)



The location of the distribution center in a Health Department building near a city jail and central police headquarters has been blamed for the low turnout. Original plans had called for four needle-distribution sites centered in areas where drug abuse is prevalent, but in the face of pressure from critics, Mayor Edward Koch prevented the opening of those centers. Spokespersons for minority groups, in particular, have charged that government-sponsored needle-exchange programs perpetuate and legitimate drug abuse among minorities.

No other major city has successfully introduced a needle-exchange program, although a private citizen in Tacoma, Washington has been distributing free needles paid for with private donations. (See the January *Bulletin*, p. 9.) New York has a larger AIDS problem than any other American city, with 18,000 total cases of the disease and an estimated 100,000 addicts infected with the virus.

Positive attitude may help fight AIDS, study says

Preliminary results of a study of HIV-infected men indicates that an optimistic mental attitude combined with an exercise program may help to combat AIDS.

While the researchers cautioned that it will be "at least four years" before the evidence is conclusive, early results indicate that HIV-infected men who exercised and followed other "life promoting measures" showed less anxiety and depression than infected men who did not, and their immune systems appeared almost as strong as those of uninfected men.

The authors of the preliminary report, which was presented to the American Academy for the Advancement of Science, encouraged infected men to join support groups, study relaxation techniques, engage in exercise programs, and maintain an optimistic attitude. However, they cautioned that patients should not feel responsible if the disease progressed despite their optimism.

HHS questions ethics of marketing mechanized lounge chairs

A new report by the Department of Health and Human Services challenges federal Medicare expenditures of \$60 million per year on "seat-lift chairs," which help elderly and arthritic patients move from a sitting to a standing position. The

report did not argue that the chairs worked as claimed, but rather that physicians were pressured into writing prescriptions for them after patients responded to an "aggressive" nationwide TV campaign. The chairs, designed for home use, look like La-Z-Boy recliners and sell for \$600-1800.

"This is almost fraud, if not fraud, the way these [chair manufacturers] solicit our beneficiaries," said a Nebraska physician quoted in the report. "The more money we spend on things like these, the less there is going to be for the really necessary, truly medical care services and equipment." Medicare spent \$185 million on 1.6 million claims for seat-lift chairs between 1984 and 1987.

The television commercials in question told viewers that anyone covered by Medicare could receive the chairs for free by calling a toll-free number. Many manufacturers waived the 20% share of Medicare equipment bills usually paid by the recipient and sometimes sent the chair before receiving authorization from the patient's physician. Doctors then felt compelled to sign the prescription lest the patient be billed for the full price of the already delivered chair.

A Washington lawyer who represents the Seat Lift Chairs Manufacturers Association responded to the report by saying that he didn't "see anything wrong with advertising a product if it makes people aware of something that may be of use to them."

Physician group urges members to act on domestic violence

The 28,000-member American College of Obstetricians and Gynecologists announced a nationwide campaign against domestic violence.

"We don't expect [ACOG] doctors always to treat the pathology of the battering," explained Dr. Luella Klein, a past president of the group, "[but] we do expect them to be able to tell women what their rights are under the law and advise a woman how to plan for dealing with her abusive partner and to refer them to where they can get the best help."

The ACOG estimates that each year at least 3-4 million women per year are beaten badly enough in their homes to warrant police or medical attention. Thirty percent of female homicide victims in 1986 were killed by their husbands or partners.

The organization is supplying brochures for battered patients, as well as technical information to physicians about what kinds of injuries to

"I received a call from Ms. Roe last week, the secretary to a Mr. J. Doe. Ms. Roe said that her boss wanted to take a course in some area of professional ethics. I described IIT's offerings in ethics, [but] Ms. Roe did not think that her boss really wanted a semester course that met three hours a week for sixteen weeks. She finally explained that Mr. Doe had agreed to attend a course in professional ethics as part of the settlement of a criminal case. He had to complete the course before regaining his license to practice. He really wanted something he could get out of the way in one day. A half-day seminar would be ideal. Poor Ms. Roe had been calling local universities all day, trying to find something convenient. Checking the bulletin board, I found the announcement of a one-day event at a nearby state university. Ms. Roe was extremely thankful."

—From a true story (with names changed) published in *Perspectives on the Professions*, published by the Center for the Study of Ethics in the Professions, Illinois Institute of Technology, Chicago (Aug. 1988)



look for. Doctors are also being told to be alert to behavioral cues, for example, if women patients appear to be "evasive, frightened, or embarrassed" or frequently miss appointments.

The association did not recommend mandatory reporting—as required of doctors when child abuse is suspected—because many women will not press charges. However, the member physicians were urged to inform patients about legal options and shelters for battered women.

Federal study links smoking, education level

Level of education has replaced gender as the most accurate sociodemographic predictor of whether a person smokes cigarettes, according to a new study by the U.S. Centers for Disease Control.

In a study published in the *Journal of the American Medical Association*, researchers reported that 36% of those who did not finish high school smoke, compared to 33% of high school graduates, 26% of those who had some college, and 16% of college graduates.

For many years, men were much more likely to smoke than women, but men have been quitting smoking more quickly than women, causing this "gender gap" to close. By the mid-1990s, the sexes should be tied and by the year 2000 experts predict that 23% of women will smoke compared with only 20% of men.

New York takes steps to curb caesarean deliveries

New York became the first state to respond to calls for hospitals and doctors to reduce the number of caesarean deliveries. A committee of the state health department will visit New York hospitals with particularly high or low rates of caesarean deliveries to determine if and how the number of caesareans performed statewide can be reduced.

As reported in the January *Bulletin* (p. 7), public health officials and physician groups are questioning the frequency of caesarean births, which account for one-quarter of all deliveries nationwide. Some experts think a figure of 10% is a realistic goal. "I can't believe that 25 out of 100 women cannot deliver a baby normally," stated Dr. Mortimer Rosen, who heads the New York State task force on caesareans. A spokesperson for the American College of Obstetricians and Gynecologists agreed that the rate

should be reduced but was not sure what an ideal rate would be.

Caesarean deliveries are slightly riskier for both mother and baby and are much more expensive than vaginal births. Nationwide, hospitals charge an average of \$3,000 more for caesarean deliveries than for vaginal births, while doctors charge \$250–\$500 more. In a report in the *New England Journal of Medicine*, researchers at a Chicago hospital estimated that a reduction in the rate of caesareans could save \$1 billion annually. The report described how through stricter in-house rules, including one requiring a second opinion, doctors reduced the percentage of caesarean births in the hospital from 17.5% to 11.5% in two years.

Many obstetricians have cited fear of malpractice suits as a major factor in the higher rate of caesarean deliveries. There is widespread ambiguity in the term "fetal distress," and when labor is prolonged or there is some form of fetal distress doctors usually opt for caesarean deliveries to prevent possible harm to the infant. In addition, until recently it was believed that women who had had caesarean deliveries could not give birth vaginally in subsequent pregnancies; according to the *New York Times*, repeat caesareans accounted for about a third of the total.

The New York committee plans to have doctors explain what they mean when they cite "fetal distress" as a reason for performing a caesarean. The commission will also request evidence that the doctor discussed and urged vaginal delivery whenever possible and that the woman understood the risks and benefits of a caesarean.

"Caesarean sections" probably got their name not from the way Julius Caesar was delivered (which is unknown) but from a Caesarean law that forbade the burial of a pregnant woman until her baby had been removed.

Source: *Black's Medical Dictionary*



FEBRUARY

AIDS controversy divides U.S. Buddhist group

Allegations that the leader of America's largest Tibetan Buddhist group infected his male sexual partners with AIDS during sexual encounters with them has divided the 5,000-member sect. Although the particular branch of Buddhism, Vajradhatu, does not prohibit homosexual or multiple sexual partnerships, the church is divided over how to respond to the possibility that the leader, Osel Tendzin, knowingly infected members of his own church.

Each side in the dispute believes that the teachings of the church support their position. "I don't want the head of this organization to demonstrate reprehensible moral behavior," explained one church member who supported the board of directors' request that Tendzin step down (Tendzin has so far not complied). Many fellow members apparently agree, partly out of concern that the issue could tarnish the sect's reputation and lead the public to regard it as a "cult." Supporters of Tendzin, however, claim that he did not intend to spread the disease and thus should not be dismissed.

Tendzin, 45, who was born Thomas Rich in New Jersey, discussed his illness with his superior in 1985 but said he thought he could "change the karma." Tendzin, who is in seclusion in LaJolla, California, reportedly said he thought he had "some extraordinary means of protection" and so did not change his life style.

Pregnant woman in coma sparks abortion debate

The husband of a comatose pregnant woman in New York has applied to become his wife's legal guardian so that he may authorize abortion of the fetus. The case has drawn the attention of both prochoice and antiabortion forces, who are debating the medical effects of pregnancy on a comatose woman, the right of a husband to be declared legal guardian, and the welfare of the mother against that of her unborn child.

At issue is the question of whether aborting the baby would increase the chances of recovery for the mother, who suffered extensive brain damage in an automobile accident in December 1988, and has been comatose ever since. Most of the medical experts testifying at the trial agreed

that the pregnancy added to the health risks that the woman faces, but two physicians testifying in behalf of the county district attorney's office claimed that the pregnancy did not represent "a life-threatening situation." Because of the rarity of this type of case, there has been no significant medical research on the effects of pregnancy on a comatose woman and no legal precedent on the right of a husband to be named legal guardian in such a situation.

Surrogate mother ban submitted to House

A bill submitted to the U.S. House of Representatives and aimed at ending surrogate parenting for profit was cosponsored by one of Congress's most conservative members and one of its most liberal members. Republican Henry Hyde of Illinois and Democrat Barbara Boxer of California coauthored the bill, which targets brokers who charge a fee to match prospective mothers with adoptive parents. The maximum penalty under the new law would be five years in prison and a \$50,000 fine. The law would not punish the biological mother or the adoptive parents, even if money exchanged hands, because "both are considered to be victims." Both Hyde and Boxer said they feared the effects of allowing poor women to, in effect, rent their wombs. "In the case of surrogacy, there is a desperate, childless couple and a surrogate mother desperate for money," Rep. Boxer told the *New York Times*. "Into this circumstance a commercial brokerage business has emerged which could lead to the creation of a new class of women in our society—paid breeders, and eventually a new class of children who will be forced to accept the reality that their natural mothers sold them." Mr. Hyde likened surrogate parenting to slavery and said that "by reducing childbearing to an occupation, surrogacy arrangements attack the essential human dignity of every person."

A "Perspective" column by ethicist William F. May published in volume 8 of *Second Opinion* addressed the issue of surrogate motherhood.

Hospitals begin competing for AIDS patients

In a development many gay activists say would have been "unheard of" several years ago, several California hospitals have undertaken marketing campaigns to attract patients with AIDS. Through low-key advertising campaigns in gay newspapers and increased support of the

As allocation-of-resource issues grow ever thornier, University of Minnesota ethicist Arthur Caplan suggests that one criterion might be what he calls a "sin test."

"It's those people who engage voluntarily in vice," Caplan told *Medical Ethics Advisor*. "It could be smokers, drinkers, those who engage in unprotected promiscuous sexual activity, or people who don't wear seatbelts or helmets for motorcycles."

Caplan says there is already a tendency to avoiding giving such patients priority for expensive care, and "maybe we ought not even give them access to expensive medical care if they need it."

Source: *Medical Ethics Advisor* 5 (Feb. 1989):19



homosexual community, eight Los Angeles-area hospitals are competing to lure patients who need hospital-level care to their special AIDS units. Seven of the eight hospitals are private, for-profit facilities, and many of them appeal to the Los Angeles entertainment industry, where upper middle-class AIDS patients have ample medical insurance to pay the high cost of treatment and care (uninsured patients go to the county hospital, which has no designated AIDS ward).

Most of the hospitals have lowered the nurse-to-patient ratio and permitted nurses to spend time just talking with patients rather than merely performing physical tasks. Because of the improved nurse-patient relationship, many nurses volunteer for the wards. "It really gets us back to the kind of nursing we all went to nursing school for," one AIDS-unit nurse told the *Chicago Tribune*.

New York Christian group granted AIDS education exemption

The New York State Supreme Court granted an exemption to a small separatist Christian sect after the group argued that state-mandated high school AIDS education was contrary to its religious beliefs. The Plymouth Brethren, a group formed in Ireland in the 19th century, claims about 2,000 members in the United States. Spokespersons for the group said that their doctrine forbids instruction in sexual or moral ethics by anyone outside the faith. The presiding justice in the case concluded that the strict moral code to which the teenaged members of the group adhere "precluded any health risk from AIDS."

Muslims offer bounty for British novelist

Indian-born author Salman Rushdie went into hiding in Great Britain, where he is a citizen, after a worldwide death threat was made in response to his most recent novel. *The Satanic Verses*, which many Muslims consider blasphemous, quickly rose to the top of U.S. best-seller lists in the wake of the controversy, which reached a peak when Iranian leader Ayatollah Ruhollah Khomeini offered \$4 million to anyone who would kill Rushdie.

The controversy highlighted the role of religion in modern culture, as mobs took to the streets in Iran, India, and Pakistan, and more than a dozen protestors were killed in the uproar over the book. In the U.S. rallies were held in

five cities to support Rushdie's right to write the book, with appearances by numerous prominent American authors. More than a hundred bomb threats were received at American bookstores that carried the book; one chain temporarily stopped selling the book, and many stores took it off of display racks.

It was not clear why there was such an uproar over the book, and Western observers believed that most Muslims protesting the book had not in fact read it (the book has not been distributed in Pakistan, and virtually all of the copies in Iran were reportedly destroyed). Rushdie, who is Islamic, was said to be "surprised, saddened, and confused" by the response to his book. According to the *New York Times*, however, Islamic fundamentalists were upset at "the author's effrontery in projecting Islamic myths and Koranic motifs in contemporary and futuristic settings." The novel begins with an airplane crash over the English channel, and though one of the leading characters sprouts a halo and another horns, there is no clear designation of which is good and which is evil, and observers could only speculate that the protests were sparked by some readers' interpretation that one of the book's characters, Mahound, was supposed to represent the prophet Mohammed.

Survey: Americans less satisfied than Britons or Canadians with health care

Nearly identical opinion polls taken simultaneously in Canada, Great Britain, and the United States indicate that a much higher percentage of Americans find their country's health system unsatisfactory. Only 10% of Americans surveyed agreed with the statement that the country's health system functions "pretty well," compared with 56% in Canada and 27% in Britain. (The British health care system is entirely nationalized, while Canada has a national health insurance program.) The survey, which was underwritten by the philanthropic foundation of the Baxter International medical products firm, polled more than 1,000 adults in each country.

Dr. Robert Blendon, chairman of the department of health policy and management at Harvard's School of Public Health, said he was surprised by the degree of dissatisfaction expressed by Americans and predicted a gradual move toward a Canadian style system of universal health insurance. The president of the Louis Harris organization, which conducted the U.S. version of the poll, said that he interpreted the

Calling for development of a drug that would be routinely injected into youngsters to blunt the euphoria that comes from using cocaine or heroin, the police chief of Washington, D.C., said that such a drug would be "the greatest contribution the medical community of this great nation can conceive for our children. I'm convinced that the medical research and capability to make this idea a reality are here."

Source: *Chicago Tribune*



British results to mean that most Britons would be quite satisfied with their health care if "a little extra money" was spent on it. American respondents to the survey, on the other hand, were confirming that "we have the most expensive, the least well-liked, the least equitable, and, in many ways, the most inefficient system," Harris said.

Other results of the survey:

Seven times more Americans than Britons or Canadians said they had failed to obtain needed medical care in the past year for financial reasons.

Two-thirds of the Americans who said cost had prevented them from obtaining needed care said they had some form of health insurance, leading the pollsters to suggest that U.S. health insurance may frequently be inadequate.

Sixty-one percent of the Americans surveyed said that they'd prefer a health care system like Canada's government-funded insurance program. Only 3% of the Canadians and 12% of the Britons surveyed said that they would opt for the American system over their own.

Physician posits power of prayer

A southern California internist who studied nearly 400 heart patients over a 10-month period reports that prayer appears to be "a measurably effective therapeutic tool for seriously ill individuals who worship God."

Dr. Randolph C. Byrd randomly selected 393 cardiac care patients and with their permission divided them into two groups. Byrd assigned a number of Catholics and Protestants outside the hospital to pray daily to "the Western world's most-worshipped deity" on behalf of the 192 patients in one group; the remaining 201 patients were not assigned any pray-ers.

Although no significant differences in health appeared between members of the two groups in the short term, in follow-up studies Dr. Byrd found fewer complications in the first group, as well as less need for various treatments and medications and even a lower incidence of death.

Byrd admits that his experiment may be flawed; he knows that some of the designated pray-ers outside the hospital probably cheated and prayed for those in the nonprayer group, "even though they were expressly told not to." In addition, there was no limit to the amount of praying performed, "nor was anyone hired to check up on the praying individuals to make sure they were doing their jobs." Finally, he con-

cedes that nonassigned persons might have been praying along with those who were instructed to pray, thus increasing the total sum of prayer.

Dr. John Thomison, editor of the *Southern Medical Journal* (which broke the story), said he'd like to see more research on the topic, noting that prayer "is about as benign a form of treatment as there is. There is no danger whatsoever." The surviving patients reportedly agreed that "prayer probably helped and certainly did not hurt."

Can mothers be held liable for endangering their fetuses?

Prosecutors in several states have brought cases against women whose drug abuse during pregnancy resulted in birth defects in the newborn baby. In Orlando, Florida, a woman was charged with "providing drugs to a minor" (her newborn daughter) after she allegedly smoked cocaine up to an hour before delivery. Officials in other states are clamping down as well. According to *U.S. News & World Report*, a judge in New York ruled during a woman's pregnancy that she was not competent to raise the child and the baby was placed in foster care at birth. And in Washington, D.C., a judge sentenced a pregnant woman to an unusually long jail term for forging checks because he wanted her to stay away from cocaine.

Prosecutors claim they are only trying to protect newborn babies, 10% of whom are born with drug dependencies. Critics of the increased prosecution, however, say that the trend reflects a subtle effort to redefine fetal rights so that abortion laws can be made stricter. Some women's rights groups claim that fear of prosecution will deter women from seeking treatment for the dependencies, and civil libertarians fear that women who drink or smoke too much during pregnancy could be prosecutors' next targets.

"Vietnam style" triage techniques used to treat urban assault weapon injuries

Physicians in emergency rooms serving drug-ridden urban areas report that they are besieged with patients whose injuries are identical to wounds incurred by soldiers in Vietnam. The injuries result from increased use of semiautomatic "assault weapons," rapid-firing, high powered guns favored by drug traffickers. Because assault rifles can fire dozens of bullets

One out of every 61 newborns in New York City tests positive for AIDS.

Source: *Commonweal*



per minute at 3 or 4 times the velocity of an ordinary pistol, the resulting internal injuries are usually extensive. Organs that would have been merely grazed or even cleanly pierced by a handgun bullet are exploded by assault weapon fire, requiring massive transfusions of blood. A physician in Los Angeles reported that assault weapon victims accounted for 2% of the patients at his hospital, but consumed more than 40% of the blood.

Because of the severity of assault weapon injuries, paramedics have borrowed heavily from military medicine techniques learned in Southeast Asia, such as dressing victims at the shooting scene in inflatable trousers to maintain blood pressure, replacing high volumes of lost blood with saline solution, and ensuring that patients are on the operating table within 20 minutes of receiving an ambulance call.

After a gunman in Stockton, California, used an assault rifle to kill five children in a schoolyard in January, many members of the medical community and the public at large called for a ban on assault rifles, but the National Rifle Association claimed that such restrictions would infringe on the rights of hunters. President Bush endorsed only mild restrictions on the sale and importation of these weapons.

Study finds that drinking during pregnancy has long-term effects on intelligence of offspring

Researchers in Seattle have found that even moderate drinking in the early stages of pregnancy can negatively affect a child's intelligence. The study, which involved 491 women and their children, isolated alcohol consumption from other predictors of the child's intelligence, such as parents' income and education level, and from generally acknowledged health risks, such as smoking and caffeine consumption. In fact, the scientists found, alcohol consumption had more adverse effects than tobacco, caffeine, aspirin, or marijuana.

The study addressed effects that are more subtle than those found in fetal alcohol syndrome, in which a baby is born with birth defects because of the mother's alcohol dependency. The Seattle study is notable because it is the first to suggest that moderate drinking can affect a child's intelligence. The most drastic effects, of course, are reported on children whose mothers drank the equivalent of three or more glasses of wine a day; these children averaged five points lower than average on I.Q. tests ad-

ministered at four years of age. However, the researchers noticed negative effects on children whose mothers quit drinking as soon as six weeks after conception, and "children born to mothers who had as little as one or two drinks a day in the first months of pregnancy were found by their early school years to have a slower reaction time and to have difficulty paying attention."

Because the effects were detected in children whose mothers quit drinking as soon as they learned they were pregnant, "we recommend that women who are trying to become pregnant or might become so do not drink alcohol at all," said the psychologist who directed the study. "The effects on children occur even at the social drinking level. The women in this study did not see themselves as having alcohol problems."

Britain moves toward free market health system

Prime Minister Margaret Thatcher's Conservative government proposed comprehensive changes in Britain's National Health Service aimed at orienting the system toward the free market. The proposed reorganization represents the most sweeping revision in the history of the NHS, which was founded 41 years ago and now employs 1 million health workers who treat 30 million patients annually.

Critics of the proposal contend that it would result in a "high-cost, two-tier" health system. One opposition party leader who is also a physician declared that "the commercialization of health care is the primrose path down which inexorably lies American medicine: first-rate treatment for the wealthy and 10th rate treatment for the poor." British citizens, though unhappy with delays in their state-run health program, generally support the continuation of publicly funded health care.

Thatcher promised that health care would remain available to all citizens regardless of income, and said that she wanted to improve cost effectiveness and increase patient choice without dismantling the nationalized system. The new proposal includes decentralization of the health bureaucracy and increased financial incentives for hospitals, physicians, and other health care workers. Patients would be encouraged to "shop around" for health care, rather than limiting themselves to their local "health district" as at present, and hospitals and doctors who attracted more patients would be rewarded with increased reimbursement, permitting them

Percentage of U.S. Gross National Product spent on health care

1970:	7.4
1986:	11.1

Comparable figure for Japan:

1986:	6.7
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Source: *NEJM* 319:1167 (data from U.S. Census Bureau)



to expand their services and attract even more patients. "For the first time since 1948, British doctors will be encouraged to see patients as revenue sources and expense centers," commented the director of a health management training institute.

According to the *New York Times*, critics of the proposed changes fear that younger, better educated, and more wealthy patients—who tend to be healthier and thus more attractive to health care providers—would be better able to travel for quality care and would receive more attention from hospitals and physicians. Patients who are poorer, less educated, elderly, or suffering from long-term illnesses would be shunned by hospitals driven by a profit motive, these critics say.

Wife of presidential candidate undergoes alcohol dependency treatment

Kitty Dukakis, wife of unsuccessful 1988 presidential candidate Michael Dukakis, entered an alcohol treatment center for a 30-day period. In a statement released to the press, the Massachusetts governor said his wife had never had an alcohol problem until after his November loss to George Bush, although during the campaign she revealed a 26-year struggle to overcome dependence on amphetamines. "A combination of physical exhaustion, the stress of the campaign effort, and the post-election letdown combined to create a situation in which, on a limited number of occasions while at home, she has used alcohol in excessive quantities," the governor's statement said. Mrs. Dukakis freely discussed her amphetamine dependency in public during the campaign, advising audiences not to start on drugs because "life is too rich." After President Gerald R. Ford left office, his wife, Betty, underwent treatment for drug and alcohol abuse; dependency experts applauded the "courage" of these women in going public with their dependency problems.

Parkinson's tissue transplants "no miracle"

A Chicago physician who monitored the transplantation of adrenal tissue in 19 patients has concluded that the surgery does have some effect on the course of Parkinson's disease in those patients but it is only very limited. As reported previously in the *Bulletin* (Jan. 1988 and Jan. 1989), Dr. Ignazio Madrazo of Mexico City claimed dramatic success in reducing the effects

of Parkinson's disease when patients had tissue transplanted from their adrenal glands into their brains (adrenal glands produce dopamine, a "message carrying" chemical; the portion of the brain that produces dopamine is destroyed by Parkinson's). Dr. Madrazo also claimed success with implantation of fetal tissue into Parkinson's patients, a claim that has since been refuted by physicians in the U.S.

In the latest study, Dr. Christopher Goetz reported in the *New England Journal of Medicine* that "all of the patients in our group have said they felt [the surgery] was worthwhile, but in no case has it achieved what they hoped it would." As Parkinson's progresses, it lessens the effectiveness of drugs used to control symptoms of the disease, such as tremors and difficulty with physical movements. Before the surgery the drugs worked about 50% of the time; after the surgery, Goetz reported, the drugs had an effect about 75% of the time.

FDA responds to calls for quicker AIDS drug approval

The Food and Drug Administration, smarting under criticism that it has responded slowly in approving drugs used to combat AIDS and AIDS-related illnesses, announced several policy revisions:

—The FDA began a two-year project to update research guidelines for drug manufacturers in order to speed the approval process for new antibiotics. According to the director of the project, pharmaceutical companies often submit inadequate information with the approval applications, lengthening the time required for approval. The testing guidelines have not been updated since the mid-1970s, and the approval process can take as long as 10–12 years.

