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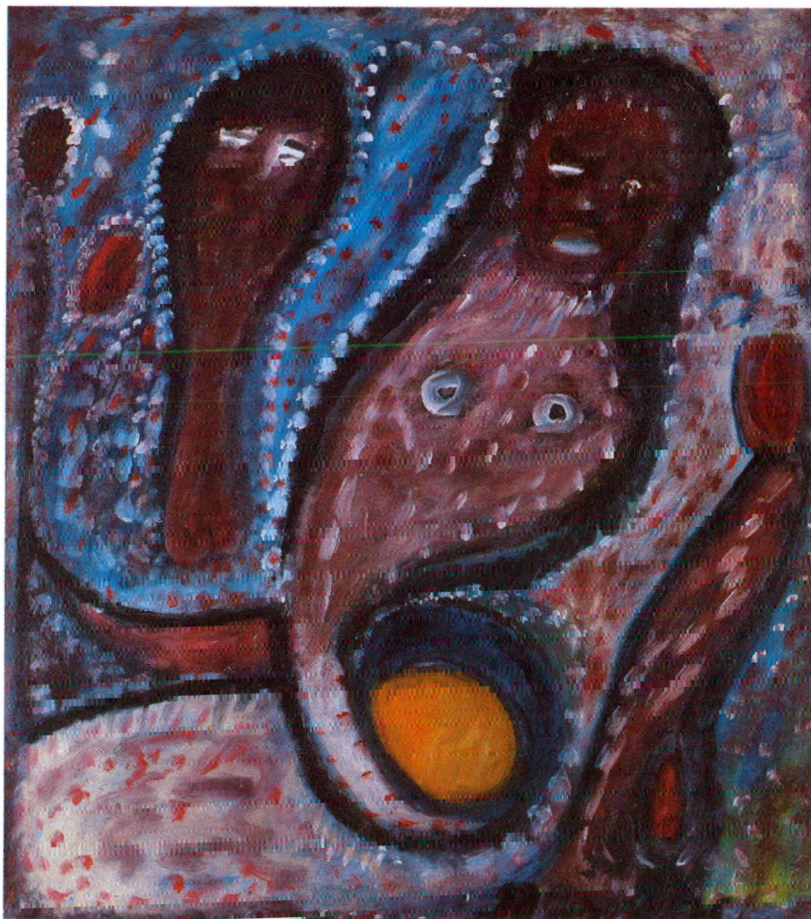
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Second Opinion

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health, faith, and ethics



**Voices from
Overlooked Worlds**

Haitian Spirituality • Sexuality and the Church • Child Abuse • Childress Profile

Cover

Dambala Ouedo and Aida Ouedo (ca. 1965), by Haitian artist and Vodou priest Robert St. Brice. The god Dambala (the smaller figure) and his wife, the goddess Aida Ouedo, together represent the wisdom of humanity. Coiled within the snakelike figure of the goddess lies the primordial egg, from which the universe was created.

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Second Opinion

health, faith, and ethics

Attention Please

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.



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

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

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Initial Comment

The “No Room” Problem

In 1985 Dr. David Hilfiker, then a physician in rural Minnesota, wrote that “the medical profession seems to have no place for its mistakes.... And if the medical profession has no room for doctors’ mistakes, neither does society” (*Healing the Wounds*, p. 85). This conclusion came after several firsthand encounters with what the experts euphemistically call iatrogenic disease. My dictionary defines *iatrogenic* as “caused by a physician’s words or actions.” In Dr. Hilfiker’s case, his own words and actions had led, quite by accident, to tragic outcomes for several of his patients. After an intense period of soul-searching and reflection on a key paradox of his profession—“I am a healer, yet I sometimes do more harm than good”—this physician decided to make some fundamental changes in his professional life. Those who wish to probe more deeply into Hilfiker’s experience will find much to ponder in this issue’s interview and the excerpt from Dr. Hilfiker’s latest work in progress.

But before paging ahead it is important to consider the “no room” problem he raises. Hilfiker found that there was no place within his profession or community for him to raise his personal questions, nowhere to talk about some of life’s most weighty experiences. The consequences were impoverished physicians, people cut off from resources that might have helped them come to terms with failure and then move on. Certain

dimensions of human need were ignored, yielding “thwarted and stunted” healers. Individual physicians and society were both the poorer.

Recently Renée Fox, one of our nation’s most distinguished medical sociologists, pointed to an analogous “no room” situation. Reviewing the sociological literature about death in our nation’s hospitals, she found virtual unanimity among her colleagues that a “socially patterned silence” existed around our deathbeds. Patients, physicians, families, nurses, and other key actors in these most human of moments were conspirators in maintaining this silence. All too often there was no room in the process of dying for the transcendent dimensions of the encounter with death to be acknowledged (*The Sociology of Medicine: A Participant Observer’s View*, 1989). Like Hilfiker, Fox concluded that humans were diminished by their failures to attend to deep human needs.

How pervasive is this “no room” syndrome? These days some are expressing doubts about our nation’s moral discourse, finding our first language of “rights and autonomy” too cramped for multi-dimensional humans. We hear calls for alternative ways of speaking about moral issues; new models are being proposed for our common life.

But the problem can be much more palpable. Consider the groups of humans and the types of illnesses that individuals and societies, including our own, have attempted to ignore or repress. In

ancient days it was the lepers or victims of plague. Today our list is much longer. Some would exclude alcoholics; others, the retarded, the elderly, the homeless, homosexuals, or people with frightening illnesses like AIDS. The message sent to such people (whether we marginalize them via sophisticated strategies or simply ignore them) is the same: there are some dimensions of human experience for which we have no room.

At personal levels similar phenomena occur. As articles in this issue remind us, we have little room in our daily lives for the troublesome sides of existence. Substance abuse in our homes and among our colleagues and friends, patterns of familial violence—for the most part these remain unmentionable topics. Aging people, the chronically ill, grieving members of our communities all carry painful realities into our midst, but their deep agonies go frequently unaddressed, unmentioned. People like David Hilfiker help us identify unhealthy patterns in our lives. We create social and personal structures which leave little space for expressing some of the deepest of human needs. We lack room for essential human interactions. And we end up with malformed lives—whether we are the excluded or the excluders.

This issue of *Second Opinion* calls attention to several of these neglected dimensions. Several articles seek to account for some of our current patterns. Each article in its own way clears new

ground. Each author makes room for something important and often unstated to come to expression. The burdens of care. The long-term consequences of poverty. The complicity of communities in maintaining structures of unhealthy silence about personal brokenness. Alternative religious traditions that are present in our midst but ignored. The spiritual dimension of care for alcoholics.

As these difficult subjects are discussed something strange happens. At times the immensity of human need and the inadequacy of our attempts to care become nearly overwhelming. Yet these authors challenge us to ask whether encounter with the dimensions we have no room for can enrich personal and social life, whether such encounter can even heal. They do us the favor of goading us to look for places in our home, our work, our social, political, and religious worlds where new space can be made, where we can become more hospitable to the full mystery of being human. In so doing they make our imaginations a bit more capacious and provide room for something new to happen.

A handwritten signature in dark ink, consisting of the letters 'J.P.W.' in a stylized, cursive script. The 'J' is large and loops around the 'P' and 'W'.

James P. Wind



*Family Circle (1977), by sculptor Paul T. Granlund,
sculptor-in-residence, Gustavus Adolphus College,
Saint Peter, Minnesota*

Sexuality and the Family

Part 2: The Role of the Church

Christine E. Gudorf

SEXUALITY ENCOMPASSES much more than just sex—however sex is defined. It has to do with social roles, with relations between persons old and young, female and male, married and unmarried, with love and power and violence and sacrifice, with communication or lack of it, and with many other aspects of our life together.