—In light of loud protest from physicians and representatives of AIDS patients, the FDA is rethinking its request for more research before approving an AIDS drug. The drug, gancyclovir, is the only drug currently available to treat a kind of infection that eventually afflicts most AIDS patients. The infection frequently causes blindness as well as severe intestinal damage, and many physicians believe the drug to be extremely effective in preserving sight, even though the manufacturer applied for approval on the sole basis of clinical experience rather than the kind of controlled trials required by the FDA. (The drug has been available free to many patients through an FDA rule allowing "compassionate use" of unproved drugs for certain kinds

"I know I'm clean and I think someone I meet in a nice spot like this is clean, too. Maybe I'm indestructible."

"Hormones are hormones, whether it's 1959 or 1989. People who go out to get picked up will get picked up. Absolutely."

"Nobody has stopped, and nothing has changed. I don't think there's been any curbing of behavior whatsoever."

—Quotes from a *NYTimes* article on how the AIDS epidemic has not affected the social behavior of "well-dressed professionals" who meet after work at SfuZZi and similar bars in Manhattan



of serious illnesses.) FDA Commissioner Frank Young was reportedly considering a conditional interim approval of the drug, which would still have to undergo controlled testing to confirm dosage amounts, scheduling, and the like.

—The FDA announced it was granting conditional permission for physicians to distribute an experimental aerosol drug used to fight a strain of pneumonia that frequently afflicts AIDS patients. Doctors who agree to participate in a research program aimed at eventual formal approval of the drug will be permitted to prescribe pentadimine, which fights the organism responsible for the strain of pneumonia that is common in AIDS patients but very rare in the general population.

Another federal agency, the National Institutes of Health, announced that it is making an experimental drug treatment available to all employees who risk occupational exposure to the AIDS virus. NIH employees who are exposed to the virus on the job will start receiving injections of AZT, the only FDA-approved drug for fighting AIDS. Some experts believe that quick ingestion of the drug can prevent the virus from entering cells and reproducing.

Approximately 100 AIDS researchers worldwide have become accidentally infected with the AIDS virus, including three employees at the National Institutes of Health.

New York physicians administer cocaine treatments despite warning from medical society

An 89-year-old physician is at the vanguard of a controversy on whether physicians should be permitted to use cocaine to control pain in patients. Dr. Milton Reder says that he has used a 10% solution of cocaine for certain afflictions since the 1930s and he vowed to continue the treatment even though the state medical board has threatened to revoke his license. Reder has been one of 20 New York physicians who used the treatment, but after the health department's Bureau of Controlled Substances declared that other drugs were equally effective, most of the doctors discontinued the treatments. Although Reder charges only \$25 per treatment and says he has never had a patient who got high or became addicted to cocaine, the state health department claims that some physicians charge as much as \$500 per treatment and some patients return for treatment every day.

Chicago funeral home offers video visitation

Taking a cue from drive-in banks, restaurants, and movie theaters, a Chicago funeral home now offers drive-through visitations so that friends of deceased persons can "view" the body on a TV screen without leaving their cars. The innovation was the brainchild of Lafayette Gatlin, owner of the Gatlin Funeral Home, who says that in his previous occupation as a construction worker he would get embarrassed coming to visitation in his dirty work clothes.

Visitors pull into the drive-through area and push a button to specify which body they want to see on the closed-circuit TV monitor. After signing a "conveniently mounted" guest register, guests pull ahead to the 25-inch monitor, where a "head shot" of the deceased is displayed for several seconds. By pushing a button, visitors can make the image reappear on the screen, and the funeral home operator reports that some visitors repeatedly press the button, lingering to look at the picture for as long as a half hour. Although drive-through funeral homes displaying the body in a window have existed before, the Gatlin home is the first to employ a complicated system of relays, cameras, switches, and timers to permit viewing of as many as 12 different bodies. That feature, for which Mr. Gatlin is seeking a patent, worries more traditional members of the funerary industry. "You could have the curious going through and checking out whoever happens to be laid out today," the president of the Illinois Funeral Directors' Association told the *New York Times*.

However, Gatlin, with characteristic entrepreneurial flair—he rents out the chapel for weddings on slow days and sells sympathy cards and flowers to forgetful mourners—believes his high-tech system permits viewing of the body by many who might otherwise stay away.

For example, he said, when the deceased had both a wife and a girlfriend, the wife can stay inside with the mourners while the girlfriend can pay her respects at the drive-through. In a different application, a recent funeral featured a vanload of the decedent's friends, each of whom was confined to a wheelchair and thus unable to attend the funeral. Although the van had to make two trips through the drive-through—one in each direction so that people on both sides of the van could see the body—it was a big hit all around. "It was like watching a good picture on television," a family member of the deceased reported to the *New York Times*.

AIDS is the leading cause of death for women aged 15-24 in New York City.

Source: *Commonweal*



MARCH

State and local governments begin composing lists for rationing health care to the poor

Several governments in the U.S. responsible for spending public funds on health care for the poor are explicitly spelling out priorities for allocation of those resources. The decisions being made are often agonizing for legislators and promise to cause widespread controversy.

According to the *New York Times*, the state of Oregon has decided that "prenatal care for a woman ranks higher than an organ transplant for a dying child, the elderly need bunions removed before teenagers are taught the dangers of drug abuse, and having a single physician supervise a patient's care is vital while dental work is not." The two largest jurisdictions to consider this listing of priorities are the state of Oregon and Alameda County in California, which includes the city of Oakland. Dr. John Golenski, a Jesuit priest who runs the Bioethics Consulting Group in Berkeley, California, is the architect of both the Alameda County and the Oregon rankings.

The creation of such lists makes many Americans uncomfortable, experts say, because although most citizens are aware of subtle health care rationing, spelling out priorities in list form seems "so black and white" and almost cruel in its implications. Lawmakers argue that since resources are limited, their allocation should be spelled out in advance to prevent inconsistency and inequality. To counter charges that its plan uses the poor as "guinea pigs," the Oregon legislature would tie the priority list to a program guaranteeing health care to 100% of the state's poor and would require constant reassessment of the medical priorities.

The *New York Times* spoke to participants drawing up the Oregon list, which has not yet been finished or released to the public, and found that "priority has been given to prenatal care, disease prevention, and the treatment of chronic and acute disease." The Oregon bill is expected to have some sort of "prenatal care package" that includes transportation vouchers, child care, and nutritional support for pregnant women. Also high on the list are said to be "services that improve the quality of life for the elderly, like treatment of bunions and home nursing," while low-priority items include death

delaying measures for terminal patients, most organ transplants, dental care, plastic surgery, infertility services, and drug abuse education programs, "which participants of the focus groups considered crucial until they reviewed data that showed them to be ineffective."

Medical ethicists around the country seem to agree that the Oregon and Alameda County rankings are the wave of the future, because allocation decisions are increasing in frequency and importance, and central planning permits more public participation and is more equitable than resolving allocation dilemmas on a case-by-case basis.

Supreme Court won't overturn ruling on hospital chaplain

The U.S. Supreme Court let stand a lower court decision on the right of a public hospital to use public funds for the services of a chaplain. The largest county hospital in Iowa hired a Protestant chaplain at \$23,000 a year after failing to persuade enough local ministers to volunteer for the role. An avowed atheist charged that the hiring of the chaplain violated the principle of separation between church and state, but the Eighth Circuit Court in Iowa did not disallow the chaplain's employment, and the U.S. Supreme Court let the circuit court's decision stand.

Senate approves HHS nominee after lengthy abortion controversy

The U.S. Senate voted to approve Dr. Louis Sullivan as Secretary of Health and Human Services after he clarified his stance on abortion to the satisfaction of antiabortion legislators. Sullivan, president of Morehouse College School of Medicine in Atlanta, had come under fire for reportedly telling an Atlanta newspaper that women should be free to have abortions (see *Bulletin*, Jan. 1989). Sullivan subsequently stated his opposition to abortion except in the case of rape, incest, or when the mother's life was threatened, and he favored federal funding of abortion only when the mother's life was threatened. Except for these three circumstances, in fact, Sullivan said he supports a "human life amendment," which would place a constitutional ban on abortion. Many antiabortion critics still were not satisfied with Sullivan's position, and he reportedly underwent simulated Senate hearings in which he was challenged with tough abortion questions while sitting under bright lights.

The highest paid lobbyist in the U.S. works for the American Medical Association. He makes \$698,000 per year.

Source: *National Journal*, 2/18/89, p. 410



The issue of using fetal tissue in research also came up during the hearings (fetal tissue is of interest to physicians because of its regenerative capabilities, but antiabortion groups contend that using tissue from intentionally aborted fetuses is unethical and could increase the number of abortions). Sullivan refused to commit himself completely on the issue, stating his opposition to aborting specifically to obtain tissue for research but saying he would await a National Institutes of Health report before deciding on the ethics of all forms of fetal tissue use. "Blanket prohibitions are very dangerous," Sullivan told the Senate Finance Committee, which approved his nomination 19-0 before sending it on to the full Senate. The Senate approved Sullivan by a vote of 98-1, with antiabortion North Carolina senator Jesse Helms the lone dissenter.

At HHS, Sullivan will direct a \$400 billion budget, more than one-third of the entire annual federal budget.

California approves drastic measures to improve air quality, public health

Acting to fight the worst urban air pollution problem in the U.S., officials in southern California approved a sweeping set of measures that will cost billions of dollars, change the nature of thousands of jobs, and affect the life style of almost everyone in the region. The three-phase plan, which awaits approval by the state Air Resources Board and the Environmental Protection Agency, was designed to head off imposition of even stricter federal controls after a court last year ruled that the federal government should step in if the region does not get its own house in order. "Southern California, as a world economic power and a model of ethnic diversity, will enter the 21st century known for its commitment to public health," predicted the director of one regional air quality program.

If approved, the air quality measures would drastically affect the daily lives of most Los Angelenos, who are accustomed to relying on the automobile. Among the auto-related regulations are virtual elimination of free parking and increased parking fees for cars that only carry one person, limits to the number of cars each household may have and increased fees for citizens with more than one car; elimination of the sale of bias-ply tires (which throw more rubber particles into the air) in favor of radial tires, and most drastic of all, the steady conversion of all vehicles to alternative fuels by the year 2007.

Auto industry experts claim that the plan is unrealistic because the requisite technology isn't there and it would raise the price of cars to unacceptably high levels. (The middle phase of the plan would require converting 40% of all cars and 70% of all freight vehicles and buses to methanol and other clean fuels by 1998; the third phase would ban all gasoline-powered vehicles by the year 2007.)

The first phase of the plan will immediately affect some industries: laws requiring reformulation of paints and solvents will quickly change the way business is done in auto, furniture, and house painting and refinishing businesses. Other short-term changes include a ban on all gasoline-powered lawn mowers and a total ban on the use of lighter fluid.

Cost estimates of the new plan vary widely, with industry critics of the proposal projecting much higher costs than the air quality control groups who devised it. Opponents of the plan say that the first phase alone will cost the average household an additional \$2,200 per year; proponents claim an annual cost of only \$220 and benefits worth \$600 per year. One independent study estimated that 52,500 jobs would be lost under the new programs, but the air quality board estimates creation of 80,000 new jobs.

Tobacco company stops production of "smokeless" cigarette

The R. J. Reynolds Tobacco Company halted test marketing of its new "smokeless" cigarette, citing decisive consumer rejection of the product. The new "Premier" cigarette, on which R. J. Reynolds spent more than \$300 million on development and marketing, was characterized by one industry analyst as having an "unacceptable taste and an unacceptable smell" and "you needed a blowtorch to light it."

R. J. Reynolds owns about one-third of the domestic cigarette market, which has been declining overall by about 1.8% a year for the past several years. The company apparently had high hopes for Premier, which promised a "cleaner enjoyment" for smokers while producing a smaller amount of smoke to which nonsmokers might object. A spokesperson for RJR said that the company did not consider the cigarette "to be a failure" and although Premier was being dropped, the company would continue research on a smokeless cigarette.

Although Reynolds never claimed the Premier was "safer," the product drew ardent

Health care expenditures per capita (1986):

Japan:	\$ 831
West Germany:	\$1,031
Sweden:	\$1,195
Canada:	\$1,370
U.S.:	\$1,926

Source: NEJM 319(1988): 807



protests from various health groups. Premier looks like a normal cigarette, but instead of burning down its entire length only a small piece of carbon at the burning end is ignited. When the smoker inhales, the hot air is sucked through rolled tobacco surrounding an aluminum "flavor capsule" containing nicotine and various flavorings. The cigarette was done being smoked when the charcoal was consumed, not when it was burned down to only a butt. It was sold in four-packs and bundled with a lighter and a container to hold used cigarettes.

Surgeon General C. Everett Koop had labeled the product a "drug delivery system" and requested regulation by the Food and Drug Administration rather than the less strict Bureau of Alcohol, Tobacco, and Firearms. A coalition of health groups petitioned the FDA to classify Premier as a drug, and still other groups charged that RJR's claim that the new cigarette was "cleaner" would be interpreted by many consumers to mean that it was "safer." Analysts discounted suggestions that a cash crunch brought on by the recent \$25 billion takeover of RJR-Nabisco was responsible for Premier's withdrawal. "The test markets were so bad it didn't matter who owned the company," commented one industry analyst.

Court upholds Catholic University's right to dismiss Fr. Curran

The judge of a superior court in Washington, D.C., ruled that Catholic University of America was not bound to retain Rev. Charles E. Curran, who was suspended in 1986 after the Vatican declared him ineligible to teach Catholic doctrine. Curran, 54, had sued for the right to teach because he was a tenured professor at the university, but the judge declared that as a university of the Catholic Church the school could choose between academic freedom and fealty to the Holy See.

Curran ran into trouble soon after he began teaching at Catholic University in 1967: many tried to have him removed from his professorship for his liberal teachings on contraception. However, he was tenured in 1971. In 1986 the committee of the Vatican that monitors doctrinal orthodoxy censured Curran for his disagreements with the Vatican on a variety of sexual and medical matters, including homosexuality and birth control. Curran contended that Catholic University should have followed American practice in allowing a faculty member's peers to judge his fitness as a professor, but the judge

ruled that universities of the church had a right to operate under different rules.

Curran, who is presently teaching at the School of Religion at the University of Southern California, said that he will not appeal the decision. "I have fought for academic freedom at Catholic University for more than 20 years," he said, "[and] I have lost. As far as I'm concerned, this was the last battle."

French scientist claims to have transplanted tissue into a fetus

A scientist in Lyons claims to have transplanted fetal tissue into a fetus in what many experts say is the first successful human prenatal tissue graft. The fetus was suffering from a genetic immune system deficiency that killed an earlier child born to the same mother several years ago. The researcher who performed the transplantation, Dr. Jean-Louis Touraine, said he injected about 16 million liver and thymus cells into the 28-week-old fetus's umbilical cord with the aid of a sonogram. The baby is now seven months old, and though he is still in a sterile plastic "bubble" to protect him from infection, Dr. Touraine claims that the baby is more resistant to disease than he would have been without the transplants and is expected to be out of the bubble within two months.

Scientists elsewhere lauded the operation pending confirmation of Dr. Touraine's claims, although some said they saw no reason not to wait until birth to transplant the cells. Researchers believe that such "in utero" grafts could help fight numerous blood disorders, including severe combined immunodeficiency and sickle cell anemia.

Children's health advocacy group sees serious decline in health of U.S. youth

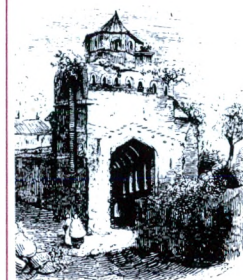
The National Association of Children's Hospitals and Related Institutions issued a report warning against the danger to U.S. youth from AIDS, child abuse, inadequate immunizations, and inadequate medical insurance. The group called for increased federal funding through expanded Medicaid coverage to combat these problems.

The report renewed concern that federal spending is unevenly skewed toward caring for older Americans at the expense of children. Representative Patricia Schroeder told the *New York Times*, "When you look at the Federal dollar and how it's spent on medical care, a very high percentage of it is spent on the last few days of

"To the editor:
...In [the past three months], 13 patients ranging in age from 12 to 19 years were admitted to the Georgetown Surgical Division of the District of Columbia General Hospital with isolated gunshot wounds in the lower extremities. Twelve either admitted to or demonstrated the stigmata of involvement in the drug trade (e.g., large sums of cash, beepers, and portable phones) and four required major vascular reconstruction procedures.

"Children as young as eight years of age are now recruited to play a part in the distribution of illicit drugs. The injuries we report here are considered by the perpetrators as unlikely to be fatal or permanently incapacitating and may be viewed as symbolic punishment for runners who do not perform as expected."

Source: Letter to the *New England Journal of Medicine*



someone's life. It should not be either/or, and you should not pit one age group against another. But we've totally ignored one age group: children."

Among the findings of the report:

—The number of uninsured children in the U.S. increased approximately 13% in the past five years, to a total of 12 million.

—Though the number of people living below the poverty level increased by a third in the last decade, Medicaid is serving 400,000 fewer children.

—Seven million children do not receive routine medical care; only 60% of children under the age of four have received the complete basic series of immunizations.

—Reported deaths from child abuse and reported cases of children with AIDS are both rapidly increasing. Both Congress and the president have called for increasing Medicaid funding to reach poor women and children whose income is around 125-130% of the federally designated "poverty level," rather than keeping the required minimum at 75% where it is now.

The hospital group that prepared the report represents about 100 hospitals in North America. The report "Profile of Child Health in the United States," is available for \$20 from the National Association of Children's Hospitals and Related Institutions, 401 Wythe Street, Alexandria, Virginia 22314.

Bishops to Pope: Blame U.S. society, not Vatican rules

American archbishops in the Vatican for a four-day "summit meeting" with Pope John Paul II told the pontiff that American society was responsible for disagreements over their roles as teachers. The meeting was billed as an opportunity for American bishops to voice their disagreements with the Vatican, but according to observers most of the discussion centered around compromises that must be made in the face of societal realities such as a more liberal culture, aging congregations, and a shortage of priests. Rev. Robert Lynch, the Catholic Conference observer of the meeting, said that the 34 archbishops said they were willing to "compromise to resolve differences in their pluralistic society, but would not compromise on major articles of faith." Religion editor Michael Hirsley of the *Chicago Tribune* noted that the bishops "complained that their roles as teachers were hindered by such cultural phenomena as the sexual revolution and changing attitudes on what con-

stitutes sin; heightened priorities of science, technology, and social sciences such as psychology over religion, instability of families, and certain aspects of feminism."

Medical school applications increase after years of decline

Medical school applications are up for the first time in seven years, according to the American Association of Medical Colleges. Although the increase was only 1%, medical school officials were cheered because it was the first increase since 1982.

Spokespersons for the AAMC cautioned that it would take a couple of years to see whether the increase is part of a trend or represents a single-year aberration. The number of applications began declining in the mid-1970s, falling from 42,624 in 1974 to 25,377 in 1988. There is no clear cause for the decline, although experts suggest that some factors were projections of a surplus of doctors by 1990, more lucrative opportunities in business careers, damaging and expensive malpractice litigation, and high tuition at U.S. medical schools.

Similarly, medical educators were hard pressed to explain why applications may be on the rise. Some speculated that the increase can be tied to several states' capping of malpractice awards, while others cite less strenuous residencies or even public relations efforts to "make the public aware that careers in medicine are possible and not just for the superstars," said a vice-president for the AAMC.

There was a small rise in the number of women and minority applicants and an 11% rise in Asian applicants.

Pediatric association solicits member donations to help children

All 37,000 members of the American Academy of Pediatrics are being asked to contribute \$100 each to support a national "partnership" aimed at improving infant and child health in the U.S. The program, Partnership for Children, is a coalition of federal, state, and local organizations which will use both private and public funding to finance 10 projects per year. The academy hopes to raise the level of private funding to the point that the partnership programs could continue even if public funds were cut off. The academy is basing its model of public-private partnership on the work of Irving B. Harris, the Illinois businessman whose Beethoven Project

Percentage of American doctors who disclosed cancer diagnoses to patients

in 1961:	10
in 1970:	25
in 1977:	97

Source: JAMA, Psychiatry in Medicine



and Ounce of Prevention Fund were nationally copied programs for supplying inner city citizens with childhood medical and nutritional care and prenatal care.

The academy is inviting its members to contribute suggestions for the 10 projects, which are "designed to meet children's health needs in the communities where they live," according to the executive director of the academy. The U.S. infant mortality rate is 10.6 deaths in the first year for every 1,000 births, which puts it 19th among industrialized countries. The former president of the academy termed this rate "atrocious" and said that although it is a national "social" problem, local medical professionals can help by increasing access to community-based health services for infants and pregnant women.

Chickens help in fight against cancer

A cancer researcher at the University of Southern California uses chickens to study oncogenes, genes that can contribute to the growth of cancer. Two years ago the chicken research paid off when the research team located an important new oncogene that apparently "switches" certain genes on or off, a discovery that helped the cancer researcher win a \$50,000 prize for distinguished research.

Unlike most animal researchers, however, the scientist, Dr. Peter Vogt, does not raise his research subjects in the laboratory but gets them instead from a Los Angeles slaughterhouse that inspects the insides of more than 30,000 chickens per day. Tumors don't appear often in the slaughtered chickens—only in about three or four per million—but when one is found Dr. Vogt gets it for his research. Why chickens? "There is no other vertebrate animal that is autopsied in these numbers," Vogt explained.

Supreme Court extends definition of religious freedom

The U.S. Supreme Court has ruled unanimously that people who identify themselves with a general faith are entitled to the same freedom of religious expression as those who identify with a particular church. The court ruled in favor of an Illinois man who identified his faith only as "Christian" in his rejection of a job that would have required him to work on Sundays. The state of Illinois denied him unemployment compensation, claiming that his principle was not dictated by the tenets of his church, and the Illinois Appellate Court upheld that decision,

declaring that refusals to work on holy days must be grounded in "a tenet or dogma of an established religious sect." The Supreme Court, however, overturned the ruling. Admitting that membership in an organized denomination would make such cases easier, and noting that states had a right to reject claims that were not sincere or were "bizarre or incredible," the court nonetheless dismissed the appellate court's suggestion that widespread refusals to work would cause "chaos" in the economy.

The individual involved in this case, William Frazee, currently attends a Presbyterian church and in the past has been Congregationalist and a Baptist (none of these three faiths require Sabbath observance). Numerous religious groups filed briefs on Frazee's behalf, including evangelical Christian and Jewish representatives. The Anti-Defamation League of B'nai B'rith, for example, suggested that even though a third of American Jews are not formally members of any branch of Judaism they should still have the right to observe Jewish holidays as they please.

Care providers debate ethics of nutrition therapy for AIDS patients

Increasing numbers of U.S. AIDS patients are turning to nutrition therapy, prompting questions about the ethics of providing the very expensive treatments for patients who will soon die. According to an article in the *New York Times*, some physicians say they fear an insurance crisis if too many patients turn to total parenteral nutrition (TPN), which costs \$200-\$500 per day, while others assert that TPN's ability to prevent patients from "wasting away" provides important psychological comfort to patients who know they are dying.

Traditionally, parenteral nutrition has been used to sustain patients who weren't terminally ill, helping them get their weight back until their body was strong enough to maintain the weight. The AIDS epidemic represents the first widespread use among patients who are virtually certain to die. The therapy consists of a permanently implanted catheter near the heart into which a highly concentrated solution is pumped for 8-12 hours per day. Patients who have lost a significant amount of weight (e.g., one man's weight dropped from 157 to 97 pounds in one month) may require nutrition around the clock. Moreover, many question whether the quality of life while on TPN justifies the expense. Some physicians and patients reject it because it's an admission of the seriousness of the disease;

Percentage of Americans who feel AIDS can be contracted from:

mosquitoes and other insects:

32

getting coughed or sneezed upon:

25

a drinking fountain:

22

a swimming pool:

21

a toilet seat:

20

sharing a locker:

13

sharing a telephone:

12

household pets:

11

jointly handling money:

10

shaking hands:

8

Source: NEJM



others find being tied to an invasive catheter and its attached tube to be excessively burdensome. "It's like being hooked up to a respirator," one patient says.

Although Medicare and Medicaid often do not pay the full cost of TPN, most private insurers do—up to a point. According to the *Times*, "even when initial coverage is not at issue, the therapy is so expensive that it has drained some patients' insurance, even their major medical coverage."

U.S. loosens methadone restrictions for addicts to curb AIDS spread

Two federal agencies proposed making methadone available to all heroin addicts on waiting lists for drug treatment rather than requiring them to first enroll in a program. The Food and Drug Administration and the National Institute on Drug Abuse made the change in response to increased spread of AIDS through needles that are shared among drug addicts. Methadone is by far the most effective replacement for heroin addiction; it, too, is addictive but does not produce a "high" like heroin does.

Some critics of the policy revision worried that the small dent it might make in preventing the spread of AIDS would not be worth the damage it could do to addicts who would bypass treatment programs and the accompanying support and counseling.

New York company hires only workers with AIDS

A new office service company in Manhattan has been established to provide jobs for persons with AIDS. The new firm, Multitasking Systems, Inc., was formed by a hematologist at New York University Medical center, Dr. Linda Laubenstein, who also serves as its president. Laubenstein says she got the idea for the company when she realized how important a job is to self-image and daily purpose—and then saw her AIDS patients losing their jobs because of the attitude of their employers or because the tasks were too demanding.

Multitasking Systems is a nonprofit company that receives a small stipend for each worker-day from the New York Office of Vocational Rehabilitation, which subsidizes companies that hire the hard-to-employ. The services performed include photocopying, word processing, desktop publishing, facsimile, and other office services. Employees are paid \$7–\$12

per hour and generally work 20–25 hours per week. Ten people have been hired so far, and company administrators hope to have four times that many working by the end of 1989. "We got 225 responses (to employment ads) ranging from drug abusers who had never worked at all to two medical doctors who themselves had AIDS," the executive director of Multitasking Systems told the *New York Times*.