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.

In certain areas the church needs to re-examine its teachings and correct its ignorance. The church can also take some practical, positive steps to insure that its influence in matters of sexuality works to honor, support, and minister to the sexual people who comprise the church.

Looking Backward: What Churches Have Taught About Sexuality

Sex Roles and Subordination

As one of the most important teachers and enforcers of sex roles, the church has traditionally taught the subordination of women to men, and children to parents, as God's law. Three general reasons have been used to

Much of what the church has taught, or ignored, about sexuality, has had a profoundly destructive effect on believers.

justify this subordination. The first is that woman in the person of Eve was responsible for sin. God therefore punished Eve and her daughters by subordinating them to men. Early fathers of the church, especially Tertullian, stressed this rationale.¹

There are two objections to this argument. First, even if we accept the Genesis story of the Fall as a historical account, it is not clear that the result of the Fall should be interpreted as what God intended for human beings, rather than as the result of humanity's upsetting God's intentions through sin. Moreover, Christian theology insists that Christ's death and resurrection overcame the sin of the Fall and restored to humanity what was lost through sin. If subordination was not a part of God's intention, but the result of sin, it is also overcome in Jesus Christ (Trible 1978).

Second, recent New Testament scholarship has shown that the household codes—the three reciprocal pairs of injunctions to wives/husbands, children/parents, and slaves/masters—reversed the radical egalitarian practice that had prevailed in the first-century church (Schussler Fiorenza 1983).

Wives, be subject to your husbands as is fitting in the Lord. Husbands, love your wives and do not be harsh with them. Children, obey your parents in everything, for this pleases the Lord. Fathers, do not provoke your children, lest they become discouraged. Slaves, obey in everything those who are your earthly masters, not with eye-

service, as men-pleasers, but in singleness of heart. . . . Masters, treat your slaves justly and fairly. . . . (Col. 3:18–4:1)

In the Jesus movement, women, slaves, and the poor were granted equality. Many women were active as missionaries, deaconesses, patrons, and prophets, as the Epistles and Acts verify. In the second century a movement arose to replace this egalitarian order with a more patriarchal one, more in keeping with the prevailing mores of society. The household codes represented the patriarchal direction in which one part of the church wanted to move. Over the next century, all leadership and ministries were placed in the hands of men and presided over by male bishops. Given these two divergent New Testament models of roles appropriate to the sexes, should we assign priority to the patriarchal model because it won out, or to the egalitarian model because it was first and closer to the ethic of Jesus?

Some women and men have urged that “offensive” readings (like the household codes) from both Old and New Testaments should be skipped or eliminated from church readings. They wonder how what seems so degrading to women can possibly be said to be the word of God. I would argue that these passages should be included in worship, along with others about homosexuality, human sacrifice (of Isaac), or the buying and selling of women. In sermons, reflections, and Bible studies, we have an opportunity to talk about—even argue about—whether or not this *is* the word of God,

about what kind of authority it may or may not have had in its own context—and in ours. Does it contradict the work and teaching of Jesus? Are these texts accounts of God's intention for us, or of human sinfulness in thwarting God's intention? What is critical is that we must not use Scripture as a club to reinforce patriarchal, antisexual, inhumane attitudes. Morality, after all, is for Christians not merely obedience to a system of laws, but also the much more difficult task of responding lovingly to the needs of all in the human community—a task that requires discernment and decision, not blind obedience.

The church has also used biology to defend subordination of women to men. According to Thomas Aquinas, procreative roles are the basis of social roles. A man's role in procreation is active, rational, and controlling: he contributes the fully formed *conceptus* (fetus), while woman is a passive vessel who contributes nothing essential, but only feeds and shelters the *conceptus* (*Summa Theologica* 1:92).

The scientific recognition of women's genetic contribution to procreation has forced a revision of this argument, but its influence remains powerful. Men rule, according to the modern version, because God made women to bear and rear babies; men have different, less biologically determined responsibilities. Arguments to the contrary are often dismissed as rebellion against "natural" roles.

A third rationale for subordination is that women—and children—should be submissive to preserve peace



The Fall, by Albrecht Dürer (1511)

We must not use Scripture as a club to reinforce patriarchal, antisexual, inhumane attitudes.

and order?² When women assert their independence, men are provoked to abuse or abandon their families. The good of all, according to this rationale, demands subordination from women; men will tolerate nothing else.

This argument absolves its adherents from responsibility to change the circumstances or structures that force women and children to choose between personal independence and safety. The person who asks what a battery or rape victim did to provoke her abuser is assuming that women, to be safe, should be submissive (Martin 1976:5–6). As much as this attitude undermines the dignity of women, it also insults men by assuming that they can respond to mutuality and equality only with violent abuse and domination.

Complementarity

Simplistic reflection on both versions of the creation story in Genesis is one of the roots of the church's frequent affirmation of sexual "complementarity," the understanding that men and women were made to go together to complete one whole, that no one can be a complete, well-balanced person unless linked to a member of the opposite sex in marriage. The first story (Gen.1:1–2:3) says, "So God created man in his own image, in the image of God he created him; male and female he created them." In the second account of creation (Gen.2:4–25) God says, "It is not good that the man should be alone; I will make him a helper fit for him,"

and forms Eve from a rib taken from the sleeping man.

This notion often prevails, in spite of much evidence from the social sciences that all social roles and virtually all character traits are learned, not inherited. Even those few traits that are sex-linked are never found exclusively in one sex or the other. There is no evidence that the sexes are complementary opposites in any way besides in the exteriority/interiority of their genitalia (Maccoby and Jacklin 1974). A woman can have more character traits in common with most men than with most women, and vice versa.

Human complementarity is a fact. In order to be whole persons we have to live in community. Most human tasks require the cooperation of persons with different traits and skills. We acquire new traits from our relationships with persons who are different from us, but we do not need to be in sexual relationship with them.

The notion of sexual complementarity implies that those who are single are incomplete human persons. Adam and Eve model *human* complementarity. Adam was lonely and needed another human person in order to be fully human himself. Because they became a couple, they are often interpreted as representing *sexual* complementarity. But the story says nothing about that. It is more interested in saying they were the same than in making them different.

Sex as Sinful

Christian tradition since the early church fathers has understood sexuality largely in dualistic terms, in which the body represented evil and the soul, good. Morality came to be understood as the use of one's rational powers to control the evil body and its hungers. With the emergence of Christian asceticism, believers were encouraged to deny the body and strengthen the soul by fasting, abstaining from sex, waking often in the night to pray, and inflicting physical pain on the body—practices that today are condemned as torture when done to others.

The early church did defend marriage against those heretics who maintained that no traffic with the body

was licit. But the influence of asceticism was so strong that the best argument that Clement, the defender of marriage, could put forward was that procreation was such a good that the otherwise sinful sexual activities it required could be permitted.³ Augustine argued that original sin was passed along through sexual intercourse. Sexual pleasure in intercourse, he said, was so difficult to avoid that even marital intercourse was at least venially sinful.⁴

Although many of our churches believe that they have moved beyond the traditional view of sex as sin, church teaching—and its avoidance of helpful sex education—suggests we have a long way to go. Teaching that sexuality is one of the things God made and declared good seems to have less practical impact than the



The person who asks what a battery or rape victim did to provoke her abuser is assuming that women, to be safe, should be submissive.

prohibitions heard all too often: do not fornicate, do not commit adultery, do not masturbate, do not practice homosexuality. Instruction in sex is seldom included in marriage preparation; couples must learn what they can outside the church.

In general, churches implicitly or explicitly maintain the tradition that sex within marriage may escape being sinful, especially (sometimes, only) if it is for procreation. Couples without children are often either pitied or condemned, and church life assumes that a family includes children. In effect, we still teach that sex is suspect, and that it is tolerated primarily for the sake of having children.

Love as Self-Sacrifice

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 (Sennett and Cobb 1972).

There is a problem with this dynamic based on sacrifice. When one does not respect oneself, one is never secure in the respect tendered by others. A father may demand more and more evidence of respect from his children, often in the form of utter obedience. He may push his children to succeed, fearing that very success. For if his children succeed and no longer need his sacrifice, why should they any longer respect the father who is such a failure?

Love as self-sacrifice is also built into our cultural definitions of motherhood. It is what we celebrate on Mother's Day. Women are expected to be fonts of love in the family, to put the interests of all others first, not merely in terms of time and effort, but in terms of self, of identity. The comic strip mother who sneaks off for a few moments of privacy in the tub and is interrupted by one child asking where the clean socks are and another wanting a ride to a friend's house is paradigmatic. A mother is allowed to carve out time for herself only from what is left over after everyone else has made claims against her time; and even in this leftover time, she is supposed to be available for the unexpected demands of children. One of the stereotypic memories of children in our society is Mother saying "Don't disturb your father. He's working (or sleeping, or resting)." Only mothers just home from the hospital

receive this same level of recognition of their needs.

For a mother to say to her preschooler in mid-afternoon, “You play in your room for an hour, Mom needs a little time for herself,” is heresy, pure selfishness. To say, “I drove you to Little League and play practice all last season. This season I’ve decided to take a course on Tuesday and Thursday afternoons, so you’ll have to find your own rides to soccer practice,” is considered dereliction of duty. Mothers who work outside the home—over half the mothers of school-age children—are not exempt. Those who can say to their children, “I can’t do that for you, I have to work,” are often even less likely to take time for themselves, because of guilt about neglecting children in order to work. This is so even though the majority of the mothers who work do so out of economic necessity (U.S. Dept. of Labor 1982).

The woman who has been taught that self-love is not legitimate, and who therefore represses desires for autonomy, for power over her life, and devotes herself to children, often attempts to control her children precisely through her sacrifice. This mother is a cousin to the worker who fails to achieve upward mobility and uses his sacrifice for his children to demand their obedience.

Love cannot exist without a willingness to sacrifice. But there is a limit to legitimate sacrifice, and that limit is the sacrifice of self. We cannot live life meaningfully without ourselves. The limit will differ for each of us. Some, for example, can take on the full-time care of senile, bedridden parents for years and still continue to grow mentally and spiritually. For others, such a sacri-

fice would mean spiritual death, the loss of community and meaning. For some parents, constant confinement to the company of children, lack of privacy, and constant responsibility can cause depression, anxiety, and mental illness.

The gospel calls us to love our neighbors *as ourselves*, to recognize that we are all equally valuable because of God’s love for us all.

In her now-classic article, “The Human Situation: A Feminine View” (1979), Valerie Saiving wrote that the Christian theological tradition has encouraged women to deny themselves by the way it has defined sin and love. Essentially, sin has been defined as excessive pride that recognizes no limits in attempts to be more, to do more, to extend oneself, to control. It is overstepping the rights and needs of others in our own quest, trying to be God.

Saiving argues that this theological tradition was created by men, on the basis of male social roles. Male socialization encourages this ambition and striving in men, often with destructive effects on others and on men themselves. Defining sin as pride points out the need for limits. It fosters a creative tension in which men are both pushed to achieve and warned against harming or using others. The complementary understanding of love as self-sacrifice helps men to moderate pride, to bond to others, and channel energy into relationship and community.

These definitions of sin and love are shaped by a desire that men be more humane, more communitar-

Christian tradition has understood sexuality largely in dualistic terms, in which the body represented evil and the soul, good.



*Benevolent Old Gentleman: "Now then, little Boy.
What do you mean by bullying that little Girl?
Don't you know it's very cruel?"*

*Rude Little Boy: "Garn! Wot's the trouble?
She's my Sweetheart!"*

Drawing by Bernard Partridge in Punch, Mar. 21, 1896.

ian. But they have the opposite effect on women. Women, says Saiving, are socialized to be passive, to await the initiative of others, to be dependent. To define sin as pride and ambition is to reinforce their passivity, instead of encouraging a creative tension between passivity and ambition.

Women's typical sin is not excessive pride but excessive passivity. Both pride and passivity are equally harmful to others, and equally inhumane. Love as complete self-sacrifice quashes attempts on women's part to develop their selves, to claim responsibility as persons. The definitions of sin and of love must be broadened to include the sin of women—and the kind of love that frees women to love responsibly.

Looking Forward: What Churches Should Be Teaching About Sexuality

Sexuality and Community

The privacy ethic, according to which no one outside the family interferes in the family's life together, has built walls between congregations and their family members, especially when it comes to sexuality in the family. Such noninterference often serves to empower the strongest members at the expense of the weaker. Police do not like to "meddle" when husbands beat wives or when parents abuse children (Martin 1976:

90–97). Churches, too, usually stay out of such family affairs.

When two people marry, they publicly vow their commitment to each other with the community as witnesses. The witnessing church community has a responsibility to support that marriage by recalling each partner to their vows of commitment. When it is clear that there is strain between husband and wife, or between parent and child, persons in that church community should be willing to mediate or to support one or both of the parties through the troubled period.

When disaster hits a family, whether it be divorce, children on drugs, adultery, rape, or incest, many troubled families drop out of the church community, often from feelings of embarrassment, of no longer belonging. These are occasions when we as Christians can demonstrate that we are called to community, to be there for others, and to accept the help offered by others. God empowers communities: ought we to refuse God's help when it is extended through a community?

We need to talk about our families, and about our sexual lives in our families, within our church communities. Many of our problems, from dealing with adolescent children to sexual dysfunction, are based on ignorance of alternatives to our own experience. Excessive privacy isolates us. Privacy should mean not that no one knows what goes on in our family, but that *we choose* who knows. We need not accept help from the first person who offers support—that person may be a



The television drama "The Burning Bed" was based on the true story of Francine Hughes, who killed her husband after suffering violent abuse at his hands for more than a decade.

Movie Still Archives, Santa Fe.

Love cannot exist without a willingness to sacrifice. But there is a limit to legitimate sacrifice, and that limit is the sacrifice of self.

totally inappropriate person, a gossip, a busybody, or even a well-meaning person but one who lacks the necessary insight or experience to deal with this problem.

Sharing within our church community about family sexuality is unlikely to happen until we have greater sharing about sex within families. Grown children should be able to remember times when their parents talked about the value of their sexual relationship. This doesn't have to be a serious let's-sit-down-and-tell-the-kids-our-sexual-histories. It is often best done by casual sharing while discussing movies or TV programs or information from school.

Both parents and children need to know that there is nothing wrong with bringing up or answering sexual questions in the presence of the entire family. A child may want to ask questions in private; that is his or her right. But the basic information—about wet dreams, or menstruation, or birth control, for instance—should be able to be communicated in front of the whole family without embarrassment. What younger children don't have an interest in won't sink in.

Of course, younger children are more interested in sex than we often think. Over ten years ago when my husband and I answered our seven-year-old's questions about where babies come from, our two-and-one-half-year-old must have been listening. A month later while sitting on his grandmother's lap he suddenly exclaimed, "Gwamma, when I grow up, I'm gonna put my penis in a lady's bagina and make a baby!" Such moments are

surely not proof that we erred. The problem here was not what the child said; the problem was that Grandma could not handle that level of sexual explicitness from her husband, much less from her two-year-old grandson!