The company has had no trouble finding new clients, either, many of whom are people looking to provide work for AIDS patients. "One man with a large communications business called to say he wanted to hire someone with AIDS, but he asked us not bill him for the \$50 fee," executive director Michael Weisberg said. "We asked why not, and he said 'I have AIDS myself, and I know someone with AIDS can be productive. But my company must not know about either of us.'"

Supreme Court to consider religious use of hallucinogen

The U.S. Supreme Court agreed to hear a case of the state of Oregon versus two Native Americans who used the hallucinogen peyote in religious ceremonies. The two men were fired from their jobs at a county drug and alcohol counseling center after they used peyote, which is made from cactus and contains the hallucinogen mescaline. The state has denied unemployment compensation to the two men. All sides in the case agreed that the men believed peyote to be part of the Native American church's religious rituals, and a spokesperson for the pair said peyote occupied the same place for Native Americans as wine did in worship services for Christians. The Oregon State Supreme Court, however, denied that religious use of peyote was a constitutionally guaranteed exception to the state's drug enforcement laws.

U. S. debates China's abortion, sterilization policies

Members of Congress and the Bush administration are scrutinizing a United Nations plan to control population growth in China to make sure the program will not support efforts to force women to have abortions or undergo sterilization. The U.S. has not given any money to the United Nations Fund for Population Activities, the world family planning agency, since 1985, when the Reagan administration and Congress withdrew support under pressure from anti-

Percentage of Americans who object to working with people who don't use deodorant:

38

Percentage of Americans who object to working with people who have AIDS:

34

Source: *Hippocrates*, Sep./Oct. 1988, p. 16



abortion groups who charged that the U.N. group aided Chinese programs for mandatory sterilization and abortion. The U.S. funds were sent to other nations, and other developed countries increased their donations to compensate for the loss of the U.S. funds.

China has serious overpopulation problems, with a fifth of the world's people but only 2% of the earth's usable farmland. The Chinese government has declared a goal of stabilizing its population at around 1.2 billion by the year 2000. Outside observers, however, note that the one-child-per-couple policy has had only limited effectiveness—the average family still has 2.58 children—and suggest that the 1.2 billion figure is unrealistic.

The head of the U.N. population committee says that when she visited China in January, the government there admitted that there had been some forced abortions but that these were the fault of "overzealous" local family planning groups and did not conform to the official voluntary abortion policy. Under a law passed at the time of the U.S. funding cutoff in 1985, if China is found to be continuing forced abortions, the money will not be contributed. American anti-abortion forces are gearing up for the congressional debate, claiming the Chinese population program does in fact require abortions and sterilization.

AIDS group to import unapproved drugs into U.S.

A New York-based organization plans to circumvent traditional routes of drug procurement and directly import AIDS medicines that have not been approved by the Food and Drug Administration. The group, People With AIDS Health Group, is responding to AIDS patients' protests that the FDA has been slow to approve for sale in the U.S. drugs that could help alleviate symptoms and slow the progress of the AIDS virus. Foreign doctors will be enrolled to aid in the importation program, which will be available to any AIDS patients in the U.S. who have a prescription from a physician.

The People With AIDS Health Group is taking advantage of a 1988 FDA policy change under which Americans with life-threatening illnesses are permitted to import unapproved drugs for personal consumption. The new program is unique in that it is the first to obtain prescription drugs instead of over-the-counter medicines, and it is the first to set up a network of physicians in other countries who have

agreed to send the requested drugs. American physicians say there are a number of drugs AIDS patients want, especially fluconazole, a drug manufactured by Pfizer, to fight a strain of meningitis that afflicts about one in every eight AIDS patients. Fluconazole is available in most other countries and is still undergoing testing in the U.S.

Insurance coverage for drugs obtained through the program remains a question mark, however, as most American insurance companies will not pay for drugs that have not been approved by the FDA.

Judge: Michigan should not fund abortion for 15-year-old gang-rape victim

A judge in Detroit supported the constitutionality of a referendum approved by Michigan voters last November that cut off all funding for abortions except in cases where the mother's life is in danger. The specific case involved a 15-year-old girl who was gang-raped in January and whose family was on public assistance and unable to pay for an abortion. The American Civil Liberties Union, which had represented the girl in court, had also asked the judge to rule that the ban on public abortion funding discriminated against blacks, who make up the majority of Medicaid beneficiaries in the 13-40 age group. The judge rejected this motion.

The ACLU said that in this case there had been a private outpouring of support for the girl, and contributions would be turned over to her for use at her discretion. Michigan had averaged Medicaid expenditures of about \$6 million annually on approximately 18,500 abortions before last November's referendum.

New Jersey task force opposes even unpaid surrogacy contracts

A New Jersey state task force drafting legislation to regulate surrogate motherhood contracts is opposing surrogacy "in any form," even unpaid arrangements between friends and relatives. The task force is not seeking to outlaw all surrogacy contracts, but rather to make such contracts unenforceable in court. Policymakers across the country are watching the resolution of the issue in New Jersey, which was the site of the famous "Baby M" surrogacy case in 1988. Florida, Nebraska, Kentucky, Michigan, and Louisiana have banned commercial surrogacy contracts; Indiana will not uphold them in court, and Nevada has said they are permissible.

Room costs for an average hospital stay

in Washington, D.C.
(7.8 days):

\$3,451.58

in Mississippi
(6.8 days):

\$955.40

U.S. average
(7.2 days):

\$1,817.14

Source: USN&WR
(data from AHA)



Number of caesarean deliveries in the U.S. in 1970:

195,000

Number of caesarean deliveries in the U.S. in 1980:

877,000

Source:
U.S. Census Bureau

Surrogacy brokers, who are usually paid \$7,500 to arrange a contract between biological mothers and adoptive parents, report that their business is as strong as ever. Noel Kean, the attorney who arranged the contract that was at issue in the Baby M case, said that last year's court decision to ban commercial contracts "has done nothing except make New Jersey couples leave New Jersey and travel farther and spend more money."

The New Jersey task force reportedly had been open to noncommercial contracts, but a minority of the panel opposed to all surrogacy contracts convinced the majority to go beyond the court decision and oppose all contracts—even those between family and friends. One task force member worried about the "not-so-bright cousin" being exploited to bear a child for a relative.

Medical College Admissions Test to change to encourage general studies

Officials at the American Association of Medical Colleges announced drastic changes in the Medical College Admissions Test (MCAT) in response to criticism that the current test over-emphasizes rote memorization of scientific and mathematical facts. The new test, which will be introduced in 1991, will be more than an hour shorter than the 9½-hour version now used and will feature only four sections instead of six. The changes in the test are designed to encourage pre-med students to balance their education with more general studies in natural sciences, social sciences, and the humanities, and will include verbal reasoning and a writing sample. "Pre-med students spend their entire lives before medical school filling in little boxes but not developing great communications skills," an AAMC spokesperson explained. "We would prefer them to spend their time developing their abilities in problem solving, critical thinking, and communications."

New HHS chief Sullivan supports free needle programs to fight AIDS

Dr. Louis Sullivan, Secretary for Health and Human Services, endorsed programs whereby communities provide free hypodermic needles to drug addicts as long as the decision to have such a program is approved locally. New York is the only American city to institute a free-needle program. Such programs are designed to reduce the spread of AIDS through sharing of con-

taminated needles. Minority group representatives have objected to such programs on the grounds that government-sponsored distribution of free hypodermic needles constitutes an endorsement or legitimization of drug abuse, especially among blacks and Hispanics (Sullivan is the highest ranking black in the Bush administration).

Sullivan, a blood specialist and former head of the Morehouse School of Medicine in Atlanta, said that if such programs can be effective in reducing the spread of AIDS, "they deserve a chance for an appropriate trial." He said that he did not support a federal needle distribution program, but could foresee federal training and instruction to help communities set up such programs.

Success rate of in vitro clinics varies greatly, new study shows

A congressional study found large differences in the success rates of in vitro fertilization clinics—and numerous cases of misrepresentation of those success rates. Nationwide, 165 clinics that perform the in vitro procedure responded to the survey and reported an average success rate of 11%. Experts said the figure seemed accurate and was not as "unsuccessful" as it sounded, because even "reproductively normal" couples have only a 20% chance of establishing a pregnancy after trying for a month. The highest success rate reported was 48%, at the Medical College of Virginia, which has one of the nation's oldest IVF programs. Several clinics reported a zero success rate, but most of these had been in business only a short while.

Rep. Ron Wyden, the Oregon Democrat who chairs the subcommittee looking in to the IVF industry, suggested that if the industry didn't standardize its reporting and advertising methods, government regulation would be necessary. Some clinics reported the number of pregnancies started rather than the more useful (and lower) figure for live births. Experts also cautioned that success percentages don't tell the whole story: one California clinic with an apparently low success rate actually specialized in referrals of couples that other clinics had been unable to help, so its 9% success figure was actually fairly good. The director of that clinic urged other centers to explain the meaning of all their own figures so that couples shopping for an IVF clinic could make an informed choice.



APRIL

Florida court upholds Jehovah's Witness

The Florida Supreme Court ruled 6-1 that religious freedom takes precedence over medical treatment and a Miami woman who is a Jehovah's Witness should not have to have blood transfusions, which conflict with her religious beliefs. Jehovah's Witnesses reject transfusions because of a passage in Leviticus: "Whatsoever man eats any manner of blood, I will cut him off from among his people." The justices agreed with physicians who claimed that the woman, who was suffering from uterine bleeding, probably would have died had she not received the transfusions in 1986 (against her wishes, under a court order) and said its ruling did not condone suicide.

Because the woman may face the same situation again, the court regarded the case as more than an academic exercise; Jehovah's Witness transfusion cases often do not go to court until long after the fact. The Miami woman has stated in writing her strong objection to more blood transfusions if the uterine bleeding recurs.

Experts divided on home AIDS tests

Although a number of manufacturers and many members of the general public seem to think home AIDS tests are a good idea, the FDA, AIDS support groups, and mental health professionals are resisting the marketing of such products. At issue is the question of whether those who find they are infected would obtain adequate counseling. Critics also voice concerns about confidentiality, accuracy, and safety. Proponents argue that a properly run, well-organized home test would be more convenient, economical, and confidential than comparable tests performed in clinics and thus would encourage more people to get tested. They argue that telephone counseling works very well (all of the products suggested to date involve drawing blood at home and mailing it to a lab, after which the consumer may obtain the results by mail or phone). However, a gay issues activist who does AIDS counseling responded, "So they anonymously phone in for results. You tell them it's positive. Click—they hang up the phone. Then what do you do? You have to keep the line of communication open or they may run off and do something drastic like suicide." Results of AIDS tests are currently given in person by counselors who can help those who test positive cope with the news and steer them to additional counseling and social services.

Supreme Court hears Missouri abortion case

On April 26, the United States Supreme Court heard the case of *Webster v. Reproductive Health Services*, the most far-reaching abortion case considered by the nation's high court since the landmark 1973 *Roe v. Wade* decision that gave U.S. women the right to legal abortions. A decision is expected by mid-summer.

Even though the Supreme Court is ostensibly not influenced by public opinion, both antiabortion and prochoice groups across the U.S. did extensive campaigning in the weeks leading up to the Supreme Court hearing. Several hundred thousand prochoice demonstrators marched on Washington the second weekend in April, and antiabortion groups stepped up their "Operation Rescue" sit-ins at abortion clinics across the U.S. (A discussion of the recent abortion debate appears in the "Letters & Comments" section on page 46 of this issue.)

The Missouri law considered by the Supreme Court contained several sections that had been struck down by lower courts, including declarations that "the life of each human being begins at conception," and that "unborn children have protectable interests in life, health, and well-being." Several other requirements in the Missouri law that were struck down by lower courts included stipulations that abortions performed after 16 weeks' gestation must be performed in a hospital; that physicians perform viability tests before aborting any fetuses more than 20 weeks old; that public hospitals and personnel may not perform abortions that are not required to save a woman's life; and that public funds may not be used "for encouraging or counseling a woman to have an abortion not necessary to save her life."

The Supreme Court may confine its decision to the specifics of the Missouri law, or it may treat the case as an opportunity to endorse, reverse, or revise the *Roe v. Wade* decision.

In the April 26 hearing, the prochoice side was argued by Frank Susman, a St. Louis lawyer who represented the abortion clinic named in the case. The antiabortion arguments were split between William Webster, the Missouri attorney general (whose name was given to the case when he prosecuted the clinic named "Repro-

Women in China get two weeks' paid leave after they have abortions.

— From an article on RU-486 ("the abortion pill"), which noted that the drug could save the Chinese government millions of workweeks per year. (China performs more abortions than any other country: 11.5 million annually.)

Source: *USN&WR*,
1/23/89



Percentage of U.S. fertility clinics surveyed who would not be likely to reject a request for artificial insemination from a patient simply because she has/was:

history of serious genetic disorders:

17

evidence of alcohol abuse:

9

evidence of drug abuse:

8

evidence of child abuse:

3

HIV positive

2

Source: Office of Technology Assessment Brief (Aug. 1988) from survey of 367 clinics



ductive Health Services" for breaking the new Missouri law) and Charles Fried, who is acting solicitor general pending the approval of President Bush's nominee for the position. (In March, 50 career lawyers in the Justice Department signed a petition submitted to U.S. Attorney General Dick Thornburgh that protested the government's efforts to overturn *Roe v. Wade* through the *Webster* case or other court tests. The signers of the petition argued that the government has no compelling legal reason to get involved, and that the government's role in the case was a case of "playing politics" rather than "maintaining the traditional commitment to impartial support of the American legal system.") In addition to the three oral arguments, the justices also had for consideration 78 *amicus curiae* ("friend of the court") briefs, more than had ever been submitted to the Court for any case. The *amicus* briefs had been submitted by a variety of advocacy organizations, physicians, public officials, scientists, historians, and professional associations.

Both sides were given 30 minutes. Webster and Fried divided their half hour, with Webster concentrating on specifics of the Missouri law and Fried discussing larger constitutional issues. The exchange between the justices and the attorneys for both sides was intense and lively, focusing not merely on the right to abortion but implications any ruling would have on issues such as birth control, whether the fetus is a human, and whether the choice to have an abortion should be a judicial, legislative, or personal one. The prochoice attorney, Susman, was challenged most carefully on the question of how the right to an abortion can be defended as a "fundamental right" unless the determination is made that the organism destroyed is not a human life. Susman responded that both sides agree on the "physiological facts" but disagree on what to call those facts. "The conclusion it leads me to is that when you have an issue that is so divisive and so emotional and so personal and so intimate, that it must be left as a fundamental right to the individual to make that choice under her then-attendant circumstances, her religious beliefs, her moral beliefs, and in consultation with her physician."

The justices challenged the antiabortion attorneys most directly on whether it would be possible to separate the rights to privacy guaranteed in a 1965 case (*Griswold v. Connecticut*, which endorsed the right to use birth control) from the abortion rights discussed in *Roe v. Wade*. Fried argued that such a separation would not

be difficult; with prompting from Susman, however, Justice Antonin Scalia challenged the distinction between abortion and those forms of birth control that operate after the time of conception. Webster said he did not think the question of contraception would be implicated by a decision to overturn *Roe v. Wade*. With regard to the specifics of the Missouri law, under intense questioning from Justice John Paul Stevens, Webster said his office would not prosecute a physician who performed an abortion under the Missouri law. In response to questions of whether viability tests would be required even when physicians thought they were useless at such an early stage of pregnancy, Webster said the Missouri law should be interpreted as not requiring physicians to perform any viability tests "that would be unnecessary."

Particular public attention was focused on the newer members of the Court, especially Justice Sandra Day O'Connor, who has been publicly critical of *Roe v. Wade* but has not had the opportunity to rule on an abortion case since her appointment to the Supreme Court.

For a complete transcript of the 60 minutes of oral arguments presented to the Supreme Court, readers may consult the April 27 issue of the *New York Times*, (although some editions inadvertently omitted a portion of the transcript, an oversight that was rectified in the April 28 issue). Another source is the May 18, 1989, issue of *Origins*, published by the National Conference of Catholic Bishops, which printed a complete transcript of the oral arguments. Back issues are \$3.50 and are available from National Catholic News Service, 1312 Massachusetts Ave. N.W., Washington, D.C. 20005, att'n: Bessie Briscoe, Circulation Manager.

Comatose patient awakens, judge reverses right-to-die ruling

After four and a half months in a persistent vegetative coma that was believed to be irreversible, an 86-year-old New York stroke victim began talking and eating on her own, prompting the judge who had given permission to disconnect her feeding tube to withdraw that permission.

Ironically, the woman, Carrie A. Coons, was the first New York resident to receive permission to die since a state court ruled in 1988 that such measures were acceptable in cases where it could be proved that incompetent patients had previously expressed approval of the right to die. Doctors, lawyers, and family members who

had petitioned for the right to disconnect her life support were baffled by Mrs. Coons' surprising recovery, and experts said the case was so unusual that it only proved that physicians "are never dealing with certainties."

Since last November, when Mrs. Coons suffered a stroke and cerebral hemorrhage, she had shown no signs of alertness for four and a half months. On April 9, however, only two days after a state judge ruled that she could be disconnected from life support, Mrs. Coons began stirring and eventually ate small portions of food and said a few words. Her physician asked her what should be done about her case, and she replied, "These are difficult decisions," and fell asleep. Her statement throws her case into limbo. If she remains unconscious, her family will have difficulty getting new permission to disconnect life support because of the ambiguity of her statement. On the other hand, if she maintains consciousness and declares a wish to be disconnected, that wish would probably be granted. Her court-appointed lawyer was monitoring her progress and said that although she was well enough to speak she was delaying any decision on her fate.

The case is not unlike that of Jackie Cole, a Maryland woman who was in a persistent vegetative state for 46 days before regaining consciousness. Mrs. Cole's husband Harry, a Presbyterian minister, had been denied court approval of his petition to disconnect her life support only a few days before she began her "miraculous" recovery. The Coles told their story in volume 7 of *Second Opinion*.

Air pollution threatens public health in Mexico City

The world's largest city is gasping under the world's worst urban air pollution, and experts say that Mexico City's problems will get much worse before they can get better. An estimated four tons of lead are deposited into the city's air each day, mostly from motor vehicles, raising the average lead level in the blood of residents to twice the level of that found in any other major world city. The ozone levels have tripled in only three years, and 90% of the air samples taken in Mexico City last year exceeded the maximum allowable standard recommended by the World Health Organization.

Unfortunately, the Mexican government does not have the resources to reverse the trend. A crippling \$102 billion foreign debt diverts money that could be used to upgrade the city's

antiquated mass transit, clean up the state-produced gasoline, or enforce more stringent emissions standards on private vehicles. In addition, there is no money to rebuild portions of Mexico City's sewage system that were destroyed in the 1985 earthquake, leaving almost a third of the city's 20 million residents to dispose of their wastes in any way possible (a United Nations study estimated that 600 tons of human waste enter the city's atmosphere daily, and, according to the *New York Times*, the U.N. "found the number of colonies of microorganisms per cubic meter of air to be uncountable").

Incapable of fighting the problem, residents of the city are try to avoid it. The entire Mexico City school system was closed during the month of January so that students wouldn't have to breathe the fouled air on their way to and from school and at recess. Many foreigners doing business or diplomatic work in the capital city urge their employees to reside outside of the city whenever possible, and some foreign embassies have reportedly urged diplomats to leave small children in the home country and avoid having a baby while stationed in Mexico City.

Even if strict air quality measures were enacted immediately, however, environmental experts predict that the city's air quality would not show noticeable improvement for at least a decade, and to date the government has not formulated any affordable, long-term plan for dealing with the problem.

U.S. observers say political prisoners housed in Soviet mental wards

A team of psychiatrists from the U.S. who recently toured psychiatric hospitals in the U.S.S.R. reports that abuses are not uncommon, including institutionalizing people for political reasons, using "schizophrenia" as a catch-all phrase in lieu of more accurate diagnoses, and treating patients with large doses of "pain-causing psychotropic drugs" that have long been abandoned by Western physicians.

The Soviet government maintains that there are no political prisoners in its psychiatric hospitals, and in fact allowed the American delegation to choose seven hospitals to visit and select which patients they wanted to interview. The Western observers talked to more than two dozen patients and former patients whose names were supplied by international human rights and psychiatric rights organizations, including a man "whose family said he was sent to a mental hospital for refusing the draft," and

Percentage of Cubans testing positive for AIDS who are required to spend the rest of their lives in the national AIDS sanitarium:

100

Source: *Chicago Tribune*



a former patient who said he was locked up "for writing a thesis comparing socialism to feudalism."

The fact-finding team was preparing a report on its visit to the U.S.S.R., apparently waiting to discuss its observations in order to avoid offending Soviet hosts. Concurrent with the visit, a group of Soviet psychiatrists announced a new national association to "lobby for higher standards and defend patients who claim to have been wrongly confined to mental wards."

Religious representatives address international in vitro forum

Representatives of four of the world's major religious traditions told an international forum on in vitro fertilization that they could accept the technique under some circumstances, but not when donated sperm or ovum were used. Physicians at the conference welcomed the comments but called on the religions to be more understanding and tolerant.

There was much agreement among the representatives of the Jewish, Moslem, and Buddhist faiths, although the Roman Catholic representative said the Vatican is opposed to in vitro fertilization. Clerics representing the other three religions said the procedure "could be sanctioned within defined limits," according to a report by the Associated Press. The spokespersons for all four religions agreed, however, that implanting donated sperm, ovum, and embryos from third parties was unacceptable, as was performing experiments on human embryos.

"The mere fact that parents and doctors can play around with an embryo is very, very dangerous," a Moslem cleric told the physicians representing 42 countries at the conference. "Why approach even the boundaries of such dangers?" The chief gynecologist at Jerusalem's Hassadah Hospital said that religious opposition to sperm donation was reflected in the fact that more than a third of the countries practicing IVF, "including nations in the Moslem-dominated Arab world and Roman Catholic-dominated South America," ban sperm donations.

Physicians at the conference listened attentively and asked for religious empathy for infertile couples. "People who come to us want a baby; many of them are very religious," the AP quoted a physician from Paris. "Why don't you come to our clinics, look at our research, and make an effort to understand us?"

Newspaper reports that mentally disabled foster children are kept in New York hospitals

The *New York Times* reports that more than 100 mentally disabled foster children are being kept in 12 New York hospitals while waiting to be placed in homes. The newspaper says that in one instance, "a 9-year-old autistic boy at Woodhull Hospital in Brooklyn has spent much of his time locked in a crib with a plastic bubble on top because the hospital does not have enough workers to give him the constant attention he needs." Some children stay in the hospitals for more than a year; costs per child run as high as \$900 per day.

Advocates for the children, who have disorders such as cerebral palsy, mental retardation, autism, and hyperactivity, say the youths have needs that make them difficult to place in foster homes but often have sufficient mental capabilities that they are not a top priority on waiting lists at state institutions. State officials do not deny this assessment. "Most of these children need to be placed in some sort of institutional setting," one official said, "[but] that's a very difficult thing. The foster-care system has never really been geared to dealing with the 'hard to place' child."

The *New York Times* related the story of a hyperactive 8-year-old boy named "Troy D." who has spent almost a year at Mount Sinai hospital at a cost of \$890 per day. "He lives in a locked psychiatric ward, with his room virtually empty except for a bed that folds into the wall and a punching bag. A hospital worker who knows the boy said he was growing increasingly distraught as he repeatedly made friends with other children in the hospital and then watched them go home."

State mental health officials told the *Times* that Troy's case was an exception and that on average, children wait four months before being placed. "We move them as fast as we can," a spokesperson said.

California attorney general wants genetic tracking of criminals

The state of California is considering establishment of a computerized "genetic data base" of convicted violent criminals. The program would use blood and saliva samples to make a genetic "fingerprint" of criminals that would be useful in solving future crimes. Other states are considering similar measures, and the Federal

Age at which a child's skull finally grows enough to cover last soft spot on head:

2½ years

Source: *Black's Medical Dictionary*



Bureau of Investigation is working on a system that could tie all of the states together in a large computer network.

The criminal-tracking programs are the result of recent advances in genetics that enable forensics experts to identify criminals through DNA found in even tiny specimens of semen, hair follicles, blood, and other human tissue. DNA has been used as evidence by both defendants and prosecutors in criminal trials in a number of states.

Under the California program, all people convicted of murder, assault, rape, and other sex crimes would be required to provide two specimens of blood and a saliva sample before entering prison; samples would be taken from current inmates before release. Studies have shown that nearly two-thirds of all inmates released from prison commit new crimes within three years, according to the *New York Times*. The ability to track down criminals from minute pieces of tissue left at the crime scene is particularly suited to rape cases, less than a quarter of which result in arrest and conviction (the lowest conviction rate for any violent crime in the U.S.).

Civil libertarians have expressed reservations about the proposals, particularly the concept of a national genetic database. A spokesperson for the American Civil Liberties Union expressed concern that the genetic information would be used to "round up suspects the way fingerprints or mugshots [are used]." She also said that DNA tests on tissue samples are only "98 or 99 percent conclusive." Proponents of the genetic database countered, however, that when done properly, DNA typing is "highly reliable."

Fate of embryos in divorce cases is debated

Ethicists and legal authorities are grappling over unique custody questions involving the fate of frozen human embryos in the wake of a divorce. There are several cases said to be pending, but national attention is focusing on a Tennessee couple who are fighting over rights to seven frozen embryos. The embryos were grown with eggs from Mary Sue Davis and fertilized with sperm from Junior Lewis Davis while the couple was married, and now that they are divorcing she is petitioning for the right to bear a child from the embryos and he is trying to prevent her from doing so.

Mrs. Davis had five unsuccessful pregnancies and underwent six unsuccessful attempts at in vitro fertilization. During the last IVF attempt,

doctors decided to freeze some of the embryos before implanting them in Mrs. Davis at a later date, but two months later Mr. Davis filed for divorce and the embryos remain in the freezer.