Integrating Sexuality in Church Programming

Our sexuality is an important part of the life our faith is to transform. Churches need to integrate sexuality into all areas of parish life, not because sex is the most important or the only important aspect of our lives, but because it is the one which has been most clearly removed from church life.

Why not integrate sexual language and information into religious education? When we teach God and creation to preschoolers, we need to show that God not only created in the beginning, but goes on creating with and through us, from babies to new scientific inventions. Why not explain that husbands and wives share the love that God has for each of us with each other when they make love, and in that loving babies are made after the penis deposits sperm in the woman where it combines with her ovum to make a fetus?

Youth programming, too, offers especially rich opportunities to provide information and foster values in the area of sexuality. Far too many churches have tried to overcome common youthful rebellion against church as being conventional, a reflection of parental values, by youth programming designed to show that church can

be fun. But trips to roller rinks and amusement parks, pizza parties and dances do not in themselves convey to youth the values that bond church community or meet many of the needs of youth.

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 pre-digested 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 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.

Concern for sexuality surely has a natural place in marriage preparation. Why not teach basic sexual technique in marriage preparation? If budgeting money and sharing housework—“nonreligious” matters—have a place in marriage preparation, why not basic sexual technique? This kind of initiative might help save a lot of



The sacraments can help people identify and celebrate significant passages in their lives with the community of the church. A Baptism (watercolor and ink, ca. 1825, German text from Matt. 28:18–19).

Courtesy, Museum of Fine Arts, Boston.

Both parents and children need to know that there is nothing wrong with bringing up or answering sexual questions in the presence of the entire family.



The church can help teach the wider society that the sexual needs of older people should be acknowledged and fulfilled.

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young marriages—and dramatically increase the attendance rates for marriage preparation courses.

Older members of the church community could benefit from acknowledgement of their sexuality. They need to hear—and others need to know—at least the following:

1. The elderly are not asexual, despite the fact that they are often so treated. Respect for their sexuality includes their right to private space whether in homes or nursing homes (see Harrison 1985:164).
2. The elderly who retain relatively good health can stay sexually active into their seventies, eighties, and nineties (Crooks and Baur 1987: 511). Sexual responses will vary with age and from person to person, but sex can be just as satisfying as ever. Those who have been the most sexually active are most likely to remain so.
3. The death of a spouse does not necessarily end sexual desire. One way to deal with sexual frustration is masturbation, which the church should at least not discourage.
4. The elderly have tremendous needs for physical touch. Many of them have outlived their spouses, close relatives, and friends—those who had shown them physical affection. Often the elderly do not feel touchable; many hesitate

to ask to be touched. Many depend upon beauticians, barbers, or nurses for physical touch, even to the point of feigning aches and pains. They need to be encouraged to touch and to ask for touch.

Far too many older people, both men and women, have accepted social definitions of themselves as not sexual, and incapable of sexual relationships. Many women may never have understood themselves as sexual subjects to begin with. Many men, upon reaching retirement, lose a sense of themselves as men because (1) they are no longer productive (employed); (2) they understand manliness to be based on physical strength, much of which they have lost; and (3) they have retired to their wives' domain, the home, and so the balance of power in the relationship seems to tilt toward her.

Here the churches can help shift the definition of masculinity to one closer to Christian values. We can be productive members of our community without earning a salary, by participating in community life. Strength is best measured by our ability to love and support others, not by flexing muscles. By encouraging older—and younger—men and women to adopt these values, the church community can help free relationships from the need to control, and increase openness to God's work.



The need for loving touch—critical to the healthy development of an infant—persists throughout life.

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Churches need to integrate sexuality into all areas of parish life, not because sex is the most important or the only important aspect of our lives, but because it is the one which has been most clearly removed from church life.

Rites of Passage

Most religions have recognized rites of passage which mark off the stages of human life. Many sacraments in pre-Reformation Catholicism functioned in this way. Baptism marked birth; confirmation, after it was separated from baptism in the fifth century, was eventually understood as a rite of adolescence. Marriage and holy orders marked adulthood and the choice of vocation. Extreme unction marked death. Church reformers in the sixteenth century objected that the seven sacraments were not personally instituted by Jesus Christ, as the church had claimed, and came to recognize only two: baptism and the Eucharist. (Penance was among those excluded.) The post-Reformation Catholic church, in defending the divine institution and spiritual character of the sacraments, has denied them any earthly function as rites of passage.

Sexuality is intimately bound up with rites of passage. We are born of a sexual process, and we become capable of independence and sexual activity as part of the process of maturation. Our choice of vocation and life-style has much to do with how we decide to structure our sexual lives: in singleness, marriage, or parenthood. The gradual waning of our sexual drives and capability parallels the process of aging and finally death. As an important community in our lives, the church can help signal these “passages” to the community and to the individual and clarify the duties and privileges of the new stage.

Adolescence is one of the most difficult stages, for both parents and youth. Eighteen-year-olds, for example, are legal adults. They can decide to move out, enlist in military service, marry, quit school, get a job, own a car, and, in some places, drink. But most are years away from autonomy, dependent on parents for an education, unable to find work that will support them, and unready for parenting. For many, sexuality seems one of the only adult freedoms open to them.

Adolescence has become an increasingly profound challenge to family life. While the period of dependence has been extended—for some it lasts until education ends in the mid-twenties—physical maturity occurs earlier because of better health and nutrition.

Church-based ritual that recognizes in some meaningful way that adolescents are no longer children, without insisting that they be fully adult, could help. But ritual must emerge from the life of the community (see Turner 1969:128ff.). It cannot be imposed from outside that community. Before we in the churches can begin to establish new ritual in relation to adolescence, we must look again at adolescent sexuality. There is more than a “problem” at stake; there are persons who look to us for ministry.

Sexuality and Spirituality

Some fifteen years ago I heard a respected theologian say that her only direct experience of God took place in bed and on the delivery table. If we believe that God is

experienced only in church or in prayerful solitude, we may not recognize that every aspect of our lives—even our sexuality—is open to God’s initiative. Because it triggers some of our deepest and most powerful feelings, sexuality is a natural area of our lives for experiencing God.

For me personally, one of the most valuable aspects of my Catholic tradition is our heritage of viewing marriage as a sacrament. Within this perspective every sacrament has a sacramental sign, and the sign not only stands for some important reality but also creates that reality. The sign of marriage is sexual intercourse, or more specifically, orgasm.

Orgasm is not only an expression of a couple’s love for one another. Orgasm can create love. I do not mean that we would love everyone with whom we share orgasm. But within a loving relationship the experience of orgasm makes both persons more loving, more sensitive, more attuned to the other. It puts a smile on our faces, a spring in our steps, and it inevitably pulls us toward the other.

I believe that this experience is a participation in the Godhead, the Trinity. We say that the Spirit is the product of the love between God and Jesus Christ, that divine love cannot be contained but expands and overflows creatively. All real love is divine in this way (see Gallagher et al. 1985). The love we give each other in orgasm is creative, not only in the physical sense of procreation, but in a communitarian sense as well. When we feel loved and loving, we work, play, and



Lovers (Mithuna) (carved from rust-colored sandstone,
11th century, Madhya Pradesh, India).

The Cleveland Museum of Art, Leonard C. Hanna, Jr., Fund, 82.64.