Mrs. Davis contends that because the embryos are living, this is not unlike a standard custody case and she should have the right to decide whether to bring the pregnancy to term. Mr. Davis, however, says the embryos are not alive and do not yet constitute offspring that warrant "custody;" he sees this as a joint property of the marriage and does not want Mrs. Davis using the embryos to bear a child after the marriage is dissolved. Mr. Davis's lawyer says that "nothing Mrs. Davis has been through gives her the right to compel Mr. Davis to be a father, to deprive him of his rights."

Experts say that most fertilization clinics state in the contract what should happen to unused eggs, but the Davises' doctor did not make any such provision. Neither of the Davises wants the eggs destroyed or donated to another couple trying to have a child, although Mrs. Davis says she would be open to such a donation if she could first have two children from the frozen embryos.

The most celebrated embryo custody case occurred in Australia in 1988, when relatives of a couple killed in a plane crash sued to preserve the couple's stored embryos. A law was passed to permit implantation of the embryos in another woman "if a suitable recipient were found."

Smokers pay their "social cost" but drinkers don't, new study says

A study published in the *Journal of the American Medical Association* compared the taxes paid on cigarettes and liquor to the "social cost" of smokers and drinkers and concluded that smokers "pay their way" but drinkers don't. The researchers reasoned that the higher cost society pays for smokers in the form of days lost from work and extra medical care are offset by the earlier death of smokers, which saves society millions of dollars on Social Security and Medicare benefit payments. The 7,400 deaths annually resulting from drunk-driving accidents, on the other hand, were not offset by the 23 cents per ounce tax on liquor. The researchers calculated a value to society of \$1.6 million for each nondrinker life lost in drunk-driving accidents, which worked out to a social cost of 48 cents per ounce of alcohol consumed, more than double the current liquor tax.

Contrary to popular belief, drinking drivers involved in accidents do not walk away with fewer injuries than sober accident victims. Recent studies indicate that drinking drivers are more than four times more likely to be killed than sober drivers (in accidents of comparable seriousness).

A researcher involved with one of the studies noted that alcohol "impairs the body's ability to withstand trauma... it increases vulnerability to shock, increases the potential for arrhythmias, and can exacerbate the degree of spinal cord and head injuries."

Source: *JAMA*, 260:2480



FDA advisory panel approves five-year contraceptive for women

A hormone implant that protects women from pregnancy for five years or more won unanimous approval from an advisory board to the Food and Drug Administration; full FDA approval is expected to take several months. The 11-member advisory committee found that the implant, trade name Norplant, was "as safe and effective as any other contraceptives currently available." The only side effect is that because of Norplant's progesterone-like nature, it can change the menstrual cycle and some users may miss some periods.

The hormone in Norplant is similar to that of present oral contraceptives, but the new product consists of small capsules that are surgically implanted under the skin. Research conducted by the Population Council indicated that Norplant's effectiveness apparently diminishes as body weight increases; it has been 99.8% effective over five years when implanted in women weighing less than 110 pounds but was only 91.4% effective in women weighing more than 153 pounds.

Asian Americans protest murder sentence lightened for cultural reasons

Several Asian American groups in New York protested the actions of a New York judge who cited cultural factors in his decision to reduce the sentence of a Chinese man convicted of killing his wife. The case stirred new questions of whether cultural attitudes should affect sentencing or "relieve people of responsibility for violent behavior," according to the Brooklyn district attorney.

The state supreme court judge sentenced the man to five years probation for the fatal hammer beating of his wife after she admitted to him she was having an affair. The court-appointed lawyer for the man argued that Chinese attitudes toward adultery prompted "an overwhelming sense of shame and humiliation" that led to the loss of control and beating death. An anthropology professor brought in as an expert witness supported this claim, testifying that in China "adultery is an enormous stain," not only on the husband "[but] is a reflection on his ancestry and progeny."

The judge cited several factors in his decision, including the man's lack of a criminal record, his meek demeanor during the 18 months he spent in jail awaiting trial, and the unlikelihood that he would murder again. "The

culture was never an excuse," the judge explained, "but it is something that made him crack more easily." The district attorney, however, said that she may reopen the case, and Asian American groups said the decision "cast a shadow on Chinese culture."

"We have always wanted a more culturally informed judicial system, but this case completely crosses the line—to the point of excusing a murder," one Asian American spokesperson told the *New York Times*. "The judge is using a very archaic, academic interpretation."

New statistics show widening gap between health of whites and blacks in the U.S.

A new report by the National Center for Health Statistics indicates that white Americans are living longer than ever but the life expectancy for blacks is actually decreasing. The report, "Health, United States," blames AIDS, homicide, poor nutrition, poverty, and less access to medical care for the lower life expectancy rate.

A white child born in 1986 had a life expectancy of 75.4 years, while black children born the same year could expect to live an average of 69.4 years, down from 69.7 years in 1984. High mortality at the beginning of life was a major factor in the lower rate among blacks; the infant mortality rate among blacks was twice as high as among whites, although the overall figure has been cut in half since 1970.

In introducing the report, officials credited "dramatic declines" in the incidence of heart disease and stroke for the slight increase in overall life expectancy figures for all Americans. Thanks for the most part to a decrease in the number of Americans who smoke, the number of deaths from heart disease has fallen 31% since 1970 and from strokes, 53%.

Dr. Louis W. Sullivan, Secretary for Health and Human Services, said the nation now needs to concentrate its health efforts "on such critical areas as prevention of AIDS, unintentional injuries, homicide, and suicide."

Researchers revise AIDS incubation time

After reviewing the latest data, AIDS researchers revised upward the average time it takes to develop AIDS following infection. A study of homosexual men in San Francisco indicates that only half had symptoms of the disease 9.8 years after they were infected with the virus. The previous estimate had been 7.8 years.

Percentage of British citizens who are cremated after death:

63

Percentage of Americans:

8

Source: *Encyclopedia Britannica*; *Black's Medical Dictionary*



The new study, published in the science journal *Nature*, was by far the most comprehensive conducted so far, combining three studies done in San Francisco with data from the city's Department of Public Health and including more than 50,000 men. The researchers predicted that the number of AIDS cases would peak before the end of 1989 and decline by 15% over the next two years. This forecast is based on the new 9.8-year incubation figure and data indicating that gay men began practicing "safe sex" in 1982, reducing the infection rate by more than 80% in the subsequent two years.

The researchers refused to speculate whether some infected men will never develop AIDS.

New treatment data prompt experts to recommend wider AIDS testing

Because of significant new gains in the treatment of AIDS, experts are urging people in high-risk groups to be tested for the virus even if they do not exhibit any symptoms of the disease.

An article by Lawrence K. Altman, M.D., in the April 24 *New York Times* quoted a national health official saying there's "no question" that it is advantageous for people to know whether they have the AIDS virus, because new treatments can use early detection to stave off complications, ease suffering, and in some cases prolong lives for as much as a year. The recommendation represents a shift in attitudes from only three or four years ago, when most people assumed that it didn't make any difference whether they were tested or not. "Here we said, don't test, don't find out because all it will do is cause trouble," commented Dr. David Rogers, who advises the governor of New York and the mayor of New York City. "Now we are saying it is to your advantage to know your HIV status" because physicians closely follow infected patients and usually recommend immunization against influenza and a certain strain of pneumonia. (Rogers said, however, that he "shuddered to think of the logistics of suddenly testing more people in New York City," where an estimated 400,000 people may be infected.)

Advances in diagnosis and treatment of AIDS are starting to show up in increased longevity figures. The *New York Times* quoted new data from the New York State Health Commissioner that indicates the percentage of homosexual or bisexual men diagnosed with AIDS who lived 18 months or longer was 60% in 1987, up from 40% in 1986, 35% in 1984, and 30% in 1982.

The health commissioner's office found similar—though lower—survival rates among AIDS victims who were intravenous drug users, but did not see such improvements among AIDS babies, who usually also have extensive drug-related medical problems.

Postal service rejects AIDS stamp proposal

The U.S. Postal Service has repeatedly rejected the efforts of a Wisconsin nurse to get an AIDS message on a postage stamp. Jean Hlavacek, a clinician at the University of Wisconsin Hospital in Madison, says that she has spent two years and \$3,000 of her own money trying to win approval of the stamp, which features the word "AIDS" in a red circle with a line through it, surrounded by the words "research," "education," "prevention," and "compassion."

AIDS groups have lauded Hlavacek's proposal, as has Surgeon General Koop, but the Citizens' Stamp Advisory Committee, which advises the Postal Service on all proposals, finds the message too depressing. "Our experience has not been good with any of these medical-type stamps," a spokesperson said. "People don't want disagreeable or gloomy stamps on their mail." He cited the example of a previous stamp which read, "Alcoholism, You Can Beat It," which he said "couldn't be given away." "If we really thought anything could be done about AIDS by putting out a postage stamp, we would do it, but we are not convinced it would do anything at all."

Ms. Hlavacek, according to the *New York Times*, continues to resubmit the design to the stamp committee every other month and she says she'll keep trying for approval. "I think it's too important an issue to let it sit. If at first you don't succeed," she said, "try, try, try, try, try."

Leader urges Jesuits not to sign controversial public statements

The Superior General of the Jesuits has urged members of the Catholic order not to sign collective public declarations that "for one reason or another can be embarrassing." Observers believe the warning from leader Rev. Peter-Hans Kolvenbach was a response to a January, 1989, declaration by 170 Roman Catholic theology professors that criticized the Pope on a number of counts, including his method of selecting new bishops and some of his theological positions.

In an average lifetime, the average American will spend six months waiting at stoplights and eight months opening junk mail.

Source: *USN&WR*, 1/30/89 (data from Priority Management, Inc.)



Percentage of California doctors who wish their colleagues would go somewhere else to practice:

82

Source: *Hippocrates*, Nov./Dec. 1988, p. 18



Several Jesuits signed that declaration, which took to task Pope John Paul II for not naming a more liberal prelate as archbishop of Cologne last November.

The Jesuits, members of the Society of Jesus order founded by St. Ignatius Loyola in 1540, is regarded as one of the more "progressive" forces in the Catholic Church, often taking controversial stands on political and social issues in society—sometimes disagreeing with official Vatican policy. Father Kolvenbach said that his purpose was not to squelch all public declarations but rather to remind the order's 25,000 members to consult their superiors before taking controversial public stands since these can affect the image of the entire order. "Jesuits should avoid supporting any declaration whatever whose presentation is in contradiction to the spirit of our vocation and ecclesial mission," Father Kolvenbach wrote. "Failure to observe this directive could lead to the Society losing the trust it needs to accomplish its mission."

Though there was no explicit tie, the letter to the Jesuits followed by one day a letter from the Pope to bishops criticizing the tendencies of some religious groups in the church toward "excessive self-fulfillment and autonomy in living, working and decision making."

Gallup poll finds Americans support cuts in military but oppose Medicare reductions

A new public opinion poll conducted by the Gallup organization has found that the U.S. public supports cuts in military spending and increases in social spending. Twenty-two percent of those polled said drug abuse is the most important problem, followed by the budget deficit (19%) and homelessness (10%).

When given a system of 100 "coins" representing the budget and told to make reductions where federal cuts were most appropriate, more than half of the total amount cut was in the area of military spending. Federal pensions, foreign aid, and transportation spending were also subjected to cuts, but the respondents wanted only minimal changes in education, health, Social Security, and Medicare.

The Gallup organization reported that once the question of the deficit was put aside, more than half of those surveyed favored spending increases for the war on drugs, health care, programs for the homeless, AIDS research, programs for the elderly, and the public schools.

Christian Science couple convicted in death of daughter

A jury in Sarasota, Florida, convicted a Christian Science couple of third-degree murder and child abuse in the 1986 death of their daughter. It was the first time in more than two decades that a Christian Science couple has been convicted for the death of their child; numerous other cases have come to trial, but juries have usually ruled that the parents were exercising their right to religious freedom in opting for spiritual treatment over medical attention (Christian Science teaching promotes spiritual treatment over medical treatment but does not prohibit members from seeking medical care).

Amy Hermanson, a diabetic, was seven years old when her parents elected to have her diabetic complications treated by a Christian Science practitioner (rather than a medical doctor) on the day before Amy died. They also summoned a Christian Science nurse on the day of Amy's death, who testified at the trial that she had urged the practitioner to call for an ambulance when the young girl's condition seriously worsened.

The Hermanson case was closely watched by legal, religious, and ethical groups around the country because similar cases are pending elsewhere. However, the case hinged on conflicting statements in Florida law that may not be applicable in other states. Parental religious exemptions enacted by the Florida legislature in 1978 stipulate that parents who for religious reasons do not provide medical care for a child may not, for that reason alone, be considered "abusive or neglectful" or "negligent parents." This statute was a key foundation for the defense in the Hermanson case. However, Florida's criminal code states that anyone who through "willful or culpable negligence" withholds medical treatment from a child is guilty of criminal child abuse. This statute was the foundation for the prosecution. The state's attorney told the jury, "If they wish to become martyrs for their religion, they have that right. But I contend to you that they do not have the right to make a martyr of a 7-year-old girl."

Florida sentencing guidelines recommend three to five years in prison for third-degree murder and child abuse, although defense attorneys said they may ask for a new trial and the Hermansons will remain free on their own recognizance until sentencing.

CENTER NEWS

Center announces new president

Ethicist and theologian Laurence J. O'Connell has been named the new president and chief executive officer of the Park Ridge Center. He was most recently vice-president for theology, mission, and ethics at the Catholic Health Association of the United States, in St. Louis, Missouri, and began directing the Center on May 1, 1989.

O'Connell's extensive background in the fields of health, faith, and ethics includes four years of leadership at CHA. He has also been chair of the Department of Theological Studies at St. Louis University and international advisor for the Research Center on Ethical, Legal and Forensic Issues Related to AIDS at the Ministry of Health in Rome, Italy. He serves on several ethics committees and boards in the United States and Europe.

The Park Ridge Center searched broadly—throughout the United States and within various disciplines—for the new president. Martin E. Marty, interim president, reported on what the Center's board of directors looked for and found in its new president. "We wanted a leader who would understand, affirm, and promote the Center's mission, which is to keep the faith dimension up front in understandings of medical ethics.

"We sought and found an inventive, articulate thinker. All are impressed by O'Connell's zest for innovation and mature judgment about what will fulfill the Center's mission and be of greatest human service." Martin Marty will continue his involvement with the Center as senior scholar-in-residence.

The Park Ridge Center, founded in July 1985, is the first research center in America to undertake the study of medical ethics in light of various religious perspectives. The Center has expanded rapidly in the last year, relocating to downtown Chicago from suburban Park Ridge and doubling its staff. These expansions will

facilitate its growing research agenda, under O'Connell's direction, in the fields of health, faith, and ethics.

Purpose of religious hospitals considered at Center conference

The Park Ridge Center is contemplating an extensive study of certain hospitals, senior citizen homes, centers for treating substance abusers, and other institutions of care. The purpose of the study would be to assess the condition and prospects of such agencies and to make recommendations toward their survival, growth, and improvement. Needless to say, this Center for the Study of Health, Faith, and Ethics, sees a need to concentrate on institutions related to Christian or Jewish religious groups. No such comprehensive study has ever been undertaken though there have been specialized analyses, for example by the Catholic Health Association.

Why should a center whose purposes include keeping the faith dimension in the forefront of health issues put energies into appraising institutions? The question all but answers itself. For example, a center for promoting relations between religion and higher education would sooner or later, and probably sooner, focus on church-related colleges and universities. While hospitals established under secular auspices, the "investor-driven," Veterans Administration hospitals, and the like, may be the sites of most opportunities for dealing with the faith issues simply because such institutions predominate in American culture, those with relations to religious organizations are special cases with special challenges and opportunities.

To advance deliberations on such a study, the Park Ridge Center held a six-session conference in Tucson, Arizona, late in winter. Members of the board, staff, and consultative panel heard presentations by three nationally recog-

"Despite the fact that almost half of Canadian media coverage on health care was in response to the Alberta nurses' strike, doctors were interviewed more often than nurses by a two to one ratio in [Canada's largest newspaper] and by a 12:1 ratio on the Canadian Broadcast Corporation."

Source: *On Balance*, a Vancouver-based publication that studies media treatment of public policy issues



nized experts and began shaping a research design.

The conference is only the first step toward such a study, but the following report on its discussions may draw readers into the sphere of its concerns.

First, participants projected a "sense of the moment," a recognition that the early 1990s is the right time for such a study. Changes in the world of health care institutions are sudden and drastic these days. Financial stress in all health care; the growth of the "investor-driven" network (augmented by purchase of church-related institutions); changes in the situation of religion in America; proposed changes in tax structures; these and other circumstances make the study both promising and urgent. While the Catholic Hospital Association and the American Protestant Health Association monitor their own institutions, conference participants were impressed by how often questions evoked phrases such as "we don't know" or "we lack data."

At once, certain background issues emerged. For example, there is little point in analyzing the religiously sponsored health care institutions unless they are distinctive. Not to find special reasons for the existence of such institutions—decisive elements in their mission statements and operations—would be very telling.

Presenters and participants admitted that they would have some difficulty at this stage specifying what is distinctive about these institutions. At one time institutional founders may have found it easy to explain their purposes, justify their existence, and measure their contributions. But in a pluralistic society, where staffs, patients, funds, and assumptions do not come with sectarian labels, the religious intentions and practices will inevitably be diffuse. In his *Health, Medicine, and the Catholic Tradition*, Richard McCormick framed the question for Catholic institutions, "If we were indicted for being a Catholic hospital, would there be enough evidence to convict us?"

Before embarking on a study of living institutions—which have a history—it is necessary to become aware of their pasts. One speaker talked about the "disfigured present" of such agencies, implying that they have "figured pasts." That is, founders must have originally had clear goals. Pope John XXIII used to tell religious orders that they should reform "in the light of the intentions of their founders." Naturally, "you can't go home again," there was no Golden Age for these institutions, and the contextual worlds of their pasts are irrecoverable. But some elements of

those pasts survive and can be revisited as the health care institutions seek redirection.

When one seeks what is distinctive, several possibilities come to mind. Conferees spelled out some of them. For instance, some institutions had and may have *substantive* religious interests. That is, certain doctrines, certain understandings of the human body, of medicine, of illness and health, motivated the founders, and if this kind of substance survives, it is important to specify it.

More frequently, mission statements suggest that there is a special *character of care*, some "genius" in the operations that depends upon the nature of the sponsoring religious group. Leadership sets or is expected to set a tone reflecting the outlook and practices of the group. Or, third, the boards and staffs may have special reasons to express the character of *their relation to society*. Some senior citizens' homes, for instance, represent efforts by religious groups to "take care of their own." Hospitals, on the other hand, almost always reflect the outlook and makeup of their own local communities. Thus a Catholic hospital may be located in a southern, largely Baptist, environment, and serve Oriental patients with Asian religious understandings, along with the Protestants who may outnumber the Catholic clientele. What have the settings meant and what do they mean?

At the same time, if such institutions are to find and hold their place in a changing world, they have to see themselves within the larger economy of health care and show where they "fit" alongside governmental and investor-driven institutions. Thus, while church-related colleges are not opponents of state universities or private secular schools, they strive to offer something different alongside them. When they fail to do so and become nondescript, they gradually "fade into the background" or out of existence. Will the same be true of religiously related health care institutions?

When talking about their own locales, conferees with experience in health care institutions stressed that regional and local circumstances affected the expression of the religious hospitals' mission. For instance, when many Jews moved to metropolitan suburbs and away from the institutions founded to serve the ghettos a century ago, these institutions drastically altered their approaches to match changes in constituencies. Lutheran hospitals in the upper Midwest will express something of the Lutheran and public ethos of that area, where they often predominate. In the South, where Lutherans are fewer, a

Each week 210 people turn 100 years old.

Source: *Hippocrates*, Jan./Feb. 1989, p. 13



very different regional sense will color their activities.

Conferees devoted most of their energies to the current situation, as would a more extensive study. Overshadowing everything was the awareness of the pluralistic and secular nature of the society, a society often puzzling to religious movements and institutions. The puzzlement is especially intense in the health care field because so many standards set by government, accrediting agencies, and funding practices have little to do with religious purposes. To say "pluralist" or "secular" is not to suggest that everything in the culture is hostile. But the diversity of values and beliefs is complicating, and religiously related institutions at their best struggle to make sense of the complications.

Some analysts observe, and conferees noted, that year by year there has seemed to be less and less of a rationale for religiously sponsored care institutions. Should they seek merely to survive, or by doing so do they write their own death sentences? Should they (as many of them have had to do in the present economy) abdicate the scene and go looking for buyers among the investor-drivers, or close? Will there be less and less of a generating center, a clarified purpose, every time one looks at them than there was earlier? Does "high-tech" medicine especially become the consuming interest, obliterating all traces of religious meanings and character in institutions of care?

No one at the conference gave voice to anti-technological outlooks that sometimes come with religious criticisms. One might instead phrase the questions often voiced like this: "Is a humane technological order possible? How does one attain it? What does religion contribute to the pursuit of the humane in specific institutions?"

Numbers of participants observed that it would be difficult for religious organizations to abandon the field. Catholic hospitals alone represent a \$26 billion investment. Also, most religious groups do not want to depart the scene. The Tucson conference again and again heard positive voices. They stressed what the Park Ridge Center has found: a recovery of religious understandings, evidence of interest in bringing the "faith dimension" to bear on issues related to health care. Perhaps the question can be put: Can religiously sponsored institutions respond to the renewed religious interests of a secular society quickly enough to assure their own survival?

The Tucson conference speakers and respondents began to sketch some distinctive attributes of religiously sponsored institutions to be explored and developed, for example, mission statements. Do they exist? Have they been revised? Do they match circumstances? How does religious intention live in each? Second, do religious institutions evince the special regard for persons that is expected to come with religious motivations? No one suggested that religious people have monopolies on the impulse to care or on high-quality care. Many religious people suggest that they have special reasons for expressing care—reasons deriving from the center of their faith. Can one find and measure such special reasons embodied in the personnel of religiously related institutions?

Some panelists at Tucson stressed that religious motivation shows through best in cases requiring long-term care, as in the care of the addicted or the aged. It is harder to find the distinctive qualities in acute care agencies, for obvious reasons.

Next, participants stressed that religious language is important. Religious spokespersons often talk in particular ways about "the dignity of the human person"; about justice and welfare, about interpretations of illness and health. Is this mere talk or does it become more than talk in religiously related institutions?

No report on the conference would be complete without some reference to themes that participants urged researchers to pursue if they take up the study. For instance, do religiously related hospitals have pedagogical functions? That is, at their best, do they have anything to teach the secular institutions from which they learn and derive much? Has their leadership any mission of advocacy? That is, should it be in the forefront of effecting justice in the distribution of care? Most religions profess to be thus devoted to justice. Can their hospitals set a different standard than that of an at best semijust society—and survive? Should they set such standards?

Conferees wanted researchers to consider exploring ecumenical and interfaith implications of health care in a world of religious interaction. It is hard to picture a modern hospital being sectarian, but it is easy to picture many that do not take advantage of interfaith cooperation. "Are we out there competing and killing each other?" was a repeatedly asked question.

Might recovery of the faith dimension in health care institutions, it was asked, contribute to the renewal of religion itself? Church-related colleges are expected to change the character of

Percentage of Americans who take multiple vitamins "regularly":

37

Percentage of dieticians who do so:

21

Source: *Hippocrates*, Mar./Apr. 1989, p. 16



"church"; to demonstrate that faith has nothing to fear from and much to gain in the world of learning. Is the same thing true in the world of medicine and care?

Practical issues would continue to come up, as they did at Tucson. Perhaps most crucial is the development of leadership, of chief executive officers and boards, of staffs and supporters, who find special reasons to live by and refine the mission statements of religiously related institutions. For all the realism that marks life in such institutions today, conferees observed also a strong sense of vocation among the leaders. They find reason to choose these institutions and not others as their sphere of activity. If they can better state why they do so, they might help the larger society understand the important role these thousands of agencies with their billions of dollar investments play in the medical and spiritual economies of the nation.

The Park Ridge Center *Bulletin* will report on any sustained follow-ups to the conference and will be soliciting ideas and cooperation from its readers as this proposed study progresses. Perhaps this comment on a conference will tantalize some readers to write us with suggestions of issues and methods.

—Martin E. Marty

Kinsey report to be updated; Park Ridge Center hosts discussion with research team

As the famous 1940s Kinsey report on sexuality becomes increasingly outdated, contemporary American sexual relations, attitudes, policies, and sex-related epidemics remain officially unsurveyed. Thus the National Opinion Research Center (NORC) and the University of Chicago have taken on an \$18 million study made possible by a grant from the National Institute of Child Health and Human Development, a research arm of the National Institutes of Health.

The impetus for this project, "Social and Behavioral Aspects of Health and Fertility-Related Behavior," came from social scientists who realized that the spread of AIDS has been an unexpected influence on American sexual attitudes and behavior as well as a threat to public health. Every community has been affected. However, Kinsey's report—the nation's last large-scale survey of sexual attitudes—reportedly tested only 10,000 whites not representative of different regions and socioeconomic groups.

In connection with this new study, the Park Ridge Center, on March 7, 1989, sponsored a meeting of Chicago church leaders from several denominations and religious organizations with project director Edward Laumann, dean of sociology at the University of Chicago. Dean Laumann outlined the project and asked the church leaders for informal feedback on the effect such a survey might have on religious groups.

Laumann expressed the research team's main conviction about sexual practice—that people are very selective about whom they are sexually involved with; they do not randomly and passively interact with others. A recent NORC survey showing that 80% of Americans questioned had 0-1 sex partners in the last year strengthened this conviction.

The research team expects that a better understanding of the patterns and purposes of sexual behavior will enable them to predict more accurately the direction of the spread of AIDS and other sexually transmitted diseases. They also hope to describe the distribution of sexual practices in the general population and to examine the origin, tempo, and direction of changes.

Because of the sensitive nature of the research, Dean Laumann and his staff are informing different groups within the culture about the study's nature and purpose. He hopes to forestall as many misunderstandings of the study as possible. Church leaders were informed about the study not only because members might be sampled but also because such information could be useful in church education programs.

The study will explore two central aspects of sexual behavior: First, the life-course perspective, or how a person's sexual activity relates to life events, age, and changes in environment, and second, how sexual pairs are formed. The characteristics of the pair determine the kind of sexual transaction and the paths of disease. To capture these aspects of sexuality, the project will focus on stages of life (with serial interviews) and social networks.

The team is creating a sample pool far larger and, they claim, more representative than that of the Kinsey report. They will survey persons of every race, region, socioeconomic level, and religion. The process will include both questionnaires and face-to-face interviews to begin after the preliminary research and survey-formation is finished.

—Donna Ray

"A lot of my friends feel that everybody's using the AIDS thing to scare kids into not having sex. It's not going to work. I don't know of one person my age who's died of AIDS."

—17-year-old "Marc T." of Washington, D.C., quoted in a *NYTimes* article on teenage sexuality. The Centers for Disease Control report 345 cases of AIDS among teenagers.

Source: *NYTimes*, 2/27/89



Congregations and Medical Ethics

by James P. Wind

*Director of Research and Publications
The Park Ridge Center*

The pairing in this article's title cannot help but strike readers as unnatural. Conventional wisdom does not place congregations and medical ethics into any kind of relationship. In fact, it keeps them apart, fearing an unhealthy contamination of one by the other. For more than a century, moderns have located congregations on one side of a public-private border and medicine on the other. So bringing them together implies either a naive *faux pas* by someone who does not know the societal rules of the game that keeps the two separate or an assumption that there is a fundamental flaw in our modern way of thinking, a deficit in our conventional wisdom. As I hope this article will make clear, I know the modern rules of the game, but I want to challenge that way of thinking.

A good place to begin consideration of the proper relationship between medical ethics and congregations is with the daily newspaper of any major city. Scarcely a day passes without some major "bioethics" story—decisions about federal funding of fetal tissue research, court rulings on the legality of surrogate mother contracts, celebrity cases involving dramatic transplant operations. These are but a few of the stories that take their places next to coverage of presidential campaigns or superpower negotiations on the front page of the *New York Times*. As one reads the stories or watches *Nightline*, it becomes apparent that medical ethics has become a growth industry—complete with prominent spokespersons like Daniel Callahan or Arthur Kaplan, research institutes like the Hastings Center, and specialized graduate programs like the University of Chicago's fellowships in clinical ethics. Something else also quickly becomes apparent. Unless religion poses some

odd complication—Christian Scientist parents declining medically indicated treatment for their child, for example—it will not be a part of the reports of these stories. No mention of a local congregation is made in these stories. What is more, no one expects that it should be.

Instead we talk about medical ethics in designated "public" places. The legislatures decide how to allocate precious medical resources (Should old or young get a larger piece of the nation's health care pie? Should preventive programs or life extension for the critically ill have priority?). The various health care professions have ethics codes and ethics committees and, increasingly, devote sessions at their professional meetings and articles in their journals to such topics.

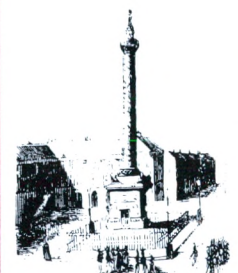
Hospitals are the most obvious places for medical ethics discussions. After all, that is where the dramatic medical ethics cases occur, where the people with medical expertise work, and where the consequences of most bioethics decisions are realized. Many of these institutions now have one or more ethics committees to deal with the special problems that arise with increasing frequency in the day to day provision of health care. When matters prove intractable, when patient and physician cannot agree, or, occasionally, when their joint decision is contrary to a hospital's policy or an interest group's cause, the law is called in. Then a judge or jury will determine if an action is in a patient's best interests or if the state's rights take priority over the wishes of an individual.

As a people and as individuals we can be grateful for the many ways in which gifted professionals have attempted to meet our new medical ethics challenges. And we should encourage those care givers to build upon the foundations they have set in place.

And the conversation is already much wider than the high culture one going on in profes-

During America's colonial period, it was common for affluent New Englanders to give away mourning gloves or rings at funerals. At the funeral of the governor of Massachusetts in 1741, his widow gave away more than 1,000 pairs of gloves.

Source: *Encyclopedia of American Facts and Dates*



Percentage of all people
who ever lived beyond
the age of 65 who are
alive today:

67

Source: *Hippocrates*,
Jul./Aug. 1988, p. 13



sional journals, think tanks, and presidential commissions. The fact that public television has devoted considerable attention to medical ethics is but one sign of growing interest. Another is the proliferation of various interest groups that wish to influence health care decisions, groups like Oregon Health Decision or Concern for Dying. And the gossip that goes on in homes, offices, voluntary organizations, and churches of our land when an acquaintance is faced with a painful, life-affecting choice reminds us that, like the weather, medical ethics is becoming a topic that "everyone talks about."

So why expand our discourse even more? (Before suggesting the congregation as an additional place, it is important to affirm the seriousness with which public institutions have approached the painful dilemmas and baffling quandaries that have become so prevalent in the past 20 years. Much of great value has been accomplished in those settings.) One could argue for congregations getting into the medical ethics act simply to give people another chance to participate in some of our era's most important decisions. That, while it would no doubt add more voices to the mix, is not the best reason. A better reason, one that brings us closer to the matter of deficits in conventional wisdom mentioned earlier, is that congregations *could* add a different quality to our current medical ethics conversations. That we need such a contribution is by no means a part of the conventional wisdom. Therefore an answer to the "why do we need this" question before turning to "how do we do it" concerns.

A good place to begin is with Daniel Callahan's recent book, *Setting Limits: Medical Goals in an Aging Society*. Callahan's important argument about the need for both society and the medical profession to change how they think about appropriate medical care at the end of life cannot be our concern here. But one thing he discovered in his years as the leading figure in our nation's bioethics discussion was that our nation has a language problem. As Callahan dealt with the difficult question of the obligations adult children have to their aging parents, he concluded that "the traditional language of morality, that of rights and obligations, does not seem to fit well in describing the bond among family members." Since language is cultural condensation—it captures and then represents a people's shared ways of thinking and believing—the language problem suggests a deeper, a thinking, problem. For Callahan the deeper problem in our current ways of thinking and talking about aging and

allocation of health care resources across the generations is that "we have created a way of life that can only leave serious questions of limits, finitude, the proper ends of human life, of evil and suffering, in the realm of the private self or of religion." In other words the very things we need to talk about to solve the big medical ethics questions that are around the corner—the deep meaning questions—are left out of our current conversations.

Callahan is a public philosopher in the sense that he seeks to make his argument in a manner that is intelligible and compelling to people of varying perspectives. Thus he does not appeal to particular religious warrants for his backing. Yet he also recognizes the limits of secular ways of approaching these difficult topics. Dissatisfied with our current language, he is searching for another, more adequate, one.

Another perspective on our cultural language problem is provided by Robert N. Bellah and the colleagues who helped him write *Habits of the Heart*. This book helped identify the "first language" of America, that of individualism. Our problem, according to these writers, is that our society "lacks a language to explain what seem to be the real commitments that define . . . life." In other words, our traditions of individualism are inadequate for dealing with the complex realities of human interrelation. The result is the absence of "a wider framework" that can make possible shared ethical discourse and action. That in turn leads to a society that cannot build satisfactory communities for its members. Instead highest priorities automatically are placed on self-realization. In terms of our medical ethics conversations, this perspective seems all too accurate. Not too long ago Renée Fox, a distinguished sociologist of medicine, compared the medical cultures of the United States and the People's Republic of China. She wrote of our "cultural myopia" and felt that a vantage point in China helped disclose how individualistic our medicine is. She noted how central the single value of autonomy is in medicine and how unaware most Americans are of this value commitment. Instead they assume that medical ethics is simply a matter of scientific weighing of hard medical facts and universally self-evident principles. She too wonders about the adequacy of such an individual-centered approach to our quandaries.

If a congregation or a pastor wanted to venture into this potentially rewarding and obviously risky area how could one proceed? The question begs for many answers, and these few

paragraphs that sketch a handful of answers to that question do not intend to short-circuit the serious effort that would be required for congregations, seminaries, judicatories, and health care institutions to respond to the difficult challenges. Instead, they can suggest approaches to stimulate others to go beyond them.

For clergy, two of the most cherished parts of their calling are preaching and pastoral counseling. They are also obvious places to begin the effort of revisioning and redescribing people's experience with health and illness. One way to discern how deeply infected one's own ministerial style is with the modern virus that splits life into public and private spheres is to review sermons to see how frequently they deal with issues like sexuality, procreation, the end of life, aging, and so on. But a quantitative inventory is not enough. When such subjects were raised how were they treated? Were they handled as private crises that people heroically responded to on their own? Were public meaning issues raised—say, the meaning of growing old, or the meaning of aborting a life, or the meaning of choosing to have a child?

In pastoral counseling were people's crises confined to the realm of ethical egoism or were they related to larger moral contexts—whether those of other contemporary relationships or of the faith communities in which pastor and parishoner live? In both the intimate setting of pastoral care and in the more public setting of congregational worship there are many opportunities to help people reperceive their religious tradition as more than personal preference, and their faith community as more than a life-style enclave where nothing significant happens or is even discussed.

Adult education programs are natural places for starting congregations in the process of moral and healing discourse. Programs on "hot topics" like surrogate motherhood, AIDS, or termination of treatment will draw many, as will courses dealing with life styles and preventive approaches to health. More difficult, but perhaps more rewarding, are courses that explore a congregation's faith tradition for its prior experience and testimony on current medical and health-related crises. There are centuries of wisdom and perspective on questions about suffering, the dignity of the human, the value of a human life, the meaning of death that have only recently begun to be re-explored in light of our new ethical questions. Not too long ago Thomas Oden reviewed the texts used in our pastoral theology courses in seminaries to see who the

most frequently cited sources were. Freud and American psychologist Carl Rogers were frequently cited. Calvin, Luther, Augustine, Gregory the Great, the Apostle Paul, and other classic figures in the Christian tradition were not. While no one wants to force moderns into medieval models of care, perhaps it is time to revisit our classics and see if they provide more adequate perspectives for some of our problems that do the moderns.

One could go farther and attempt to create a more sustained and structured congregational conversation. What if the griever of a congregation were assembled and offered the chance to tell their stories in a shared context of meaning? What if health care professionals were provided a place where they could discuss the "dirty knowledge" that goes with any attempt to heal, where they could share their moral uncertainties and their moments of failure? Or what if chronically ill people had the opportunity to search for meaning in their suffering and an antidote for their profound sense of isolation and stigmatization?

An encounter with medical ethics issues, especially if it is sustained and deep can lead to a re-examination of congregational life styles and theological assumptions. In public discourse over questions about care for the elderly or surrogate motherhood, varying traditions will inevitably collide or jostle. Such encounters can be quickening moments when congregations can reperceive their place in the public square and when individuals can develop alternative images to ones currently caught in cultural gridlock.

Percentage of Americans
aged 6-74
who are not allergic
to anything:

80

Source: USN&WR



GLOBAL REPORT

Chinese choose cosmetic surgery for Caucasian look

As many as 500,000 Chinese women have undergone various cosmetic surgeries since, following the Cultural Revolution, the government removed the stigma of "bourgeois decadence" from such operations. Most frequent are operations for double-fold eyelids and silicone implants to raise the bridge of flat noses. Also popular are breast implants and freckle or dimple removal (a dimple in the wrong spot is said to haunt its owner with bad luck for life).

Chinese citizens often pay a month's wages for the double-fold eyelid operation, in which fat and skin is removed to make the eyes appear larger and more "Western." According to the *People's Daily*, even the Beijing military hospital is performing cosmetic surgery, often on poor farm women who hope to get better employment. One woman told the paper, "If only I had bigger eyes, I could get a job at a hotel."

Soviet AIDS rate may be higher than expected

A recent outbreak of AIDS in an impoverished city in the U.S.S.R. has focused attention on the extent of the Soviet AIDS problem. Twenty-seven babies and five mothers in the city of Elista contracted the virus, apparently from unsterilized syringes in a children's hospital there. Soviet press reported that in one case the same syringe was used to give injections to seven babies.

Internal sources in the U.S.S.R. have charged that the country is not producing enough basic supplies to prevent the spread of AIDS; only seven million disposable syringes are produced a year (against an estimated need of six billion) and only 200 million condoms are produced per year (against a need of more than a billion).

As of January, the official Soviet estimate was that of 17 million people tested, 112 citizens and 334 foreigners had been found to have the virus. Only one person, a Leningrad prostitute, has died from the disease. Indeed, the U.S.S.R. had prided itself on a low AIDS rate, crediting rigorous controls on who enters the country and long (eight-year) prison terms for anyone who knowingly infects another person with the virus.

In response to the Elista outbreak, Soviet health officials moved to implement stricter hospital inspections, more international medical research cooperation, and increased AIDS testing.

117 countries agree to curb export of toxic waste

Representatives of 34 nations signed a treaty limiting exportation of toxic waste, and representatives of more than 80 other countries approved the measure, taking it back to their governments for inspection and possible ratification. Canada was among the signers; the U.S. did not immediately sign the treaty but a spokesperson stated that the delay in signing was not a repudiation of the agreement.

The treaty puts no curbs on generation or disposal of waste other than that exported from one country to another. According to the *New York Times*, Western Europe alone produces 2.5 million metric tons of toxic waste annually, and other developed regions of the world produce comparable amounts. The debate has heightened in recent years as wealthier nations have taken advantage of poorer nations by dumping waste without permission or by paying cash-poor countries to accept highly hazardous wastes.

Supporters of the treaty said that it represented an important first step in slowing the international dumping of dangerous wastes,

Nose jobs:

Number performed
in 1986:

82,230

Percentage performed
on men:

25

Average cost of
operation:

\$3,800

Source: *Hippocrates*,
Mar./Apr. 1989, p. 16



which can cause birth defects, cancer, and other diseases. Critics charged, however, that developing nations will not have the means to enforce the treaty and that it doesn't go far enough. Representatives of the international environmental group Greenpeace, which had campaigned for a complete ban on toxic waste exports, complained that the treaty "put a stamp of approval on a horrible business."

Several participants in the conference blamed the U.S. for watering down the original proposal, by, for example, excluding radioactive waste from the treaty and striking a clause that would have prevented developed countries from exporting waste to poor countries who relaxed their import policies in exchange for cash. None of 39 African nations represented at the conference signed the treaty, pending a joint decision at an Organization of African Unity meeting in July.

Health officials fear AIDS epidemic in Bangkok

International health experts say that Bangkok, Thailand, has all the ingredients for a major outbreak of AIDS: a huge sex industry, millions of tourists visiting annually, and a rapidly growing drug subculture. So far the infection rate appears relatively low, but officials with the World Health Organization believe the statistics are deceptive because so few Thais are tested for infection and the numbers among those who are tested indicate the early stages of a major epidemic. For example, 43% of 2,000 intravenous drug users tested in Bangkok in mid-1988 were found to be positive for the virus.

The biggest danger is from the country's enormous sex industry: even government officials estimate the number of prostitutes at around a half a million in Thailand, a country with only a fifth the population of the U.S. There is a steady supply of new prostitutes as poor girls from rural areas come to the city to make money; farm parents often sell their daughters to urban brothels for less than \$75, according to the *New York Times*. Thai prostitutes average 60 customers a month, largely among tourists—more than two-thirds of the whom are male, often visiting Bangkok on specially designed "sex tours." Condom use is reputed to be very low, around 5 or 6 percent.

International health organizations have earmarked more than \$3 million for education, testing, and care related to AIDS in Thailand, but some officials fear the epidemic is in its early,

latent stage and it may already be too late. "Five years from now, people will be asking, 'Oh my God, how did this happen?'" says the dean of a large school of public health in Thailand.

Health care in Ethiopia a casualty of poverty, politics

Medical and health conditions in Ethiopia vary from poor to nonexistent, according to a recent article in the *New England Journal of Medicine* (319:918-23). Authors Richard Hodes and Helmut Kloos blame a combination of poverty, overpopulation, drought, famine, underdevelopment, and political strife for the terrible health conditions in Ethiopia, where the gross national product per capita is only \$110 and the life expectancy is 41 years (third lowest in the world).

Although there is ostensibly a "pyramidal" structure of health care facilities ranging from small rural health stations to large urban medical centers, Hodes and Kloos say that there is inadequate funding to pay for supplies and personnel. The Ethiopian Ministry of Health is the country's largest medical care provider, but not enough government money is spent on health (the military receives the largest portion of the national budget, at least 20%; the percentage of the budget spent on health care was halved in the same 13 years that the percentage spent on defense almost doubled).

There are 87 hospitals for the 45 million Ethiopians, and the hospital-bed-per-citizen ratio (1:3,734) is the lowest in Africa (the U.S. ratio is 1:171). Finding personnel qualified to operate health care facilities is a constant problem; an international "brain drain" siphons off more than a third of the few dozen annual graduates of Addis Ababa's medical school; there are fewer than 800 physicians nationwide. Even less-skilled health care positions go unfilled: at last count, fewer than 5% of the 1,900 rural health stations had the full complement of three health assistants and many stations had no health assistants at all.

What can be done? Hodes and Kloos say that until the Ethiopian government gets its own house in order, the kind of socioeconomic development necessary to improve public health is unlikely to occur. While noting that injection of more capital into the national health care system wouldn't hurt, the authors believe that equally important are changes in the Ministry of Health priorities: the amount of government money spent on salaries for physicians and nurses should be reduced; medical training should con-

The first doctor to come to the North American English colonies, Lawrence Bohune, arrived in Virginia in 1610, 10 years before the *Mayflower*. At the time there were about 210 other Europeans in the colonies.

Source: *Encyclopedia of American Facts and Dates*



centrate more on primary care; present facilities should be fully used before more are built; and the government should work more closely with voluntary care-providing organizations.

Ethicists debate AIDS testing in developing nations

What right do Western scientists have to perform large-scale AIDS drug tests in developing nations? Even if the government of the developing nations give permission for such tests, do the citizens understand the implications and danger of such tests? And can expensive tests be performed without diverting attention from equally serious issues of infant mortality, malnutrition, and disease?

Dr. Michele Barry, of the Yale University Medical School's Tropical Medicine Department, recently addressed these issues in a *New England Journal of Medicine* article "Ethical Considerations of Human Investigation in Developing Countries" (319:1083-85). In discussing the urgency of testing among African populations, Barry noted that the World Health Organization's December 1987 figures recorded several times as many AIDS cases in the U.S. as in all 37 African nations, and warned researchers not to let their own needs override other very pressing health problems among the populations to be tested.

Barry analyzed the issue of AIDS research in developing countries in the context of four standard ethical principles: autonomy, beneficence, nonmaleficence, and justice.

Western conceptions of "autonomy" can be very difficult to convey in cultures with fundamentally different understandings of personhood, she writes. In many Bantu languages, Barry notes, there is no term corresponding to the English word "person," because individuals have identities only in relation to their families, tribes, or villages. The thorny questions this situation can raise with regard to issues such as informed consent are obvious: who has the right to give consent for other individuals, and at what levels of the social hierarchy? Barry also discusses the problems of language and literacy, calling for cultural and societal sensitivity when describing the nature of the investigations to be performed.

Nonmaleficence and beneficence, too, can have different meanings in different cultures. "Do no harm" and "contributing to the patients' welfare and health" can be interpreted in a variety of ways. Barry cites a case of HIV testing

among pregnant women in Tanzania, wherein the government did not want the results of the study shared with the test subjects, lest they become hysterical. The American involved in the research was accustomed to informed consent and full disclosure, and "because of ethical concerns analysis of the samples in the U.S. has not been completed."

Equally important, Barry says, is that Western researchers recognize potential political ramifications of their research: "for countries in which the chief industry is tourism, adverse or false publicity about AIDS can disrupt fragile economies." To prevent their populations from being "used" by Westerners, several African governments now prevent researchers representing more-developed countries from taking test samples out of the country; tissues and fluids must be analyzed in the host country's labs, and the results shared with native scientists.

Barry discusses the notion of justice by stating that "neither the benefits nor the burdens of research should be unjustly distributed." She says that despite the accessibility of, and low-cost of performing tests on, a high-risk population in Africa, investigators should not impose the risks of research without agreeing to share the benefits in terms of a financial commitment or a promise to make any resulting vaccine available at low cost.

Barry concludes by calling for those interested in conducting such tests to work with local review boards composed of community representatives with no financial or professional interest in the outcome of any experiments. She encourages collaboration and cooperation between health researchers of different countries, as long as the investigations are "culturally sensitive" and the research ethics are "culturally relevant."

Cost of American health care sends poor over border to Mexico

In an ironic twist, more and more Americans in Texas are crossing the border to Mexico for health care. According to the *New York Times*, poor Texans who cannot afford American care or are turned away from hospitals because they have no insurance can find affordable care and medicine across the border.

In Brownsville, Texas, the *Times* article reports, 44% of the 100,000 residents get health care in Mexico; in some smaller Texas towns the figure is as high as 70%. It is believed that nearly three-fourths of the residents in that part of Texas have no health insurance. Furthermore,

Population of Cuba:

9.9 million

Number of AIDS tests administered to date in Cuba:

3.5 million

Source: *Chicago Tribune*



Texas has the second strictest requirement for Medicaid qualification: only those who earn less than a third of the amount established as the national poverty level (\$11,650 for a family of four) are eligible for Medicaid, and they cannot have assets—including home or car—worth more than a total of \$1,500.

According to the *New York Times*, there are two private hospitals in Brownsville, but there is no public hospital for indigent residents of the entire 13-county area, which has a total population of 600,000. However, 13 physicians at a community clinic in Brownsville handle 94,000 appointments each year. The local tuberculosis rate is nine times the national rate, the infant mortality rate twice the U.S. average, and almost half of all births occur outside the hospital. Many pregnant American women cross the border to have a midwife deliver babies for less than a fifth of the cost in a U.S. hospital.

Not only is the cost of medical care and supplies lower in Mexico than in Texas, but patients also have access to a wider range of pharmaceutical drugs than in the U.S., usually without a prescription. Patrons of the pharmacies in Mexico say that they can get drugs like penicillin and narcotic painkillers without a prescription, and that the pharmacists often dispense free medical advice and drug recommendations as well.

Special Report

American church group examines health issues in Central America

In the summer of 1988, a group of 12 representatives of the Presbytery of Mecklenburg in North Carolina traveled to Guatemala, El Salvador, and Nicaragua on a Central American health care fact-finding mission. The editors of the *Bulletin* found the report of this group interesting on several counts: the members of the group represented a non-partisan cross-section of U.S. health workers (a surgeon, a dentist, a psychologist, a radiologist, two biologists, a family physician, etc.); the health problems the group identified in these three countries are similar to those of other developing countries; and their conclusions offered constructive ways for different sectors of U.S. society—including churches and individual citizens—to help.

■ ■ ■

The group identified ten major types of health problems in Central America, many of which are closely interrelated and a majority of which have socioeconomic or political roots, not merely physiological ones:

Water that is not potable. Diarrhea acquired through water-borne bacteria is the chief cause of infant death, and outside of the major cities, good water is rare. Many people are unaware of the need to sterilize water, and, even when they are aware, chlorine tablets and firewood (to boil water) are in short supply.

Lack of facilities for sanitary waste disposal. Indoor plumbing is nonexistent except in upper middle class suburban areas; the vast majority of the urban and rural population makes do with public latrines at best and open sewers in the streets at worst. Much of the runoff pollutes the rivers and streams, fouling water that people downstream later drink from and wash in.

Malnutrition. The malnutrition rates were reported at 70%–90% for first-degree deficiency, with lower second- and third-degree rates. “The visible effects of malnutrition are everywhere,” the group found, “in thin, underdeveloped bodies, lowered energy levels, and increased susceptibility to disease.”

Lack of adequate housing. In many areas, housing is completely makeshift; the rainy season means “wet floors, bodies, and clothes,” leading to lowered resistance to diseases. Crowding also contributes to the spread of disease. The group was encouraged by a few progressive housing cooperatives and programs sponsored by Habitat for Humanity.

Almost universal poverty. The average daily income is usually the equivalent of 2 or 3 U.S. dollars. Because many goods, including antibiotics, cost about as much as they do in the U.S., people cannot afford medicine even if they can find a physician to diagnose their illnesses.

War as a cause of disease and death. More people die of indirect results of the long standing conflicts than are killed in the fighting. There are many reasons for this: stray shells and hidden mines, attacks on civilians by the military, execution by death squads and other violent means. But indirect effects of the war also cause people to die from preventable illnesses: the few medical supplies are often reserved for the military; governments spend much more on the war than on public health; warring factions use a variety of means to prevent health care for enemy sympathizers.

Government policy is a deterrent to health care. Bureaucratic red tape, disorganization, and gen-

Number of boys born
for every 100 girls born
in China: 125

In U.S.: 105

(Chinese society
esteems males more
than females; because
population control laws
limit couples to one
child, many women use
ultrasound to determine
the gender of the fetus
and abort it if it's a girl.)

Source: *USN&WR*,
4/23/89



eral ineptness mean that even when medical supplies are donated by foreign sources, they don't make it to the people who need them. "In each of the three countries, government policy often seemed as much a deterrent as a help to national health care."