When we do not deal with sexual violence, we send the message to victims that sexual violence doesn't happen to good people, to church people.

interact better. We have more patience with others, more interest in our neighbor. Love frees us to love.

The *spiritual* experience of orgasm creates desire—for life, for love, for community. It is not, of course, the only way we experience God, or desire and commitment. But it is one of the most powerful, most accessible, and least acknowledged avenues for sharing divine life. When we make love we make ourselves vulnerable, open to the other. In orgasm this vulnerability is carried to the limit—we allow ourselves to be merged into a new reality. Fear of letting go of self-consciousness is a frequent source of sexual dysfunction, of inability to reach orgasm. To be able to let go is to trust the other.

The wonderful thing about becoming vulnerable in intercourse is that we are overwhelmingly rewarded. Sexual intercourse within a loving relationship is a way to learn to extend ourselves in love to others.

Jesus' message was that we should repent, love our neighbor as ourselves, and be ready to live in and cooperate with the reign of God, a new reality breaking into the world. His parables whisper, "Risk it! You won't be sorry. The reward is great" (see Perrin 1967:chap. 2). Intercourse is a sign of the reign of God, evidence of loving risk rewarded.

If we in the churches believe that orgasm can create love, then perhaps we should encourage it for members, even as those of us who believe that Holy Communion gives us the gift of the grace of love, encourage participation in it.

Some Catholic authors on marriage, underscoring

this understanding of marital intercourse, insist that the chief pastoral task of the church is to keep sexual desire alive (Gallagher et al. 1985). Sexual desire is high energy, creative energy, bonding energy. Sexual desire is desire for life. It is for all, not just for the married, not just for the sexually active. Sexual intercourse is not for eliminating or dissipating sexual desire, but for feeding it. Married couples who have managed to keep sexual desire alive and healthy can be models and teachers of others in the church community. Not all those who are married, or only the married, have managed to keep sexual desire alive. Many others have done so, and many marriages are dead or dying. But in a society where intimacy is so largely restricted to sexual relationships, those who are part of committed, intimate, and joyous sexual relationships are well-equipped to share in revitalizing parish life.

Churches often celebrate twenty-fifth, fortieth, or fiftieth wedding anniversaries by publicly recognizing the couple. How much more moving to ask these couples to speak of how they have grown in love and strength and wisdom because of their marriage! We need to be reminded of the power of committed love by the engaged, the married, by gay and lesbian couples in permanent unions. The message is not a testimonial to sex as such, but a witness to life and love, to relationship, to community.

The church's recognition of the power for good in sexual relationship conveys a message to the young that real sexual power does not reside in momentary grati-

fication, but in giving ourselves, trusting others, and opening ourselves to them. This might help discourage promiscuity. It could also dissipate some of the fear we have of sexuality.

The church has tried to tame its fear of sex for centuries by presenting marriage as a relatively innocuous outlet for the otherwise “demonic” power of sexual desire. In so doing, the church has too often domesticated marital sexuality to the point of denying its power.

Passion belongs in marriage. We should encourage passion—for our loved ones, for community, for justice, for life. If we become more comfortable with the power of sexuality within its most “conventional” form—marriage—we can begin to examine less “conventional” forms without prejudice.

Openness About Sexual Violence

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.”⁵ Rape and battery are often understood as sex that “got out of hand,” where the male “got carried away.”

Such violence is understood as a slightly rough version of “normal” sexuality. Many of us would be surprised to learn that psychologists and criminologists are

unanimous in maintaining that rape is a pseudosexual crime: it appears sexual, but it is not sexually motivated. Rapists rape for power. Batterers batter for power. It is control, domination, that gives them satisfaction.

Tragically, sexual violence is common. Between one-quarter and one-half of all women are victims of sexual violence at some time in their lives. All women, and all men, are affected by it. The existence of this degree of sexual violence makes women fear men. Even in the healthiest marriages, many women, at some level, fear the anger, or even the strong sexual desire, of their husbands. This fear, sometimes unconscious, may prompt women to acquiesce. When this acquiescence is recognized and pointed out, the husband’s response may be, “Why didn’t you just say no? What have I ever done to make you afraid of me?” But the overwhelming presence of sexual violence influences our personal decisions in ways of which we are unaware. This same husband may well respond to the social fact of sexual violence by teaching his daughter to distrust men on the streets as well as the men she dates.

To the extent that the churches do not recognize the problem of sexual violence, they cannot respond to it. Few of the ministers, priests, and rabbis who have attended workshops I have done on sexuality recognize the extent of sexual violence, even in their own congregations. Those who do are usually, but not always, women.

The same holds true in relation to sexual harassment at the Catholic university where I teach. Faculty

Homosexuals are all someone's children, someone's sisters and brothers, and often someone's parents.

and administrators say it is not a problem; there have been no complaints. Yet women faculty and administrators tell a different story. When the university instituted a strong new sexual harassment policy with mandatory training sessions for all employees, male faculty and administrators were incensed. Why was so much being made of sexual harassment? Mandatory sessions, they said, were harassment in reverse. When the sessions were held, many of the men attacked the video scenarios shown as corny and unreal. Many of the women, on the other hand, defended them and related their own stories of being fired, threatened, or quitting jobs because of sexual harassment. The men were astonished.

Whenever I teach sexuality, the class is oversubscribed. Usually more than one quarter of my students (ages twenty to twenty-two) make appointments to see me. Almost all of them tell stories of sexual violence: having been raped on a date, harassed in the dorms or by professors, molested by fathers, grandfathers, or brothers, or seeing their mothers and sisters—and occasionally themselves—battered. These predominantly middle-class, suburban students are no strangers to sexual violence.

When I have scheduled a film and discussion on the subject of sexual violence, students come with mothers, sisters, and friends. Sometimes before the session takes place they make appointments to see me or my sisters in English, psychology, sociology, and social work—not because we have any particular expertise but

because they are desperate to talk to someone about this taboo topic, and we have acknowledged that it is a problem.

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.

On the other hand, outside gay church circles, there is virtually no awareness of violence against gays and lesbians, much of it increasingly fueled by the AIDS crisis. This violence takes many forms: physically harming persons suspected of being homosexual; refusing to treat them when they have AIDS; refusing to bury them; failing to fund AIDS research, when between a million and a million and a half Americans have this incurable fatal disease; firing or refusing to hire persons

solely on the basis of their sexual orientation. How many of us have been taught that any of *this* violence is sinful? Homosexuals are all someone's children, someone's sisters and brothers, and often someone's parents. They are a part of our families.

There is much the churches can do to address the issue of sexual violence. Here are some suggestions:

1. In counseling victims of sexual violence, insist, and repeat, that they are innocent. The most important pastoral message is to repudiate victim-blaming. Victims' suffering is not proof that they sinned. Bad things do happen to good people.
2. In counseling perpetrators of sexual violence, beware of cheap grace. Too easy contrition and forgiveness often contributes to a repetition of sexual offenses. Sex offenders are the most consistent repeat offenders.
3. Train personnel in your church to deal with sexual violence. Those who do deal with it ought not to have unresolved problems of their own in relation to sexual violence. No one who can be shocked or sickened should deal with victims or offenders; those who are being counseled can too easily be led to believe that *they* are shocking or sickening. Cases requiring specialists should be referred to specialists.



Most media portrayals of rape are attempts to titillate viewers or to assign blame to victims rather than to address the crime as the ultimate expression of a pattern of male dominance and female powerlessness. From the movie Naked Flame (1970).

Movie Still Archives, Santa Fe.

Jesus deliberately relativized the natural, biological family, insisting that his family were all those who heard the word of God and heeded it.