Military deterrents to health care. Despite protestations to the contrary, in countries torn by civil war even innocent issues such as health care and education are seen as political acts. Health care workers are targets for kidnappings and executions; supplies are intercepted, clinics and schools are shut down.

Land maldistribution. When a very small percentage of an agriculturally based nation's population owns a very large percentage of its land, the majority of citizens are unable to cultivate enough food to both live on and sell. In Guatemala and El Salvador and to some extent in Nicaragua, the investigating group found that the amount of farmland allocated to the peasants is so small (and often of poor quality) that the farmers often have trouble growing enough crops to pay the rent on the land—let alone purchase seeds, fertilizer, or farm equipment. In Guatemala the problem is most acute, and peasants often migrate seasonally around the country between plantations—all of which feature horribly unsanitary, crowded living conditions—knowing that if they get sick others are lined up to take their place.

Lack of adequate, growing, gross national product. All three countries' GNPs have actually declined in recent years, reducing any tax base that could provide more money for health care. The civil strife is largely to blame: much land is out of production, many workers serve in the armed forces, and a large portion of the national budget is spent on military supplies. This combination means less and less money for health care.

However, the study group concluded, even if the conflicts ended tomorrow, the kind of health care systems that developed nations take for granted would be an unrealistic expectation for any of these three countries. Other options, public and private, must be considered, and this conclusion set the tone for the study group's recommendations.

The study group concluded with some positive, concrete recommendations for courses of action among various interested parties: the Central American governments, Central American churches, the U.S. government, the U.S. medical community, the U.S. religious community, and U.S. citizens. For the respective governments, the group emphasized the almost

impossible challenge of ending the civil strife and the only slightly less difficult task of redirecting funding and education to focus on "primary care" and "preventive medicine." Lobbying for such changes was, then, part of the proposed agenda for U.S. citizens and churches.

However, the group also outlined a number of possibilities for more direct action by U.S. religious and medical communities as well as individual citizens. For the U.S. medical community, these include a limited amount of short-term on-site work; travel seminars for second- and third-year medical students; curriculum changes to incorporate Third World medicine; two-year programs in Central America for senior physicians; foundation-supported programs to send young physicians to Central America; and partnership between U.S. and Central American health care agencies and providers.

For the American religious community, the group recommended a variety of means—including congressional lobbying and more study tours—to increase awareness of the acute health problems in Central America. Various types of partnerships and individual sponsorships were suggested among other ways of involving American churches.

For individuals, the group recommended first a "strong, faith-based compassion for those who suffer." From there, U.S. citizens should take steps to increase public awareness of the health problems of Central America, make financial contributions to support health care programs there, travel to the countries to see the problems firsthand, and become personally involved in the formation of U.S. policy for the region.

"Since the United States is so deeply involved in the conflicts within these countries," the investigators wrote, "it increases our responsibility to them. As issues are publicized and human rights organizations supported, health care in these countries will begin to improve, strengthened by the convictions of many people that to neglect these conditions is immoral."

To order a copy of the report of the Central American Health Issues Seminar, contact William H. Tiemann at the Presbytery of Mecklenburg, 1830 Queens Road, Charlotte, North Carolina 28207-2599.

Citizens of Japan who say that if a member of their family had cancer they would not tell them the truth:

65%

Persons who would want to be told if they had cancer:

65%

Japanese doctors who say that if an incurable cancer is diagnosed, patient should not be told:

76%

Source: NYTimes, 1/19/89



CONFERENCE NOTES

Reports by Donna Ray

Loyola conference explores meanings of illness

Since the early 1900s medicine has been dominated by a model termed "biomedicine," with roots in Descartes's 1650 concept of the human body as a biochemical machine and illness as a biochemical dysfunction. In recognition of dimensions of illness and health beyond that model, the Department of Applied Sociology, Loyola University-Chicago, sponsored a round table seminar on "Psychosocial Factors in Illness and Health."

The aging of the population, shortage of funds and consequent allocation dilemmas, and different cultural models of health are a few factors that make a broader understanding of well-being imperative. Awareness of emotions, social trends and interactions, and religious faith as determinants and variables in people's experience of illness will, these scholars hope, enlighten and humanize clinical procedure.

"The biomedical model has tended to rely heavily on medical specialization and the applications of drugs and technical procedures, not balancing emphasis upon combatting disease with emphasis on ease, prevention, and self-care," said Ross Scherer, seminar coordinator. "The medical humanities and religion seek to understand the whole person, illness as a behavioral experience, and the roles of personal belief, culture, and social support."

Several practitioners of behavioral medicine explored the psychosocial factors in illness and health and the process of coping. The issues included social epidemiology and the roles of gender.

Leo Levy, of the University of Illinois, Chicago, School of Public Health, began the first morning's session on social and psychological factors of epidemics. He explained that basic causes of epidemics are often simple, for example, high concentrations of schizophrenics in the inner city seemed clearly linked to stresses of urban life.

The fundamental rule of epidemiology has been since its beginning that the course of an epidemic may be changed behaviorally. An understanding of the technical aspects of a cause (the organism) may not be required to eradicate an effect (the disease). Sir John Snow for example, through simple detective work that led him to close the Bow Street well, ended the 19th-century cholera epidemic in London. The rule continues to apply to many infectious diseases.

The seminar moved from large social aspects of well-being to personal psychological ones as Judith Richman, of the University of Illinois College of Medicine, presented statistics showing that men and women suffer equally from postpartum depression. Thus wife and husband may both be depressed and unable to support each other after a baby is born.

Other studies have shown that, for a variety of chemical and social reasons, women are more often depressed than men and expect that men, including their husbands, will be supportive and not depressed. After a baby is born, Richman advised, a woman should lower her expectations of her husband and look to parents and friends for support instead.

Consideration of the anthropological dimension of medicine completed the day's discussion. Elena Yu, of the Pacific Asian Center and School of Public Health, University of Illinois, Chicago, began with a general discussion of aging and then compared how China and the U.S. differ in their attitudes toward and treatment of the aged. She noted that the world's median age is now 31.5; in 2050 it will be 41.6. People of all cultures must consider the added years and consequent shortage of care givers in their life-planning.

Dr. Yu claimed that the elderly population of China is healthier and happier than that of the United States. She cited several reasons, including health habits and support systems in both countries. Chinese citizens over 40 have easier access to drugs and eat less meat and more vegetables than their American counter-

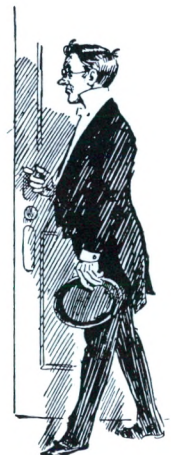
Number of times per year average Japanese citizen visits a doctor:

15

U.S. citizen:

5

Source:
NEJM 319(1988):810



A district court judge in Hastings, Nebraska, acquitted a 19-year-old man of making and selling the drug "ecstasy" because the drug's scientific name was misspelled in the state law. Because the defendant did not possess the drug named in the state statute, he did not violate the law, the judge said. The scientific name for ecstasy, correctly spelled, is "methylenedioxymethamphetamine."

Source: Associated Press, 12/1/89



parts. The Chinese culture, with fewer elevators, cars, and similar amenities, is more conducive to constant low-grade aerobic activity. Dr. Yu also credited breathing exercises and ancient folk remedies for longer and better life in China.

"Care giver" is found only in the English vocabulary. In China, one who cares for the elderly is known, in approximate terms, as a caretaker. "Care giver" in American culture implies an excessive giving up of oneself for the sake of a dependent, sick, or elderly person. In contrast, a Chinese caretaker's deference to the elderly is expected, granted, and accepted without shame. The caretaker has high status.

Greater community accountability, less social mobility, a sense of continuity both with the past (one's elders and ancestors), and with the future (rewards in later and other life), and a reverence for old age account for this difference in China.

Russell Burck, of Rush Medical College, Chicago, and coordinator of the Park Ridge Center's clergy ethics seminar series, led the next morning's discussion on how religious faith alters the experience of illness and, conversely, how illness constructs and alters faith. Dr. Burck uses a "spiritual assessment" form for patients referred to his Department of Religion and Health at Rush-Presbyterian-St. Luke's Medical Center in Chicago. The form explores the patient's social and emotional background, attitudes toward religion, and the felt effects faith and illness have on each other during the illness.

Burck explained problems that illness raised for people of faith, especially the discovery of unconscious beliefs during the time of pain and enforced inactivity. The patient might question whether a good God would allow such pain. She or he may have guilt over failure of the body and an inability to think hopefully, thus not "living up to" the faith. Normal human frailty, Burck said, was confused with guilt.

Illness calls for new ways of thinking about God and faith. Some patients were able to adjust their religious categories to the new experience of illness. They changed their expectations of God and notions of what God expected from them in return. Others were less successful in creating "a faith of their own" that was not broken by pain and dependence.

Burck found that the ability to integrate faith with illness and to find friendship with other patients was the antidote to feelings of shame and loss of faith. He found however, through the spiritual assessment, that many patients did *not*

feel helped by their faith and were unable to reconcile their beliefs with illness. Burck suggested that superficial, or external, belief structures would inevitably be broken by illness. Faith under the tension of pain may eventually deepen, may remain broken, or may return to an external structure when the illness is over.

The two-day seminar, ending with an anthropologist's thoughts on cultural differences in healing, thus brought to the table spokespersons from each of the sciences of behavioral medicine: psychology, sociology, anthropology, and theology. Scholars within these core disciplines hope to continue, together with those in medical practice, to expand modern notions of illness and to carry ideas of health beyond the American clinic.

Self-help groups seek alliance with professions

Newly ill people expect modern medicine to be a panacea. Medical professionals carry the burden of the public expectation that they are able not only to create chemical balance and physiological soundness but also a sense of wholeness and well-being in their patients. The coordinators of the first annual self-help seminar discussed how people who share a common disability can form a partnership with professionals to achieve both physical and psychological health.

Veterans of illness, disability, deformity, and helplessness know that good health requires more than technology and professional expertise. This symposium of self-help group leaders was held in Chicago, March 30-April 1, 1989, and was sponsored by the Illinois Self-Help Center.

Over 4,500 self-help organizations—involving 15 million people—exist in America. The 35 exhibits at this symposium were a small sample but illustrated the range of services and support available for people in need of different types of emotional and spiritual community: those with facial disfigurement or with eating disorders, Jewish alcoholics, parents of murdered children, those who have tested positive for HIV, children with cancer.

While disabilities differ, most self-help groups have common beliefs and goals. They share the conviction that medicine and professional guidance alone do not heal. Neither do support groups, they recognize. Rather, a partnership of the two is necessary for optimal recovery. Many self-help leaders have felt pushed aside by clinical professionals and hope for

reconciliation and a respected place in health care.

Ideas of how the medical-self-help partnership should work varied. Some groups, such as Northwestern Memorial Hospital's "Take Charge!" support group for breast cancer patients, are hospital-based and led by medical professionals. Take Charge! offers an atmosphere of emotional and spiritual support as a complement to physical care. Likewise, the Bulimia Anorexia Self-Help (BASH) Center provides individual psychotherapy, nutritional guidance, and a support group.

Other groups, independent of the medical and psychological professions, trusted professional and technical forms of healing to varying degrees. The Test Positive Aware (TPA) Network—a bi-weekly support system for those infected with HIV—is "nontherapeutic;" it offers no professional direction. The group is not hostile toward conventional medicine but encourages the use of all healing methods available—including crystals and acupuncture.

The purpose of self-help with or without professional guidance is to introduce people who share a kind of pain and thus relieve feelings of fear and alienation. Symposium co-chair Hannah Hedrick, of the American Medical Association, has long realized the importance of self-help, witnessing group members create "tracks and traces for others to follow."

These people know well the painful details of their problem and handle them with boldness. They are finding empowerment—a catchword and theme for these groups—by making a shared science of their feelings. They believe strongly that a threatening condition is just one part of the life-cycle, that illness is not a regression but a change.

Many groups offer guidelines not only to themselves but to the non-disabled public. Let's Face It, a self-help group for people with craniofacial disfigurement, lists ways to support the disfigured person, beginning with "look them in the eyes." BASH suggests that one put away the scale and diet foods when a bulimic friend visits. The notion of being a "charity case" is clearly repugnant to group members, as they encourage each other to give as well as to take. The interdependence of all people is imperative and they stress that all humans, at all times, are both patients and caregivers.

Many groups stress the importance of dependence on God. Even groups that are not church-based and do not use explicit religious language, such as Alcoholics Anonymous, have

religious overtones, as in the need for a "higher power." Groups that are overtly religious use and express their faith differently. Susan Berman, a Jewish rabbi and recovering alcoholic, expressed her problem from the perspective of a middle-class American Jew: "Many of us grew up hearing that 'Shikker is a Goy'—a drunk is a non-Jew. To be chemically dependent meant that one's Jewish status was questionable."

Rabbi Berman has, like most members of religious support groups, the double obligation to support others while integrating faith into her crisis. These members relearn the healing elements of their faith and religious practice. Terms such as sin, God, salvation, miracles, and prayer must be adapted to the pain and feelings of shame.

The symposium ended with the "first self-help and public health award" to Surgeon General C. Everett Koop, whose official opinion was highlighted: "I believe in self-help as an effective way of dealing with problems, stress, hardship, and pain. . . . Mending people, curing them, is no longer enough; it is only part of the total health care that most people require." This unusual gathering with its strength of conviction, large following, and no-nonsense approach, was its own endorsement.

Percentage of nurses who wouldn't encourage their children to become nurses:

77

Source: *Hippocrates*, Nov./Dec. 1988, p. 18

It has come to our attention that many Associates have failed to receive all of their subscription materials due to transitions in our list-management process. We are now bringing all Center business operations into our own office. Please let us know which volumes of *Second Opinion* and/or issues of the *Bulletin* you have not received since you joined the Center (the *Bulletin* was bi-monthly in 1988 and went to three-times-per-year in 1989 with cover dates of January, May, and September). And, of course, we welcome any response or question you have about the Center and our publications. Please direct all correspondence to us at 676 N. St. Clair, Suite 450, Chicago, IL 60611.



LETTERS & COMMENTS

The search for middle ground in the abortion debate

The Park Ridge Center takes no formal stand on abortion—at least not in the sense of being “pro-life” or “prochoice.” We are, however, “pro-discussion,” constantly looking at how underlying values, assumptions, philosophies, and beliefs guide the way people form opinions on controversial issues like abortion.

A survey of the public debate in the U.S., however, reveals that there hasn't been a lot of fresh discussion on the subject of abortion; if anything, polarization seemed to increase in the days leading up to the Supreme Court hearing. Bullhorns are used by one side, images of coat hangers by the other; photographs of torn fetuses clash with pictures of the bodies of women hastily abandoned when they died from botched abortions; and one side stakes its claim on the right to “life” while the other emphasizes the right to “liberty.” The Supreme Court's decision to reconsider abortion rights (temporarily displacing AIDS as the “health/faith/ethics” topic of the day) has generated a volume of articles and columns that overwhelms the summarization capacity of this *Bulletin*.

Yet we must publish *something* on abortion; “letters and comments” that we've received in response to the “Abortion: A Middle Ground?” feature in the March *Second Opinion* indicate that our Associates are as concerned about this issue as is the public at large. But how can we narrow down the literature to review? Can we choose articles that won't favor one side over the other?

It's clear that what slightly moderated voices there *are* certainly aren't coming from the camps entrenched at both ends of the prochoice and prolife spectrum. A review of the literature and the national debate, in fact, shows that the energy of the two poles is focused on the middle—because both sides are battling to win the undecided, their goal often seems to be proving

that there is, as Barbara Ehrenreich said in the *New York Times*, “no middle ground.” In this respect, the two poles have more in common with each other than with those in the middle. They need each other, including the mutual antagonism, the horror stories and horrible photographs and scare tactics, to keep the movement alive.

This is not to impugn anyone's motives or to say that there isn't genuine, deep-seated belief on both sides. The 10%–20% at each end of the spectrum obviously believe in their cause. Consider the depth of commitment of the half-million people who dropped everything and crossed the country for a weekend to march on Washington. Or consider the “normally conformist churchgoers cringing inside a ring of shouting counterdemonstrators, [who are] then dragged past the shuffling hoofs of mounted police . . . to risk prison sentences and the loss of all of their property in the work they have set for themselves” (as noted by Garry Wills in a recent *New York Review of Books* article on “Operation Rescue” abortion clinic sit-ins).

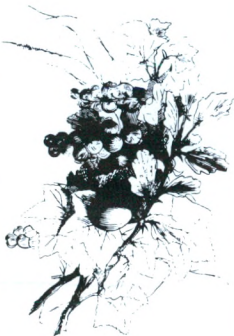
But polls indicate that a majority of Americans *are* somewhere in the middle and wouldn't mind more discussion of the gray areas. They do not see abortion as a mere form of birth control like a contraceptive, “no more serious than a tonsillectomy” (as Gloria Steinem termed it). On the other hand, they do not equate aborting a fetus with, for example, murdering a five-year-old—a capital crime—as others would have it.

A *New York Times* poll of 1,412 adults published the day of the Supreme Court hearing finds Americans “deeply ambivalent” about the issue.

The *Times* poll proposed five circumstances in which an abortion might be considered and asked poll respondents whether it should be

Sixty percent of female single parents believe their families are stronger than those with two parents.

Source: *Hippocrates* (data from National Association of Social Workers)



possible for a woman to obtain a legal abortion under those circumstances:

- if the pregnancy seriously endangered the woman's health
- if there were a strong chance of serious defect in the baby
- if the family had a low income and couldn't afford more children
- if the woman were not married, and did not want to marry the father
- if the pregnancy interfered with work or education

The pollsters found that 70% of those surveyed thought abortion should be possible in some—but not all—of those circumstances; only a tenth thought abortion should be legal in none of the circumstances, and a fifth thought it should be legal in all five circumstances.

"In a striking indication of the nuances of opinion," the *Times* reported, "roughly one third of those who agreed with the statement, 'Abortion is the same thing as murdering a child' also agreed with the statement 'Abortion is sometimes the best course in a bad situation.' Put another way, one of every six Americans says simultaneously that abortion is murder and that it is sometimes the best course."

Obviously, "prolifers" tend to quote the first half of that public opinion, and "prochoicers" the second half. But the *Times* pollsters said their findings, which "parallel those of other detailed studies of opinion on abortion, suggest that it is misleading to claim public opinion for either side." The poll takers also noted interesting variations in response depending on the wording of the question, and the gender, class, or religious convictions of the respondent.

When asked if a woman "whose pregnancy interfered with work or education" should be able to get a legal abortion, only 26% said yes, and 65% said no. "Women were more opposed to legal abortion in this case than men," the *Times* reported. On the issue of poverty, "if the family has a very low income and cannot afford a child," 43% favored the right to a legal abortion and 49% were opposed. "Lower-income people were more inclined to oppose abortion in this case than the better-off," the pollsters said. When it came to religion, two or three times as many Catholics and Protestants for whom religion was "very or extremely important" opposed legal abortion compared to Catholics and Protestants for whom religion was "somewhat or not at all important."

To bring the issue closer to home, the *Times* asked "would you approve or disapprove of

someone you know having an abortion?" While 39% said they'd approve and 32% said they would not, 30% said they either didn't know or that "it would depend on the circumstances"—a response that wasn't even included in the question. "The lack of a clear majority for either of the unequivocal responses to this question may be the best indicator of where public opinion really stands on this issue," the *Times* concluded.

■ ■ ■

Assuming that our search for discussion of the middle permits us to review any articles between "Abortion is murder, pure and simple" and "A woman's body is her own, pure and simple," how can we further narrow it down? One criterion could be elimination of those who call for concessions from the opposing side; efforts to get the *other* guy to compromise don't really qualify as "moderation."

Fortunately, even after this winnowing, there are still some moderate voices left. More often than not, however, their motives are not to reach some politically agreeable compromise, but to reach out to the undecided middle to draw it to their side. Antiabortion (or "prolife") columnist Charles Colson isn't compromising his position on abortion, but he writes in *Christianity Today* (Feb 3, 1989) that he senses a change in strategy for prolifers in light of developments like "the abortion pill," RU-486. This abortifacient will mean that "our fight will no longer focus on the clinic, the dumpster, the Supreme Court steps. It will be relational and educational. . . . The struggle will no longer be focused on legislatures and suction machines, but on people and the individual battles they hold, the values that create their choices." Colson's tone is generally moderate, but he reveals his motives when he adds, "What it means is changing the hearts and minds of a self-centered, callous generation."

Similarly, the prochoice *Boston Globe* syndicated columnist Ellen Goodman sees a need for prochoicers to change their tactics and talk if they are to win over what she calls "the wobbly middle" of the American public that is "uncomfortable with abortion on demand"—but also with "the idea that some outsider could force a woman to carry a child against her will" (April 16, 1989). Goodman says that to present their position as "caring and responsible" rather than merely "selfish," prochoice advocates "have to stop making excuses for women who won't use birth control." She quotes Frances Kissling, pres-

Playing a tape recording of information to a sleeping person will not enhance learning, because nothing of what was played during sleep will be recalled.

However, "if a list of nonsense words is learned, and memory of them is tested eight hours or twenty-four hours later, more of the list will be remembered after twenty-four hours, given an intervening period of sleep, than after eight hours without sleep."

Source: *Oxford Companion to the Mind* (1987), p. 719



When asked how much money they would require for removal of a front tooth, 15% of those surveyed said that they'd want at least \$1 million; the average asking price was \$309,300. Almost a quarter of the respondents said they wouldn't sell a front tooth no matter what the price.

According to the American Association of Endodontists, which conducted the survey, the calcium, phosphorous, and water that comprise an average tooth have market value of about 12 cents.

Source: *Chicago Tribune*, 2/19/89



ident of Catholics for a Free Choice, who says that "some abortions are indeed immoral. . . . I accept abortion on every level, but I still firmly believe it would be better if women did not become pregnant when they were not prepared to create life." Goodman's column, like Colson's, strikes plenty of moderate notes, although she makes it clear that the goal should be to persuade the middle about the "need" for abortion.

One could argue that neither Colson nor Goodman is truly in search of a philosophical middle; both are revising strategies and moderating rhetoric only to woo the uncertain middle. The tone of discussion *after* the decision of the Supreme Court will reveal whether either side moved toward the middle to hedge its bets in case it "lost" the decision, or whether they truly saw some gray areas—or whether they simply thought moderated rhetoric was more likely to win public support. Will the winning side remain open-minded, helping to accomplish some of the goals of the losing side? Will the losing side become bitter, resorting to more divisive tactics than before?

Will either side work toward public education after the battle, rather than focusing on legal enforcement of their point of view?

If we wish to further narrow our selection of published opinion to rule out those who only moderate their rhetoric to lure the uncertain middle—the Colsons and Goodmans—we are left with a few solitary voices. Since publication of the "Middle Ground" piece in *Second Opinion*, however, we have kept a lookout for these voices, and we hope that their numbers will continue to grow.

Consider *Newsweek's* George Will, a consistently conservative, "prolife" columnist who would like to see more discussion and less effort to reach a "final decision" on the issue of abortion. "Differences should be split between those who defend the intellectually indefensible Supreme Court formulation of abortion policy and those who, like George Bush, would constitutionalize the issue in a radically different but also problematic way," Will writes (*Newsweek*, Feb. 13, 1989). Will calls for reversal of *Roe v. Wade*, not because he thinks it will eliminate abortion or forcibly change public opinion, but because it will *clarify* public opinion if the question is returned to 50 states. Will writes that if *Roe* is reversed, the Republican party will have a choice it has been indirectly demanding: to retreat from its nearly categorical opposition to abortion, or to suffer "severe reverses in state

legislative contests—and hence in its party building efforts."

Will says that "millions of Americans are, and many more can be persuaded to be, troubled by late abortions of fetuses that can be treated as patients and delivered as infants." Calling for *Roe's* reversal on the grounds of poor constitutional reasoning and its "dismaying" ramifications, Will says that even though politicians won't like it, "this democratic nation needs vigorous argument, not judicial fiat, about abortion." Differences can be split, Will concludes, "if the argument is not about when in pregnancy life begins but when in pregnancy abortions should stop."

In an article published the same week in *The New Republic*, Harvard law professor Mary Ann Glendon asserts that "a middle ground does exist." Even though "many people consider moral compromise on abortion impossible," she writes, "Western European experience shows that *political* compromise is not only possible but typical, even in countries as deeply divided on the abortion question as ours." Glendon says that European legislative restrictions on abortion mesh "remarkably well" with the American public's ambivalence about abortion, claiming that most Americans are uncertain "if not about the morality of abortion, then about how it should be dealt with in a pluralistic society."

Glendon suggests that but for the *Roe* decision, state-by-state abortion legislation would have followed the course taken by many European nations, "try[ing] to balance compassion for pregnant women with concern for fetal life, emphasizing the former in the early stages and the latter as the pregnancy advances." She concludes by concurring with many of George Will's sentiments, suggesting that public argument about abortion would help us "define ourselves" in a way that the *Roe* decision, which allowed the right to privacy "to trump all others," did not. "The process of bargaining, education, and persuasion that goes on in and around [state] legislatures is well suited to issues like abortion, where most people are unsure what the 'right' approach is," Glendon writes. "With a social problem of such complexity, the best way to proceed is not through a showdown in court, where winner takes all, but by keeping dialogue alive in the nation's statehouses, where there is always another day."

In an article in the April issue of the *Washington Monthly*, Jason DeParle discusses the issue of "why liberals and feminists don't like to talk

about the morality of abortion." Announcing that he is "prochoice," DeParle notes that "pro-lifers" often are often accused of overlooking the woman involved, but then takes "prochoicers" to task for ignoring the fetus. Paying quick homage to liberal values that make "prochoice" a natural cause for the Left—civil liberties, fairness between genders and economic classes, population control—DeParle returns to supply numerous published quotes by prominent abortion advocates that reflect their belief in the unqualified right to abortion: "I have no regrets," "Women should feel no moral tension," "Women *should* feel good about abortion," and so on. Yet in interviews with the same advocates, their statements—including references to the fetus as a baby and admission that the fetus does have interests—seem to belie their own professed resolve. (There's also an excellent, though short, section on the usually ignored topic of men's failure to shoulder their part of the responsibility for the high rate of unplanned, unwanted pregnancies and the resulting high rate of abortions). Though DeParle doesn't make any specific policy recommendations, many of his criticisms of the prochoice movement "from within" are legitimate, interesting, and could be repeated and applied to both sides of the debate.

We'll give the final word to an anonymous woman who wrote the "Talk of the Town" piece in the April 24 *New Yorker*. The author, whose journey to march on Washington reminded her of an illegal abortion she had in New Jersey two decades ago, does not explicitly call for a "middle ground" or compromise on the issue. However, her heartfelt search for increased understanding from both sides could promote healthy dialogue, and her emotional memories of her own experience bring home the intensely personal nature of this very public issue.

Referring to a small group of pro-life counterdemonstrators at the abortion rights march in Washington, she writes: "There were also women praying. They were, I believe, really praying. Their gesture was incongruous with the rah-rah aspect of the march, and yet this praying arose from a feeling appropriate to the largeness of this issue. I disagreed with these women politically, but I also felt that they, and the sentiments they were expressing, belonged *with* us marchers, and not against us. I felt that their feelings, too, arose out of the female bodily experience. In fact, I was more comfortable with their sentiments than I was with some of the prochoice rhetoric—especially the militant

assertion that a woman's rights override the rights of a fetus. Full-grown, healthy human beings cheering for their precedence over the most vulnerable form of human life did not seem to me to be a glorious triumph. For me, the special meaning of the day, of my history in common with other women, was that I was able that evening to relive my experience in Elizabeth, New Jersey—to remember the fierce, despairing love that I had felt for the vague half-being forming within me as I was driven blindfolded and alone to a motel; to remember how the men in attendance were lewd and flippant; to remember disappearing into the darkness of the anesthetic—and, remembering these things, to weep wholeheartedly for the first time."

Alcohol is a factor in only about 9% of all traffic accidents, but is present in more than half of all fatal crashes.

Source: *JAMA*, 260:2480



BOOKS

Morsels from the Philosopher's Table

by James P. Wind

Director of Research and Publications
The Park Ridge Center

Like the menu in a fine French restaurant Jeffrey Stout's *Ethics After Babel: The Languages of Morals and Their Discontents* (Boston: Beacon Press, 1988) offers readers fare that is far too rich and too varied for one sitting. Too complex to be hurried through, it is better to savor this book in small bites. A philosopher with a gift for well-turned phrases and an amazingly wide vision, Stout serves up portions of Kant and Hegel, MacIntyre and Rorty, Gustafson and Donagan, among others. He addresses topics like the eclipse of religious ethics, moral discourse in a pluralistic society, and the debate between the liberals and communitarians of our age. Stout's philosophical colleagues are the appropriate judges of his nuanced arguments and his handling of many philosophical sources. But it would be a mistake to restrict discussion of his work to only his guild.

One way to introduce nonphilosophical types to his important ideas is to show how some of his ideas have significant consequences for religious and medical ethics. Here, in abbreviated form, is a verbal *degustation* of some of Stout's major contributions to current ethical reflection. Those desiring larger portions of his "moderate pragmatism" will need to sample further.

1. *The misleading image of Babel.* Stout opens his book with reference to the ancient story from the Hebrew Scriptures about the ruined tower where God confounded human speech. That story, he claims, continues to shape our imaginations in not so helpful ways. Too often the unfinished tower is held up as a symbol of our moral condition and chaos. Nostalgically, many of those who ponder our public discourse suggest that if only we could speak one common

moral language our problems might be solved. Stout's book is an extended rebuttal of such thinking. Speaking only one moral language impoverishes us. Our current situation is made more difficult by our refusal to recognize the many moral languages around us, and our reluctance to welcome the gifts they have to offer.

2. *The delusions of ethical Esperanto.* Looking back on the history of ethics, Stout describes a tactic employed by his philosophical predecessors in their effort to rise above the limits imposed by the pluralism of traditions. Rather than attempt to refine the various existing Western religious languages, these individuals fashioned a new form of ethical discourse, one Stout dubs "Esperanto" after the failed attempt in the last century to create a universal language that could overcome existing national and cultural loyalties. At best, the philosophers' strategy has had mixed results. On the one hand, the Enlightenment effort to create an ethical discourse that did not replay the struggles of the religious wars made it possible to find new types of agreement where previously only conflict resulted. But on the other, this attempt to create a tradition-free new universal language, a moral Esperanto, "tends, in fact, to focus attention too narrowly on one strand of moral language wrongly thought to have been purified of historical contingency—local custom masquerading as universal speech." Unaware of their own history, the moral philosophers failed to recognize that "any version of Esperanto is itself a product of a process in which one begins with bits and pieces of traditional linguistic material, arranges some of them into a structured whole, leaves others to the side, and ends with a moral language ready to use, possibly a quite novel one" (p. 74).

Take, for example, the secular language of human rights, currently one of our most popular

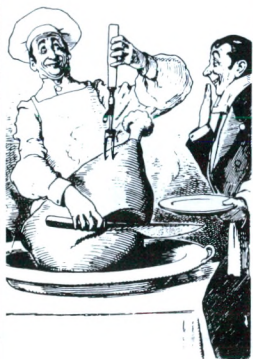
Percentage of Americans who know that a poor diet can increase their risk of cancer:

82

Percentage of Americans who have changed their diet to reduce the risk of cancer:

15

Source: *Hippocrates*,
Jan./Feb. 1989
(data from American
Cancer Society)



forms of Esperanto. Upon close examination, Stout suggests, this language "seems in fact to have begun as what the linguists call a *pidgin*—a sparse dialect used entirely for communicating with members of other groups, nobody's native tongue or first language of deliberation but a handy mode of discourse with strangers. But what used to be a pidgin can undergo further development, catch on as a language to be learned in infancy, and function as a subtle medium for deliberation and discourse with friends and family. Linguists call such a language a *creole*" (pp. 80–81).

By refusing to see that their language was one creole among many, or that their foundational principles were really "abridgements" of existing ethical traditions, the esperantists failed to notice how they had drawn "a relatively tight circle around morality" (p. 161). A great deal of human moral experience was being screened out. Whether they spoke either of the two "main dialects" of Esperanto (the utilitarian idiom of Bentham and Mill or the categorical idiom of Kant), they didn't catch what Mary Midgley called the "sad little joke" about universal languages: almost nobody speaks them (p. 166).

3. *The need to reconnect religious ethics and moral language.* One of Stout's most interesting moves is his attempt to invite religious ethics back into the moral discourse where Esperanto has reigned. He does so because disconnecting the history of Western ethics from the history of religions "risks radical distortion" (p. 109). A secular philosopher who does not share the "austere" Calvinistic piety of a theologian like James Gustafson, Stout nonetheless welcomes the diagnosis of idolatry and narcissism that a theological perspective like Gustafson's provides. Further, attention to religious ethical traditions helps the esperantists recover their location within ethical traditions and relativizes their claims. Openness to the insights of other (religious and nonreligious) moral languages becomes possible once Esperanto recedes to creole. Stout also lays much of the responsibility for the eclipse of religious ethics at the door of the theologians who "have largely accepted the very philosophical assumptions which, on my account, have made genuine dialogue difficult or impossible" (xii).

4. *Reconsidering the "new dark ages" interpretation.* No figure plays a more prominent role in Stout's book than Alasdair MacIntyre. While welcoming several of MacIntyre's insights (about social practices and institutions, for example) Stout challenges the portrait of overwhelming

moral chaos and dissensus that rules much of our current ethical conversation and literature. "Take all agreement away and we would simply be dumb and brutish" (p. 28). The fact that we can have meaningful disagreements presupposes the existence of a "background of agreement" that is all too often overlooked. We have become accustomed to "a picture that hides the actual extent of our commonality" (p. 237). Our society focuses on the things we disagree about and fails to notice the many places where agreement exists. Babel may not be as close as we think.

5. *A new agenda for ethics.* In order to overcome the limits of the Esperanto style Stout calls for an ethics that is comparative and historical. Comparative ethics such as that which Stout demonstrates in his treatment of Gustafson can reveal distortions and blind spots. Historical perspective helps one see how ethical discourse changes, how new ways of speaking about problems emerge and make possible new solutions. But such studies are in their infancy. "It must be said that ethical theory is still a long way from the kind of turn toward historical specificity that began to reshape the philosophy of science decades ago" (p. 121).

In addition, "a kind of reflexive ethnography" is needed. "It begins at home with languages in use, and then reaches out to other possibilities, accessible from its particular historical position. Its first method is participant-observation, its initial aim the understanding of all-too-familiar uses of words and related goings-on" (p. 72). Were ethicists to pay attention to moral conversations in the middle-class home, the classroom, the playground, or ghetto streets, he claims, they would be much more likely to discover the real "first moral language of America" (p. 270).

6. *Relationships between social practices like medical care or baseball and the supporting institutions.* If one carefully observed the social practice of medical care, for example, one would discover that it "already employs a nuanced and supple language." To understand it "one need only listen in patiently as doctors and nurses talk about their lives, their patients, and each other" (p. 270). Rather than reduce this rich experience until it is expressible within the conventional language of the moral philosophers Stout is suggesting that we immerse ourselves in its particularity. There are sources of agreement and moral wisdom present within the languages peculiar to each social practice. "The more we learn about the social practices around us

Length of time typical doctor lets a patient talk before interrupting:

18 seconds

Length of time patient will talk if doctor takes notes and nods encouragingly:

1 minute and 40 seconds

Source: *British Medical Journal* 298(1989):39



(whether by participation, observation, or hearsay), the more variegated our conception of human excellence and our vocabulary of appraisal can become" (p. 271).

But we dare not focus on social practices alone. Stout advocates a "stereoscopic social criticism" which keeps one eye on a given social practice and the other on the institution that shapes it. Institutions today "typically pose significant moral threats to the social practices they make possible." Social practices like medical care are in precarious circumstances: "Without the market place and the bureaucracies, the practice [of medical care] would undoubtedly suffer terribly. With them, it tends to be overwhelmed by goods and roles alien to its own telos of caring for the sick" (p. 275).

If Stout's suggestions were followed bioethics would be very different. The language of autonomy would still be spoken but others would be welcomed. More time would be spent

observing the actual practice of medicine. And institutional ethics would not be divorced from clinical or bedside ethics. Above all, ethicists would become multilingual, able to speak several moral languages well. Stout does not despair but welcomes the challenge and possibility of this new focus. "The languages of morals in our discourse are many, and they have remarkably diverse historical origins, but they do not float in free air, and their name is not chaos. They are embedded in specific social practices and institutions—religious, political, artistic, scientific, athletic, economic, and so on. We need many different moral concepts because there are so many different linguistic threads woven into any fabric of practices and institutions as rich as ours. It is a motley: not a building in need of new foundations but a coat of many colors, one constantly in need of mending and patching, sometimes even recutting and restyling" (291-2).

Over the past 150 years, average adult height in developed Western countries has increased approximately 1 centimeter per decade. Girls have their first menstrual period approximately 3½ years earlier today than did girls in the mid-nineteenth century.

Source: *Oxford Companion to the Mind* (1987), p. 92



SECOND OPINION

Volume 11 of *Second Opinion*, to be published in July, explores the idea that a glimpse into unfamiliar worlds—some as close as within our own families, others just blocks away in the deteriorating neighborhoods of our major cities, and still others halfway around the world—can help us see more clearly the hidden patterns of our own lives. The pervasive threat of sexual violence, the lonely battle of the alcoholic, the abused child's struggle out of a mire of despair, all challenge us not only to confront the darker sides of our own lives but also to respond to those who need help. A look at a religion centered on healing relationships and at an ethicist who asks us to examine our actions and motives can help us put our human pain in a more hopeful perspective.

"Sexuality and the Family, Part 2: The Role of the Church," by Christine E. Gudorf

The church needs to repudiate the parts of its past teaching that perpetuate patriarchal, antisexual, and inhumane attitudes; to deal forthrightly with problems like domestic violence, rape, and harassment of gays; and to proclaim sexuality as God's good gift to humanity.

Whether or not we are believers, the Christian church has played a powerful role in shaping our lives together, including our understanding of human sexuality. It has done so directly and indirectly, through teaching and preaching as well as by what it has left unsaid and undone. Over the centuries, much of what the church has taught, or ignored, about sexuality, has had a profoundly destructive effect on those within

the family of believers—as well as on the wider society in which the church lives. There is room for repentance, and there is need and room for change.

■ ■ ■

The Christian theological tradition has emphasized true love as entailing the sacrifice of self. Nowhere is this more true than in church treatments of the family. This emphasis distorts the meaning of the gospel. We all need to love ourselves in order to love others, in order to respond to God's love for us. The capacity to love ourselves is intimately linked to the capacity to believe that God loves us.

The belief that self-love is illegitimate and real love is self-sacrificial can have disastrous effects in a family. Men, for example, may come to believe that they are not sufficiently upwardly mobile to meet their own (and society's) standards of success. They may feel like failures. Seeking to be worthy of the respect of their families, especially their children, they may claim the right to set goals for their children not on the basis of their own achievement but on the basis of the sacrifices they make for their family.

■ ■ ■

Many of the needs of youth—to discover who they are and who they want to be, to examine and share family and peer relationships, to feel they are agents of their reality, to experience intimacy—have a great deal to do with their sexuality. Religious programming for youth often lacks any substantial content, or has predigested content. Young people need instead content that they can adapt and relate to themselves. Rather than telling our children how they should behave sexually, or how they should get along with their families, we can provide materials and

"You supply the bride and we'll supply the diamond."

—Theme of a mass marriage ceremony held for 13 couples before a minor league baseball game in Kenosha, Wisconsin, where many Illinois couples go to avoid Illinois' premarital AIDS test.

Source: *JAMA* 260(1988): 1883



leadership to help them clarify their needs and desires, and offer options for negotiating such realities.

Youth retreats can be very effective if the emphasis is on peer sharing about important areas of their lives. Teens want peer intimacy, but they often do not know how to structure it. Sex sometimes seems the only way to obtain such intimacy. In a context where other kinds of sharing can occur, alternatives are recognized and practiced.

■ ■ ■

Sexual violence is not an aberration in our society. It touches all our lives. We train our daughters to be constantly alert against rape, to travel in groups, to fear male sexuality. We understand sexuality itself—particularly male sexuality—as a form of violence. Popular language for sex depicts it as something that men get or take from women; it is a thing, a “piece.” Rape and battery are often understood as sex that “got out of hand,” where the male “got carried away.”

■ ■ ■

These victims of sexual violence are in our churches, as are many of their rapists, molesters, and batterers. Often the victims do not come forward because their church has not let it be known that they care. When we do not deal with sexual violence we condone it. We send the message to victims that sexual violence doesn't happen to good people, to church people. If it does happen, the victims must be in some way responsible. Unbelievably, there are pastors who actually say this to victimized women and children.

The difficulty most churches have in dealing with homosexuality has also made it virtually impossible to focus on either the problem of violence in the lives of some homosexuals, or social violence against homosexuals. On the one hand, where there is violence (sado-masochism) in homosexual, as in heterosexual relationships, there are obstacles to love. It is wrong to cause pain to another, and desiring pain denies self-love.

■ ■ ■

Family is important, but no family is perfect. Many more than we think are warehouses for fear and pain, training grounds for destructive, violent relationships. Sometimes husbands and wives *should* separate. Sometimes children are better off not living with either parent. Decisions

about family—divorce, custody, adoption, marrying, having children, or maintaining ties with parents after adulthood—are most lovingly made on the basis of the welfare of the individuals concerned. Over against the interests of persons, the institution of family deserves no consideration for its own sake.

“Afro-Caribbean Spirituality: A Haitian Case Study,”

by Karen McCarthy Brown

To understand the healing properties of the African-based Vodou of Haiti, it is necessary to know that the individual is defined within a web of relationships that includes not only the extended family, but also ancestors and spirits. Most Vodou healing is directed at restoring damaged or broken relationships.

■ ■ ■

“*Mizè mennen parespè*,” the Haitians say, meaning, if you show you are suffering people lose respect for you. *Mizè* (literally, “misery”) is an interesting word choice here, for while it can be used to refer to suffering in general, it is used most often to refer to poverty with all its attendant pains and indignities. There are many beggars in Haiti. One sees them everywhere, but most often in markets, cemeteries, and churchyards. In spite of their numbers, there is a special shame associated with begging. This becomes apparent in the way begging is used within the Vodou system. When the spirits want to teach a lesson in humility to a devotee, they command that person to don the ritual version of rags and go to the market and beg. The ignominy of begging comes largely from the fact that beggars are seen as isolated individuals whose activity announces to the world that they have been abandoned by the extended kin group and now must forage on their own. Even if the family were lost through death rather than discord, the person who must beg can easily be seen as someone who was not clever enough or respectful enough or sufficiently hardworking to find a place as adopted kin in another family.

■ ■ ■

Both men and women who no longer live with their extended families feel the loss acutely. In fact, this sense of loss can persist for generations. In the cities, it is the Vodou temple and the fictive kinship network it provides that compensates for the missing large rural family. The head of the temple is called “mother” or “father,” and

Percentage of all new mothers in the U.S. who breast-fed in 1970:

24.3

In 1980:

52.5

Among new mothers with less than 12 years of education:

32.1

Among new mothers with 13 years or more of education:

73.4

Source:
U.S. Census Bureau



the initiates are known as "children of the house." The Vodou initiate owes service and loyalty to his or her Vodou parent after the pattern of filial piety owed all parents by their children in Haiti. In turn, Vodou parents, like actual ones, owe their children protection, care, and help in times of trouble. In certain circumstances this help is of a very tangible sort: food, a place to sleep, assistance in finding work. The urban Vodou temples are currently the closest thing to a social welfare system that exists in Haiti.

The differences between men's and women's lives in the cities have also left their mark on the practice of urban Vodou. While in some parts of rural Haiti women can gain recognition and prestige as *manbo* (priestesses), herbalists, or *fam saï* (midwives), nowhere in the countryside do they effectively challenge the spiritual hegemony of the male. This is not the case in the cities, where there are probably as many women as men in positions of religious leadership.

■ ■ ■

When the spirits and the living are spoken of as separate entities they are understood to be interdependent. Although it is clear that overall the spirits have far greater powers than do the living, the relationship between devotees and spirits is nevertheless characterized by reciprocity and mutual dependence. The *lwa*, like the ancestors, depend on the living to feed them. Hungry spirits are troublesome and destructive. The living, in turn, depend on the protection and luck that only the spirits can guarantee. This relationship is not unlike the one that exists between parents and children.

**Excerpts from *Bill W. and Dr. Bob: A Historical Drama on the Founding of Alcoholics Anonymous*,
by Samuel Shem and Janet Surrey**

Before the founding of Alcoholics Anonymous, people addicted to alcohol struggled on their own. This play, which is based on historical events, shows how two alcoholics are able to regain control of their own lives by supporting each other and surrendering control to a higher power.

■ ■ ■

**Scene 10. 1934, December 11.
Town's Hospital. New York. Music**

Bill W. *in hospital bed*. Ebby *at his side*

Bill W. I gave it my best shot, Ebby, trying to get where you are.

Ebby. You'll make it, Bill, I know you will—but what *do* you remember?

Bill W. I was in a self-pitying mood and decided to make my own investigation of your mission on 23rd. I got off the subway, stopped at some bars, wound up drinking with a Finn named Alec. I brought him to the mission. That's about it.

Ebby. Well, you and your derelict Finn came back three times that afternoon—drunk, and loud—which bothered the cook, fella named Spoons Costello. Each time, he kicked you out and told you to come to the meetin' that night. I came in and sat you and the Finn with the down-and-outers, on the right.

Bill W. Yeah! I remember kneeling with those poor bastards—the stink of sweat, cheap wine—trying to do penance. And you know, for once, I *did* feel penitent. Did I speak up?

Ebby. Sure did. You said, "If Ebby can get help here, so can I!" You did right, Bill. You made a surrender.

Bill W. Didn't work—I've been drunk the whole four days since. Drunk the whole two weeks since you walked back into my life.

**"Facing Brokenness:
An Interview with David Hilfiker"**

Working as a physician to the homeless poor of Washington, D.C., Hilfiker uses those experiences to reflect on the idea of responsibility—considering to what extent people can be responsible for themselves, for others, and for the community.

■ ■ ■

People still have enormous respect for doctors. There's a godlike image, on the one hand, but a "doctors don't really care anymore" image, on the other. And there's no attempt to bring them

Percentage of patients
who want their doctors
to refer to them by
their first name:

40

by their last name:

18

Percentage of physicians
who claimed to address
patients using first name:

1

Percentage of doctors
who preferred to be
called by their first name:

3

By their title and
surname:

65

Source: *Journal of Medical
Ethics* (London)
14(1988):129-31, quoting
JAMA, 247:2415



"To the [NEJM] editor:
It is time for the medical community to address the ethics of advertising and marketing. . . . This year I received a videotape cassette describing the latest in Doppler ultrasound equipment, with images of arterial walls bouncing to a disco beat. Next came a sample of the latest vascular bypass graft in the form of a 'pop-up' book. . . . I have received pre-meeting advertising material by Express Mail, in a maneuver calculated to guarantee my attention. . . .

"In times when physicians' incomes are under attack as extravagant and when hospital services are being trimmed under the guise of cost-containment, it appears that the marketing of medical supplies knows no bounds. . . . Although many meetings are subsidized in part by the fees these companies pay, that is scant justification for this extravagant practice. We all know the source of funding for such displays and mailings. Quite frankly, I can do without videocassette mailings and free meals at conventions if the end result is decreased costs and improved resources for my patients."

—Jeffrey L. Kaufman,
M.D., Albany, N.Y.
NEJM 319:522



together, either in the public mind or in the profession. I think in large part it's because we're unwilling to come to grips with the fact that we're just people who have a job, a profession. There's this mystique about us. . . .

But we're not magical people. Part of it's the money. You can't ask for \$120,000 from people for what is after all a service profession, like being a minister or a teacher, without raising expectations awfully high. If we're going to hang on to the income, we can't say, "I'm really kind of struggling. I don't like this all the time. I'm not willing to work eighty hours a week." We've gotten ourselves in a bind. If we want to continue in the lifestyle we're accustomed to, we had better not talk about some of these things.

■ ■ ■

I came to the city with the idea of "Blessed are the poor," you know. And I am faced with a man who takes \$250 from my receptionist's purse—and he's my friend. I'm faced with people who are ugly when they're drunk. The full range of ugly people, in many cases not real nice people. There are two reactions. One is the stereotypical reaction, which is to say, "The hell with poor people, I'll go off and do something else." The other, the more typical Christian reaction is to say, "What's the matter with me? Why don't I see the face of Jesus in these people? I guess I'm not Mother Teresa, I guess I'd better leave." Both responses are really the same—to get out of there. But in the latter case I feel it's my fault, I wasn't able to see the face of Jesus in the poor.

So one of the real changes for me has been to say that poverty in this context is brokenness. And brokenness is really broken and it's ugly. And God is not saying, "Blessed is poverty." He is saying the poor are blest because they're poor, not because they are wonderful people, but because God's on their side, regardless of what happens.

■ ■ ■

Sometimes when I'm with people who don't see how we are destroying ourselves through injustice, militarism, ecological rape, I really do feel like Jeremiah—seeing very clearly the coming destruction of our culture. The judgment's been rendered. Aside from an actual, literal miracle, I don't think it's possible for our society, our culture, to pull itself away from the working out of the judgment that's coming.

We are rearing people in the cities for whom there will be no cure. We will not fix those people, and the murders we're seeing now in the

ghettos of Washington are going to get worse and worse because those people are not fixable. We're talking about parts of our culture, about a generation. Even if we did everything right, the most we can hope for is some improvement over a generation, which means having to pour in billions of dollars without visible results for at least a generation. Given the spiritual immaturity of our country, there is no way we're going to be willing to do that.

"Victims of Victims: The Unending Chain of Poverty," by David Hilfiker

Physician Hilfiker sees his children patients become parents themselves at an early age. Watching them perpetuate the chaos and violence that characterized their childhoods, he understands more clearly the depth of damage done, the futility of assigning blame, and the need for a massive social response to begin to salvage these lives.

■ ■ ■

Sarah is herself the product of an alcoholic, abusive family, and has been abandoned by the men she has cared for. Now faced with homelessness, without money enough for food and rent, she can barely manage her own life, much less provide the stability and consistent discipline for two young children. She is, in fact, giving everything she possesses, every last bit of energy, to her children. There is no doubting the love and commitment she feels toward them, but that is not in this case enough. When Derwin, sensing the chaos in the family, acts out, she resorts to the only means of discipline she knows, yelling and physical abuse, in an effort to control him. As might be expected, however, this discipline is offered in such an inconsistent manner that the boy really has little idea what is expected of him. As a result Derwin already perceives himself at age six as "bad." He has little incentive and less ability to respond positively to Sarah's discipline.

It is not difficult for me to imagine that in ten years Derwin will be one of the young men slouching in the doorways of run-down buildings, hustling on the streets. It is not difficult for me to imagine him at age sixteen as a high school drop-out, having fathered a child or two, with no prospects for legal work, a perfect set-up for the drugs and drug dealing offered at every corner in our neighborhood—if he has not long since become part of the scene, running drugs as

a twelve-year-old courier. Will it then be Derwin's fault that he is finally as "bad" as he thinks he is? Will Sarah be to blame? Her parents?