4. Construct a reliable referral network. Not everybody who specializes in sexual violence as a psychologist or social worker is equipped to deal with the religious and spiritual issues that may arise. Be knowledgeable about—and satisfied with—the way those to whom people are referred approach the issue. Ongoing support groups for victims are essential as part of your referral list.
5. Support victims who decide to press charges. This is almost certainly not the time for moralistic lectures on forgiveness and holding the family together. First, victims have to feel safe.
6. Include the topic of sexual violence in sermons and church programs, where appropriate. We should become accustomed to hearing rape, battery, and incest classed with other types of violence and other types of injustice. The Bible is filled with sexual violence, some implicitly approved, some condemned. Bible study groups should deal with these passages, not pass them over to avoid controversy.
7. Teach very clearly that sexual aggression is not “natural” male behavior; women are not “naturally” masochistic and sexually passive. These are learned behaviors. God did not create anyone to be a victim.
8. Insist that the male sex drive is not uncontrollable; an uncontrollable sex drive is characteristic of arrested sexual development and immaturity. All partners retain a right to say “No” to any sexual behavior—and to be heeded—at any time.
9. Teach that human sexuality is meant to be mutual and voluntary. There is no justification for violence, which robs one partner of freedom.
10. Judge human sexual behaviors not on the basis of who acted on whom (whether the actors were married or unmarried, straight or gay, parent or child) but on the *nature of the activity itself*. Was it voluntary and mutual? Did it promote growth for self and relationship?

Church as Family

Christians are a family, the children of a loving God whom Jesus called “Father,” sisters and brothers to one another. Jesus himself deliberately relativized the natural, biological family, both his own and others. He refused to give special priority to his mother and brothers when they came to see him while he was teaching, insisting that his family were all those who heard the word of God and heeded it (Matthew 12:46–50; Mark 3: 31–35; Luke 8:19–21; also Luke 11:27–28). Similarly, he taught his disciples that following him would mean the

disruption of family ties and that they must be willing even to hate parents, sisters, brothers, and children for the sake of the reign he announced (Matthew 10:37; Luke 14:25)

We have generally understood “church as family” to mean that the church community is based on the natural family. This narrow view has led us to see marriage mainly as focused on itself and on procreation and raising children. We have neglected to see that marriage should also be a joining of two persons whose love for one another deepens their commitment to reach out, to the church community and beyond.

Understanding church community as modeled on the natural family has frequently led us to ignore those who do not live in families—the aged, for example, or the unmarried, both homosexuals and heterosexuals. Blind reverence for the kind of family we have believed to be the model for the church has often been destructive. Insisting that destructive marriages stay intact, that damaging parent-child relationships are better than severed ties, we have made the family an idol. And this idol has had many victims: husbands who feel imprisoned by breadwinner roles in jobs they abhor or feel deprived of close relationships with their children because of stereotypic male sex roles; wives who feel stifled by their world of housework and child care, or overwhelmed by the double burden of home and job; children bound to abusive or insensitive parents.

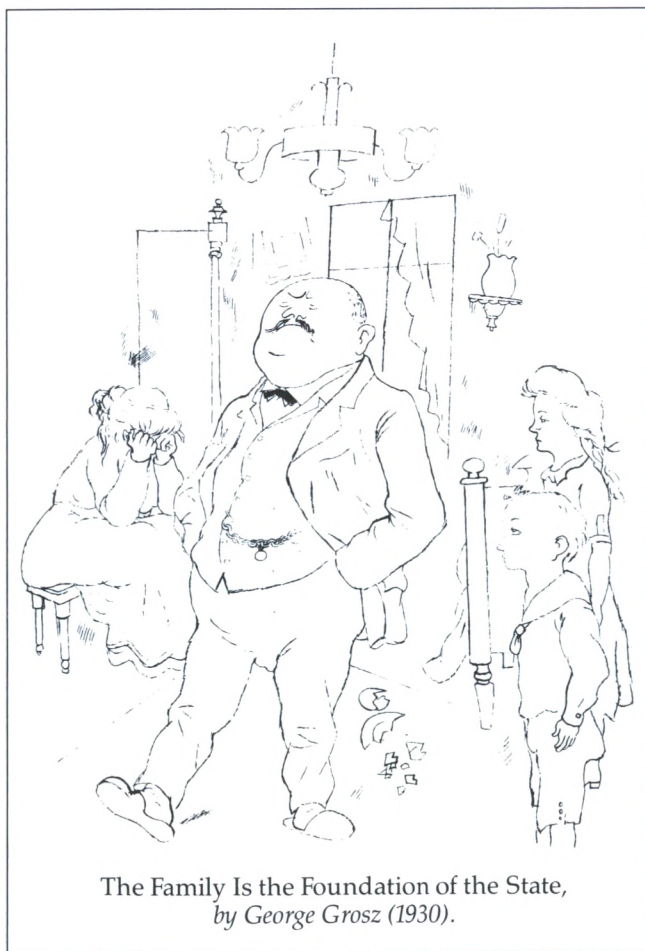
Family is important, but no family is perfect. Many more than we think are warehouses for fear and pain,



It is not only the church that has idealized the family. Widespread acceptance of the stereotypical “perfect family” makes it more difficult for real families to acknowledge and deal with their problems. From the TV program “Leave It to Beaver” (1957–58).

Movie Still Archives, Santa Fe.

We need to be on guard constantly against the legalism that Jesus condemned, the legalism that has bound us so tightly in the area of sexual ethics.



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.

Sexual Ethics

What about Christian sexual ethics?

Jesus said nothing explicitly about sexuality. His concern was to announce and prepare for the reign of God. He did prohibit divorce—a prohibition which seems to have been intended to defend women against enforced prostitution as a means to survive after divorce. But I believe that his principal concern bearing on sexuality was that the reign of God took priority over narrowly defined sexual roles. In the story of Mary and Martha (Luke 10:38–42), he opposed the imposition of female sex role limitations on Mary. Contrary to Jewish custom, he allowed women to follow him in his journeys. He regularly addressed women publicly, though his Jewish apostles were scandalized. According to tradition, one of his closest followers was a woman, Mary Magdalene. Jesus rejected the understanding of women as significant only for their reproductive capacity (Luke 11:27–28). And, as we have seen, he taught

that family obligations were not to take priority over serving the reign of God.

The reign of God had no place for domination of some persons over others, including the domination of women and children by men. Jesus made it very clear that though the reign of God was open to all, his mission was especially to the victims: the poor, the sick, the despised, the subordinate, the outcast. His teaching and ministry emphasized that we are all children of a loving God, all called to serve each other by sharing God's love for us with each other. The nature of love is that it is drawn first to the neediest. We do not divide up our time, energy, and resources evenly among our children when they are born. The sick child is given more costly medical care, the slow child more specialized education, the rebellious child more of our energy. Need calls to our hearts, as it calls to God's.

In teaching sexual ethics in the church we need to begin with Jesus' teaching. Jesus taught a very practical ethic aimed at restoring relationships and promoting love and justice. Based on the teaching of Jesus, questions we need to ask about any sexual activity are: Is this a loving act, capable of drawing persons into relationship with each other and with the larger community? Does it respect the dignity of both persons? Does it harm anyone?

Some sexual activities will never meet criteria of the reign of God. Acts of rape or battery, sexual harassment, incest, or child molestation fail these criteria. They are

acts that do not respect the welfare and will of the other; they destroy trust and obstruct growth in relationships.