What is it like to grow up as a black child of poverty watching television and listening to advertisements, the subliminal message of which is that anyone who works hard can make it? These children believe at an early age the lie that America is a meritocracy. They, too, believe they have been born into an egalitarian system in which all start out equal and where one's true merit is measured by material success. If their families are not happy, if they don't have the material things which define success in our culture, then that is evidence that they simply aren't worthy of that success. If they were worth anything they, too, would live in the suburbs and have all the things promised in the advertisements.

These children live in conditions inhospitable to the human spirit. As Jonathan Kozol has written, abuse surrounds them on all sides. I don't think I can really imagine what it is like to grow up under such conditions. I can imagine that my response would be much the same as theirs too often is: To give up, to succumb to self-blame, to know deep within myself that there is no hope, and to know that it is all my fault.

**"On James F. Childress:
Answering Every Person,"
by Courtney S. Campbell**

The common humanity of all people is affirmed by asking believers to be able to explain and defend their actions in terms understandable and persuasive to nonbelievers.

Though we are created in the image of God, Childress does not believe that we have the capacity to imitate God in our moral decision making. Human finitude and fallibility warrant particular suspicion of results-oriented moral theories, which are typically too idealistic about human nature. Even if God is a utilitarian, as the Anglican theologian Joseph Butler once speculated, Childress is quite clear that human beings have no grounds for adopting such a moral stance.

The complexity of the moral life is due not only to human limitations in determining the right or good action, but also to inabilities in per-

forming it. The pervasiveness of sin and moral weakness presents an important test of adequacy of any ethical method. Childress accounts for this "fact" about human nature in at least two ways. First, the dimension of finitude, fallibility, and sin support a rule-governed conception of the moral life. Moral principles and rules are necessary in part to compensate for human tendencies to rationalize and engage in self-interested action. They establish obligations, without which these tendencies might well lead to antinomianism ("no law"), culminating in moral and social anarchy. When defended as moral absolutes, principles and rules risk moral tyranny and legalism, Childress concedes; but given the darker side of the human condition, it is more realistic to fear *most* the situation of moral anarchy.

These convictions about human nature, according to Childress, also indicate a prominent role for procedures in moral decision making. Moral reasoning, accountability, and institutional standards provide a basis for moral interaction in a pluralistic society where people disagree over the values that ought to direct actions and decisions.

Procedures, while they do not eradicate sin from the moral life, minimize its impact. Procedures can counter the bias that afflicts moral decision making and its potential for imposing a self-interested vision of the human good on others who do not share such a vision. Given the universality of sin in human experience, Childress contends, it is necessary to "support procedures to prevent one sinful person from overriding the wishes, choices and actions of another sinful person." For Childress, this kind of moral imperialism, and the need to limit it, is exemplified most acutely in conflicts between health care professionals and patients.

"A North Carolina man went to his doctor complaining of a 'full sensation' in one ear, accompanied by a hearing loss. The doctor found that the man's ear canal was blocked by—we are not making this up—a plug of hardened Super Glue.

"Now, some of you are scratching your heads and wondering how a person with an IQ higher than pastry can get Super Glue in his EAR and NOT KNOW IT? But you parents out there are no doubt nodding and saying, 'It would not surprise me to learn that this man has a 3-year-old son.'

"And, of course, you're right. According to the AMA newsletter, the son 'squirited the glue into his father's left ear while the man was sleeping.' Fortunately, surgeons were able to unplug the man's ear, but as medical consumers we can prevent this kind of near tragedy by remembering to take these basic safety precautions:

"1. Never keep 3-year-olds around the house.

"2. If you do, never sleep."

—Humorist Dave Barry of the Chicago Tribune Syndicate, quoting an AMA newsletter



RESEARCH SUMMARY

Do Catholic women have more abortions than Protestants and Jews?

Kelly, James R., "Catholic Abortion Rates and the Abortion Controversy," *America*, Feb. 4, 1989, pp. 82-85.

In the January issue of the *Bulletin* (pp. 5-6), it was reported that a New York family planning institute claimed "women describing themselves as Roman Catholic had an abortion rate equal to the national average, [while] the rate among those identifying themselves as Protestants or Jews was 30% below the national average." Readers wrote in directing us to the story by Fordham sociology professor James Kelly in *America*, which explored in greater detail the story behind the statistics.

Kelly recalls that when he heard the abortion figures on the radio, they certainly caught his attention—and others', as the researchers were deluged with inquiries. What was one to make of the findings? Kelly says that they suggest that "religious traditions that seek to achieve an informed conscience among their membership [Jews and Protestants] rather than seeking laws prohibiting abortion, do better than the Catholic tradition in helping their membership value unborn life." He also notes that "persons of good will" might suggest that before the church presumes to change *Roe v. Wade*, "its leaders should seek to persuade their own membership to use other means of birth control."

But digging deeper, Kelly finds that the statistics don't tell the whole story—and the statistics themselves could be called into question. For one thing, many clinics and women refused to participate in the study, forcing the researchers to abandon their original random sample. The study was conducted to investigate a number of factors affecting those who get abortions—not just religion—so other factors such as race and income also played a role. For example,

Hispanic women are 60% more likely than non-Hispanics to have an abortion, and—despite gains by Protestant evangelicals—most Hispanics in the U.S. still identify themselves as Catholics. When nonwhites are excluded from the Protestant sample and Hispanics from the Catholic sample, Kelly reports, the Catholic abortion rate becomes 76% the national rate and the Protestant rate 55%. Furthermore, the questionnaire did not ask whether respondents were actively religious, "an unfortunate omission," Kelly says. He also notes that the number of people on Catholic parish rolls is only a fraction of the number who will identify themselves as "Catholic" when asked.

After figuring in a number of other factors, the Protestant and Catholic rates become fairly close, close enough that statistical error begins to play a larger role in abortion rates than religion. Without getting into "quibbling" with the abortion study, Kelly says it is useful because it "did not discover what Catholics and others had every right to expect. Catholic women are not noticeably different from Protestants in their use of abortion. . . . A Catholic hope is rudely disturbed."

But Kelly also points out other findings that undermined the claims of early advocates of legal abortion, for example, that abortion wouldn't be used as a form of birth control (43% had had previous abortions) or that it would be used primarily in cases of rape, incest, or health problems of the mother (less than 1% cited rape or incest and 7%, a health problem).

Kelly says these findings "offer little consolation for anyone, save the unreflective." Noting that "the Catholic Church has never claimed for its membership a higher degree of moral virtue than that found in other forms of committed life," Kelly says the data "can be read as showing the ecumenical basis for opposition to abortion." The study provides more proof, he concludes, that abortion is not merely a "Catholic" issue.

Age at which boys have grown to one-half of their adult height:

2 years

Source: *Hippocrates*



Why should the "haves" care for the "have-nots"?

Friedman, Emily, "The Torturer's Horse," *Journal of the American Medical Association*, 261:1481-2.

The author, who identifies herself as an "independent health policy analyst," takes the title for her essay in *JAMA's* "Commentary" column from a W. H. Auden poem that says "the dogs go on with their doggy life, and the torturer's horse scratches its innocent behind on a tree." "Most insured Americans are like the torturer's horse," Friedman writes, "minding their own business while somewhere, in another part of the forest, the uninsured poor suffer." If the "us" (white, employed, middle-class) and "them" (poor, nonwhite, homeless, oddball, mad) syndrome continues, she says, and "should we continue to treat the most fragile members of our society as strangers, we will not be acting like the torturer's horse; we will be the torturers."

Friedman takes a new approach to the "silent, largely invisible epidemic" of the medically indigent. Casting aside images of the uninsured as nonwhite welfare mothers ("who are eligible for Medicaid") or dope dealers ("[who] usually pay cash"), she attempts to show how subjecting the vulnerable to the "whims and prejudices of payers, providers, and society" puts everyone at risk. In other words, if the haves do not help the have-nots merely out of sympathy or justice, perhaps they can be motivated if shown that it is in their own best interest to do so. She lists several ways in which this is so:

"We are at risk because of disease and injury, because untreated conditions can spread or produce secondary effects." The untreated mentally ill can harm others with guns; diseases like AIDS may begin with "social outcasts" but because "viruses and microbes know no social barriers, they may come for the rest of us, in time."

"We are at risk of further hampering American productivity and competitiveness as the workforce includes more and more uninsured workers." Friedman says that uninsured workers "are more likely to miss work, to lose jobs, to spend time at home with sick family members, and to spread what ails them to fellow employees." Furthermore, almost half of the working uninsured work for companies with fewer than 25 workers, which strikes Friedman as "a strange way to encourage entrepreneurialism in the world marketplace."

"We are at risk because those found to be 'uninsurable' due to past or current health problems or test results often cannot obtain affordable coverage at all." Many of the sick are fearful of moving or changing jobs because they fear losing their insurance. Medical indigence is growing, Friedman says, noting that "the number of Americans with private coverage of hospital costs is dropping at the rate of 1 million per year."

"We are at risk of forgetting a basic rule: most fabrics unravel at the edges first. In dismissing the medically indigent as though they belong to another species, we dismiss the fact that the barrier between us and them is movable—and that it is moving closer to the rest of us all the time."

For Friedman, "the solution is obvious": reasonable health care coverage for all, or reasonable reimbursement for providers who care for the poor. She prefers the former, because it provides consumers with more options and removes the stigma of charity carried by the uninsured. We already know, she says, that the problem is serious enough to warrant drastic changes, that the poor are not "undeserving," and that we can "afford" such coverage ("a nation that can afford nearly one million caesarean sections. . . and a 25% annual increase in cosmetic surgery can afford basic care for everyone.").

Friedman closes with an appeal to avoid the risk of "moral rot at the heart of our society, born of a callousness about those whose suffering we cannot see and therefore do not acknowledge." She concludes by quoting a serious statement a comedian used to close his act: "Not to be loved is sad—but not to love is truly tragic."

Should clergy act as psychiatrists?

Coles, Robert, "Psychiatric Stations of the Cross," *Harvard Diary*, pp. 10-12, New York: Crossroad, 1988.

A friend brought to our attention this fine little essay, written in 1982 and published in Harvard psychiatrist Coles's most recent book. Coles describes visiting a terminally ill friend who had recently been visited by a priest who asked a "relentless" series of questions about how the patient was "managing" and "coping" with all of the "stress" he had to "confront." Coles says his ill friend was initially put off—and later enraged. The patient had wanted to talk about his faith, about Christ, about Luke, about Heaven and

Although sleep researchers have been able to "deceive" the daily biological clock enough to induce people to live on 23- or 25-hour sleeping-waking cycles, "a 12- or 18-hour day seems impossible."

Source: *Oxford Companion to the Mind* (1987), p. 92



Percentage of drugs developed in the U.S. that pass animal tests, are tested on humans—but do not get approved by the FDA:

80

Source: *Public Health Statistics*



Hell—and the priest had only wanted to share his newfound psychiatric sensitivity.

Coles soon found himself recalling his own impositions of psychiatry as moral authority when addressing clergy, wondering why so many in society use psychiatric concepts in a “normative, if not self-righteous and moralistic manner?” Coles’s goal is not to denigrate the value of clinical terms, he says, but to demonstrate that they have become a moral code strongly compelling to the clergy “as in ‘pastoral counseling,’ which for all too many of us has become a religious calling, with the Bible and its various messages as anecdotal adjuncts, quaint leftovers from an earlier era.”

Coles said his friend was eagerly awaiting the priest’s next visit, when he would wait for the inevitable “song and dance about my ‘feelings’ ” during which the friend would suddenly interrupt the priest, hand him an open Bible from the nightstand, and tell him to read from it. The priest would see Psalm 69: “Save me, O God; for the waters are come into my soul. I sink in deep mire, where there is no standing. I am come into deprivation, where the floods overflow me.”

Coles wonders whether America’s clergy—and laypeople—are not mired in “the dreary solipsistic world so many of us have learned to find so interesting: the mind’s moods, the various ‘stages’ and ‘phases’ of ‘human development’ or of ‘dying,’ all dwelt upon (God save us!) as if Stations of the Cross.”

When is it proper to use fetal tissue?

Greeley, Henry, Thomas Hamm, et al. “Special Report: the Ethical Use of Human Fetal Tissue in Medicine,” *New England Journal of Medicine*, 320:1093–96.

Human fetal tissue is a very useful thing. When transplanted into humans, it grows quickly and adapts well to the host organ and body. These characteristics have led to an increased demand for such tissue for use in experimental treatment of Parkinson’s disease and diabetes. As the demand for it has grown, so has the controversy concerning how fetal tissue may be obtained and when it may be used. Last year the Department of Health and Human Services declared a moratorium on all federally sponsored research that uses tissue from fetuses that were aborted electively.

This report published in *NEJM* was written by a special ethics committee at Stanford Univer-

sity. Its authors addressed the ethics of fetal tissue within “four generally accepted principles of medical ethics”: beneficence, doing no harm, respect for human dignity, and respect for the autonomy of the patient. These requirements immediately introduce some contradictions: an induced abortion respects the patient’s autonomy and the resulting tissue may be put to beneficent research or therapeutic use, but the abortion itself harms (actually, destroys) the fetus. (It is clear how attitudes about abortion and the nature of the fetus can affect attitudes toward fetal tissue use.)

The authors posit that the use of human tissue is not itself objectionable, and in the case of spontaneous abortions, fetal tissue should “be treated with the same respect and subject to the same rules” as, for example, tissue from an accident victim’s cadaver. (The only difference noted is that the fetus was never in a position to choose its fate, but the Uniform Anatomical Gift Act provides that when the decedent has expressed no preference, the next of kin may make the decision.) The committee makes clear that cadaver rules should apply to fetuses, and not mere “tissue rules” that apply to, for instance, an excised tumor or appendix: “A fetus is not simply a mass of tissues; it is at least a potential human life and should be treated with dignity.”

The issue gets thornier, however, when the focus turns from spontaneously aborted to electively aborted fetuses. To guarantee ethical use of tissue from electively aborted fetuses, the Stanford committee makes two major stipulations: neither the patients who choose to abort nor those professionals performing abortions should be allowed to benefit from the resulting fetal tissue. Both requirements obviously are intended to prevent encouraging abortions for the purpose of tissue retrieval, and the authors of this report suggest several ways to remove the woman having the abortion and the people performing as far as possible from the eventual use of the fetal tissue.

The Stanford committee calls for proscription of any use involving tissue from fetuses aborted with a specific recipient in mind. “To use that tissue is to treat the fetus as nothing but a medical product and the uterus as a factory. It would demean the potential or actual humanity of the fetus.” At this point the Stanford recommendations diverge from the Uniform Anatomical Gift Act, which permits organ donations to specific persons, and the committee recommends amendment to the act to exclude fetal tissue.

That brings up the biggest question of all: whether the medical use of fetal tissue encourages induced abortions. The authors believe that preventing the mother and the physician from benefiting from use of the fetal tissue solves that problem, but they concede that even with those safeguards "mere knowledge that a beneficial use may be made of the fetal tissue could influence some women considering abortions." They conclude, however, that because of the complex and powerful combinations of "physical, emotional, economic, and religious" considerations, the idea that this knowledge would have any marked effect is "implausible."

This is the crux of the issue, and many would disagree with this conclusion. Precisely *because* of the difficulty of those other factors, the knowledge that her fetus's tissue was going to "be put to good use"—perhaps even save a life—could tip the balance for a pregnant woman who was completely torn about what to do. Even efforts to keep individual mothers from knowledge of the fate of their fetus's tissue would be ineffective if electively aborted fetal tissue use became so widespread that tissue retrieval was assumed. The authors, aware that reasonable people may differ in their conclusions, say that "given these legitimate differences, a physician or medical center should never feel ethically obligated to participate in research or therapy involving human fetal tissue."

The proper procurement and use of fetal tissue is one of the most controversial issues in medicine and medical ethics. The Stanford committee's report is a useful starting point for the discussion; the next developments will depend on whether the U.S. Supreme Court changes the official definition of the nature of prenatal life.

How does a Jewish atheist come to be "prolife"?

Henthoff, Nat, "You don't have to believe in God to be prolife," *U.S. Catholic*, March 1989.

This article gets past our professed moratorium on abortion articles (see the "Letters and Comments" section) because it actually does offer a new perspective. It's no longer surprising to hear religious people arguing for the right to abortions, but nonreligious people arguing against abortion don't come along every day.

Henthoff, a nationally known liberal commentator and columnist for the *Village Voice*, is an unabashed civil libertarian who identifies him-

self as a Jewish atheist. Why does he oppose abortion? "Because as an atheist, all I have is life, this life," he writes. "All I can believe in is life. And once the society cheapens life—most horrendously through abortion on demand—then life all along the line will become cheapened. Including mine."

Adopting the argument of many antiabortion feminists, he declares that he is a liberal precisely because he is concerned with helping the powerless—the poor, the homeless, the exploited, the unorganized workers—and he sees no one as "more in need of being saved from destruction" than fetuses in danger of abortion.

The experience of seeing—from his perspective as a civil libertarian—numerous profoundly handicapped infants "marked for killing as soon as they were born," made him "finally see the slippery slope."

Henthoff enthusiastically embraces Joseph Cardinal Bernardin's "seamless garment" approach to a consistent ethic of life, which posits that if one is "prolife," one is not merely against abortion but also against other "forces of death in society" such as capital punishment, programs and attitudes that intensify poverty, policies that lead to war. He also sees the seamless garment principle as a way to bring a more diverse group of people into the antiabortion fold. "Too often the antiabortion forces are dismissed as being an insular, parochial group," he writes, "predominantly Catholic, predominantly right-wing, predominantly concerned with life only to the point of birth but thereafter indifferent to budget cuts in medical care and nutrition for women and their children in poverty." Wider acceptance of the seamless garment philosophy could change that perception, Henthoff argues, among his liberal colleagues and among the "many Americans who are troubled about abortion on demand."

Granted, the arguments aren't entirely new, but the source is unusual.

What do the religious traditions say about reproductive technology?

Greil, Arthur L., "The Religious Response to Reproductive Technology," *Christian Century*, Jan. 4-11, 1989, pp. 11-14.

In this densely packed, surprisingly thorough little article, sociology professor Greil explores official Catholic, Protestant, and Jewish attitudes toward reproductive technologies and finds that

The average 7- to 12-year-old can list 5.2 brands of alcoholic beverages but only 4.8 American presidents.

Source: Survey conducted by the Center for Science in the Public Interest



a majority of believers support most of the new technologies regardless of their faith's teachings.

Starting from the 1987 Vatican document that expressed opposition to most of the new reproductive technologies, Greil considers the three religious traditions' positions on in vitro fertilization, artificial insemination by donor, artificial insemination by husband, surrogate motherhood, and embryo freezing. The Vatican opposes all of these, although it "does not oppose the use of fertility drugs or surgical measures to diagnose and treat infertility." Some Jewish writers, Greil says, argue that people have a moral obligation to take all reasonable steps necessary to preserve reproductive health, and official Protestant attitudes vary with the degree of fundamentalism involved; the more conservative the tradition, the more it is opposed to the new technologies.

The grounds for church opposition vary, Greil says; for some it is the means required to achieve pregnancy, for some it is the expenditure of energy that "should be devoted to preventing unwanted births and improving the health of all infants," and for some it is a fear that reproductive technology "will promote a perception of children as products rather than as human beings to be cherished in their own right."

Greil finds that most religious objections to the new technology relate to specific methods. Some of the positions seem somewhat contradictory: Catholic teaching permits surgical methods to treat infertility, for instance, but drawing semen for analysis or insemination through an arguably more "natural" way (masturbation) is objectionable because it is a sexual activity that cannot directly lead to conception. Similarly, Greil notes, the Vatican apparently finds surgical implantation of sperm into the mother's fallopian tube more acceptable than uniting of sperm and egg outside the womb in a petri dish (in vitro fertilization, or IVF) because the former procedure is deemed more "natural" even though it requires monthly surgery while IVF requires none. Catholic teaching even affects non-Catholic treatment facilities: "most IVF clinics implant all fertilized eggs into the uterus to avoid criticism from Catholic leaders and others who believe that allowing a fertilized egg to die is tantamount to abortion," Greil writes.

One way of categorizing the technologies may be to distinguish between those that can take place within the context of marriage (artificial insemination by husband, IVF from husband) and those that involve a third party (artificial insemination by outside donor, surrogate

motherhood). Even the most conservative Protestant and Jewish opinion make some allowances for those technologies within marriage. The Vatican, of course, is opposed to any separation of unitive and procreative aspects of sexual intercourse (which rules out AIH) although Greil notes Father Richard McCormick's argument that it is "sufficient that the spheres be held together, so that there is no procreation apart from marriage, and no full sexual intimacy apart from a context of responsibility for procreation."

With regard to the second category, those methods that involve a third party, the churches' positions become more prohibitive. "Even theologically-liberated Catholics" support the Vatican view that artificial insemination of genetic material from a third party violates the marriage covenant; some Protestants liken this to adultery; and more conservative Jews reject it because "a child with unknown parentage may unwittingly commit incest." And, Greil writes, "while opinion is by no means unanimous, most religious leaders reject surrogacy."

But Greil finds a wide gulf between official teaching and public behavior, where "practical concerns overshadow ethical [or religious] concerns," because couples' "one overriding goal" is to become parents. He suggests that the proportion of Catholics who will diverge from Vatican teaching on the new reproductive technology will be similar to that who reject official doctrine on divorce and remarriage (73%) and birth control (68%). Vatican injunctions for sterile couples to turn instead to "adoption, various forms of educational work, and assistance to other families and to poor and handicapped children" are of little comfort, Greil says, to the childless, almost desperate couples he's interviewed.

Greil believes that reproductive technology itself is responsible for the "do anything, try anything" attitude of infertile couples; the hope that a new treatment or procedure will work makes it difficult to accept infertility. "Whereas a woman could once say, 'I must accept that bearing a child has been foreclosed,' now she must take responsibility for 'giving up,'" Greil writes. "Acceptance of one's infertility has been transformed from an act of humble resignation to an act of selfish will." In that light, church teachings take a back seat: "Appeals to moral rights and wrongs are less convincing when we believe we can change our condition through technical know-how."

Average hospital bill for having a baby:

\$4,300

Cost of "Video Baby," an interactive videotape for people who want to experience parenting without having a baby:

\$20

Source: *Hippocrates*



How many ministers are "wounded healers?"

Maeder, Thomas, "Wounded Healers," *Atlantic*, Jan. 1989, pp. 37-47.

With a cover that shouted in large type, "Wounded healers: The old joke that therapists are more disturbed than other people may be no joke," the January *Atlantic* surely grabbed the attention of those in the counseling and "helping" professions. A provocative inside tagline stated that those professions, particularly psychotherapy and the ministry, "appear to attract more than their share of the emotionally unstable."

Maeder, a biomedical consultant with a background in psychiatry and neurobiology, presents his case well. The few statistics he can find relating to problems like alcoholism and suicide seem to support his main premise (that the emotionally unstable are drawn to those professions that provide them with an opportunity to help others), although he admits that definitive data are hard to come by.

The bulk of this article deals with psychotherapy; one page in the middle is devoted to the emotional condition of ministers, and although there are many parallels and many of Maeder's findings apply to both professions, the ministry section is not well connected with the vast discussion of psychotherapy. Perhaps Maeder thinks ministry is very close to psychotherapy (a possibility that could warrant its own article!). Many of the weaknesses he finds in ministers are revealed specifically in the counseling aspects of their work, and it would be interesting to investigate whether ministers with a generous complement of these weaknesses are more likely to conduct their ministry in a psychiatrist-like fashion (see "Should clergy act as psychiatrists?" earlier in the "Research Summary" section).

Declaring that "the Church has often been regarded as a haven for the emotionally disturbed," Maeder says that in his conversations with several psychotherapists who started out as ministers he found that some emotional problems came with the territory but others "seem to be both causal and recurrent enough to rate as a mild but characteristic pathology." Maeder defines two types of clergy: one is "a repentant sinner who has recognized his or her weakness and can therefore align himself with other mortal men in the search for salvation." The other is a "sealed-off sinner," "rigid and damning," who has "no sympathy" for his or her congregants'

weaknesses, and is "deeply beset by uncertainty and unresolved problems." Maeder says this type of clergy cannot help with others' emotional problems because they deal with their own through suppression, and "they cannot understand their congregants because they cannot understand themselves."

He draws an interesting parallel between troubled clergy and many psychotherapists, who have had a low self-worth their entire lives and are driven into "a veritable frenzy of whole-sale helping, motivated not by altruism but by a desperate need to fill an inner vacancy—an effort that ultimately helps very little, because, like trying to fill a bucket with a hole in the bottom, it can never succeed until they have attended to the necessary repairs." He quotes a Jungian analyst/Episcopalian minister(!) who calls these people "pathological givers" who give so much that they run out of energy "and what remains is the underlying resentment."

In choosing to enter the ministry, these wounded healers have, Maeder says, "embarked on an ultimately doomed quest" because they give more than they have to give and get very little back. He quotes a bishop who says that when screening candidates for the ministry, he asks himself, "Is this person seeking to express his wholeness through the ministry? Or is this a person trying to *find* his wholeness in the ministry?"

There are other interesting observations about the ministry, but overall, the clergy portion seems almost like an afterthought, as though he wrote an article on troubled psychotherapists and someone said, "Hey, this sounds like my pastor!" What material there is on the nature of the clergy is good, however, and should be provocative enough to provide discussion material for clergy groups and religious publications for a long time to come.

"C. Everett Koop is one of the most predictable people I have ever met...All you have to do is figure out what is ethically, morally, and scientifically correct and you can be damn sure that's where you'll find him."

—Dr. Anthony S. Fauci, chief of AIDS research for the National Institutes of Health, in a tribute to the departing U.S. surgeon general



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