It is almost impossible to judge most sexual activities, however, apart from the particular circumstances of the actors. These circumstances determine, to a great extent, the motive and the consequences. Masturbation, for example, is usually beneficial, not harmful to personal relationality. But in rare cases it becomes obsessive and cuts us off from relationships with others. Adultery is usually harmful, because it destroys trust and integrity. But we all know of unusual circumstances in which a marriage is only a legal fiction, where the partners are separated, and where what we would ordinarily term adulterous relationships could be a loving gift that helps restore persons to human community.

Some of the Christian church's past judgments regarding sexual ethics have been wise, based on long experience with the consequences of particular activities. But too often, I believe, the church has made mistakes about sexuality. Doubtless we will continue to make them. We need to be on guard constantly against the legalism that Jesus condemned, the legalism that has bound us so tightly in the area of sexual ethics.

Jesus insisted, against those who condemned him for violating the Sabbath laws to heal the sick and to eat, that the Sabbath was made for humanity, and not humanity for the Sabbath. The same is true of sexuality. Its purpose is to serve the well-being of persons, to prepare for and involve them in the reign of God. ☸

NOTES

1. Tertullian, *De Cultu Feminarum* 1.1, in Florentis 1954:343. For an overview of this theme, see Ruether 1974.
2. This argument is frequently heard in pastoral counseling, but has been publicly used in some churches as well, notably in the Roman Catholic. The popes have explained how the church has benefited women by strengthening marriage, under which wives receive protection for obedience. See Gudorf 1980: chap. 5.
3. Clement of Alexandria, "On Marriage," in *Stromateis*, in Oulton and Chadwick 1954.
4. Augustine, *On Marriage and Concupiscence*, book 1, ch. 6, no. 14, in Schoff 1971. See also "Augustine: Sinfulness and Sexuality," in Clark and Richardson 1977.
5. I am indebted here to Fortune 1983:27.

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Afro-Caribbean Spirituality

A Haitian Case Study

Karen McCarthy Brown

A short time spent in the corridors of any major medical center in the U.S. leads to an inevitable conclusion: Modern medicine is an amazingly cosmopolitan affair. The people who flow by speak different languages, wear different types of clothing, bear different systems of belief. From near and distant lands, cultures, and traditions, they converge to seek healing and cure.

Those who work in such hospitals face a daunting challenge. Who will it be today—a Buddhist from Thailand, a native of South America, a family from central Africa? How will they perceive what is happening to them? Can people from worlds as different as mainline American Protestantism and Iranian Islam begin to understand each other?

*A major research effort of the Park Ridge Center has been its inquiry into the world's faith traditions. Its most recent publication in this area is *Healing and Restoring: Health and Medicine in the World's Religious Traditions*.*

*This excerpt provides a sample of the worlds of belief and practice described in *Healing and Restoring*. At first glance Haitian Vodou may seem an exotic topic, quite remote from the daily reality of a Los Angeles cardiologist or an Atlanta primary-care nurse. But one conversation with a new patient or co-worker can transport these health care professionals into worlds where a guide like Karen McCarthy Brown is most necessary and practical.*

HAITIAN VIEWS OF HEALING and wholeness as revealed in the religious system called Vodou provide the focus for this study. While the specifics of the discussion would differ if it were centered in other Caribbean locales, there are certain basic attitudes and understandings about the nature of the human condi-

tion and the causes and cures of human suffering that are broadly shared among descendants of African slaves throughout the Caribbean—areas that may be collectively named the Afro-Caribbean. Before turning to Haiti, I will first consider briefly the factors that create the differences among Afro-Caribbean cultures and

Abridged from the Park Ridge Center's book *Healing and Restoring: Health and Medicine in the World's Religious Traditions*, ed. Lawrence E. Sullivan (New York: Macmillan, 1989), pp. 255–86. *Healing and Restoring* is the companion volume to *Caring and Curing: Health and Medicine in the Western Religious Traditions*, ed. Ronald L. Numbers and Darrel W. Amundsen, published by Macmillan in 1986. Four stars indicate where text has been omitted.



Maitresse Erzulie (1985), by Andre Pierre. One of the most revered Vodou deities, Erzulie is the goddess of love, feminine beauty and charm, eloquence, and prosperity. She is the mistress or wife of many gods and spirits. The heart and snakes drawn on the ground stand for Erzulie and one of her husbands, the popular god Dambala.

Nicole Gallery: The Art of Haiti, Chicago

then attempt to outline the common foundation on which their various healing systems rest.

Traditional attitudes and practices surrounding health and spirituality vary from one area of the Caribbean to another for several reasons. Of first-level importance is the place (or places) in Africa from which the slave populations were drawn and the resulting ideas about health and spirituality that the slaves brought with them. For example, in Haiti there are three clear lines of African influence: those of the Fon peoples,

most of whom live in the area we now call Benin; the Yoruba peoples (Nigeria); and the Kongo peoples (Angola and Bas-Zaïre). By contrast Cuban traditional religion is dominated by Yoruba influence, while that of Jamaica has its deepest roots among the Akan of Ghana. Other factors that account for the differences are the nature of the slave systems under which the first generations labored, including the brand of Christianity practiced by the slaveholders; the geography, plant and animal life of the New World setting and the differences

Spirituality and healing are synonymous in the Afro-Caribbean.

and similarities that the slaves found between these and the ecologies of their homelands; and the social, political and economic history subsequent to slavery.

In relation to Haiti, the last point warrants special comment. Haiti was the second independent republic in the Western Hemisphere and the first Black one. After its successful slave revolution (1791–1804) and mainly as the result of trade boycotts, Haiti was effectively cut off from contact with the United States and Europe for nearly a century. Furthermore, even though the French colonists had established Catholicism as the official religion of the people of the island, including its slave population, Haiti was denied priests by the church for more than fifty years following the revolution. At the opening of the nineteenth century, when the long struggle for independence ended, it is possible that as many as three-quarters of the slave population of Haiti had been born in Africa. Therefore, for a substantial period of time following the expulsion of the French, several strong African cultural traditions interacted in Haiti in an atmosphere relatively free of outside influence. This phenomenon sharply distinguishes Haiti from the rest of the Caribbean and particularly from places such as Jamaica. Jamaica experienced a continuing colonial presence well into the twentieth century. As a result, the influences of Africa in Jamaican traditional spirituality are subtler and more diffuse than those in Haiti. However, the ubiquitous “balm yards” or healing centers in contemporary Jamaica are significant African survivals. It is likely that their existence is a testament to the dura-

bility of a level of religious practice that does not require elaborate temples or rituals, or the participation of large numbers of persons. More importantly, their survival is also evidence of the centrality of healing for African-based spirituality.

In spite of diverse input from Africa and divergent experiences during and after the period of slavery, the various Afro-Caribbean communities share a broad range of traditional assumptions, attitudes, and practices relating to health and healing. I have identified six such factors, which I believe to be common to the healing traditions of the Afro-Caribbean.

First, healing is the *primary* business of these religious systems. In fact, it is not an overstatement to say that spirituality and healing are synonymous in the Afro-Caribbean. Client-practitioner interactions occasioned by problems in the lives of individual persons occupy much of the time of spiritual leaders. Furthermore, even large ritual events that occur on a regular basis can be understood as healing ceremonies when placed in their proper context.

Second, the understanding of personhood operative within these Afro-Caribbean healing traditions is a fundamentally relational one. The individual person is defined by a web of relationships that includes not only the extended family but also the ancestors and the spirits or saints. Furthermore, the individual *qua* individual is also understood in relational terms. Personhood is seen as constituted by a dynamic balance of diverse spiritual energies or tendencies.

Third, healing within Afro-Caribbean traditions takes place through ritual adjustments in these relational webs. To be more specific, healing involves adjusting or reactivating the reciprocal gift-giving that characterizes all relationships in the Afro-Caribbean, whether they are relationships with the living, the dead, or the divine.

Fourth, these African-based religious traditions address a wide variety of maladies. The expertise of the healer extends beyond physical problems to include social problems arising from such areas as love, work, and family life. While a person with physical symptoms could well be given herbal treatment appropriate to those symptoms, herbs would not represent the main part of the cure. In fact, the distinction between physical and social maladies is finally an insignificant one. Basic diagnostic categories are concerned with the *origins* of problems, and problems are virtually always seen as due to disruptions in relationships. The major curative action is therefore, as we have seen, directed at healing relationships. Further, the connection between a specific cause (the root problem) and a particular set of symptoms (the presenting problem) is by no means a necessary one. In other words, failure to honor the spirits could equally well result in the loss of a job or in digestive difficulties.

Fifth, these healing systems have a penchant for working through what Lévi-Strauss called “the science of the concrete.”¹ The harmful emotional states that cause disruptions in relationships—such as jealousy,

despair, fear, anger—are addressed in ways that appeal to the nonrational and even nonverbal dimensions of human interaction. Emotional or relational states are concretized in sounds, gestures, or objects that are laden with the highly condensed metaphoric referents of such things as taste, smell, and color. Adjustments are then made in the externalized or concretized relational situation. For example, in Haiti, a marriage threatened by the destructive anger of the husband could be treated by placing ice and a little sugar syrup in a jar that also contains a slip of paper with his name written on it several times. The jar is then inverted, the basic signal within the Vodou science of the concrete that a situation is to be changed. The wife, who desires to “cool down” and “sweeten” her husband, “works the point” several times a day. She lights a candle by the jar, prays over it, and concentrates her energy on the desired end. Scientific and social-scientific thinkers alike have tended to label this sort of healing practice “magic” or “superstition,” thus dismissing it from the larger psychotherapeutic discussion, where it could well suggest middle-range alternatives to drug therapy and the talking cure.

Finally, all of these traditions are involved in one stage or another of negotiation with Great Atlantic culture, that is, with the Western world. Scientific medicine, capitalism, individualism, and modern technology all present challenges to customary attitudes and practices in the area of health. In some parts of the Caribbean, exposure to these forces has been substantial and long-term (Puerto Rico, for example), and as a

The distinction between physical and social maladies is finally an insignificant one.

result, traditional healers have circumscribed their activity, focusing on problems that would be considered insignificant by the church and by Western medical institutions, such as broken love affairs, predictive dreams, and chains of bad luck. By contrast, in rural Haiti the majority of problems of all sorts are still treated by traditional healers. Yet no area in the Caribbean has been without some contact with the trappings of modern life. African-based systems of spiritual healing characteristically accommodate elements of modernity in their worldview rather than react to them competitively or with hostility. For example, a traditional healer may advise a patient to go to a hospital or get a shot of penicillin from the local clinic. Unfortunately, there has not been the same openness in the other direction.

This summary view of the Caribbean context serves as background to a more detailed discussion of traditional healing in Haiti, which will begin with sections on the centrality of family and the view of person. The focus on exchange relationships emerging from these two topics will provide the organizing motif for discussions of Vodou rituals and of the Vodou spirits. A more specific treatment of the Haitian Vodou understandings of the causes and cures of human suffering will follow. This will touch on a variety of topics, including the etiology of problems, the sources of authority used in treatment, and the questions of morality that arise in the quest for healing.

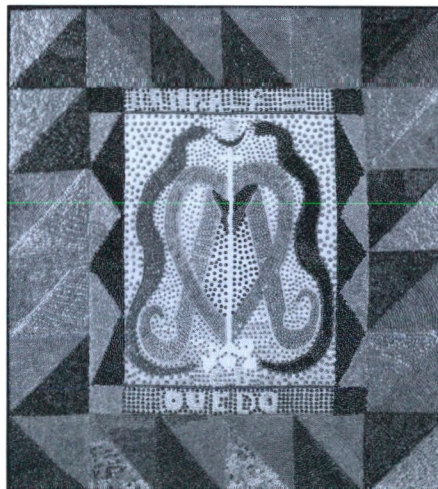
Serving the Spirits in Haiti

Haitians do not often call their religion “Vodou,” a term that in the rural areas at least is still reserved for a particular subtype of dance and ritualizing. (*Vodou* comes from the Fon language and means “spirit.”) When Haitians refer to the religious dimension of their lives they refer to a form of activity rather than an institutional entity. They say they “serve the spirits.” I have come to believe that human suffering is the major impetus for serving the spirits and, furthermore, that an understanding of Vodou ritualizing in terms of the ways in which it both comprehends suffering and ameliorates suffering yields greater insight than any other.

“Moun fèt pou mouri” (People are born to die), Haitians are fond of saying with a shrug of the shoulders. This proverb comments on the suffering and death that are commonplace occurrences in poverty-stricken Haiti and shows the stoic acceptance that, on one level at least, characterizes the Haitian attitude toward such a life. Haitians have no vision of heaven in their religion,² no ideology of progress shaping their understanding of history, and virtually no experience of upward mobility in their lives or the lives of their children. Suffering is an expected, recurrent condition. It is not an exaggeration to say that problem-free periods in life are pervaded with an anxiety that anticipates crisis just around the corner. Life as a whole is thus characterized by cycles of luck and the absence of luck. The clever, faithful, and/or powerful person is one who manages by a juggling of

scarce resources to give generously to the living, the dead, and the spirits. The resulting network of dependents who are obliged to serve and elders or social superiors who are obliged to give sustenance and protection—even though subject to the inherent unpredictability of personal relationships—provides the only means any Haitian has of controlling his or her “luck.” At the very least, the obligations created by these gifts construct the safety net that is essential for survival, given the uncertainties of life in Haiti.

Haiti occupies the western third of Hispaniola, an island it shares with the Dominican Republic. It is a small country—about the size of the state of Maryland—that is home to 5.5 to 6 million people. Haiti is still largely an agricultural country, although much of its land has been rendered nearly useless by short-range farming techniques and soil erosion caused by cutting trees to produce the charcoal most people still use to cook their food. Diseases such as tuberculosis, malaria, yaws, syphilis, and elephantiasis, which have been virtually eliminated in most of the Western Hemisphere, afflict the population in Haiti still. In parts of Haiti the infant mortality rate is above 50 percent, and anyone reaching the age of fifty-five or sixty is considered among the fortunate. The majority of children show some signs of malnutrition: spindly arms and legs, swollen bellies, reddish brittle hair. Social disease is also rampant in Haiti, a country that has survived a succession of brutal dictators who have increased their personal wealth at the expense of the people and main-



Vodou flags are designed by priests and priestesses, and women of the temple painstakingly execute the design with sequins sewn on silk or satin. The purpose of the flag is to entice the god or goddess depicted on the flag to honor the ceremony with his or her presence. This flag tells the creation story in symbols. The coiling together of the two snakes (representing god and goddess) brings forth the primordial egg of creation, from which the universe springs. The heart, which represents the heart of Erzulie, the goddess of love, is bisected by the axis of the world, linking the center of the earth to the center of the universe. The cross at the top of the axis symbolizes the ram, frequently offered in sacrifice to Erzulie.

Courtesy of Nicole Gallery: The Art of Haiti, Chicago

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tained their power through random violence and intimidation. It is estimated that 80 percent of the population is illiterate and that the average annual income for a Haitian is somewhere between \$200 and \$300. When the considerable wealth of the 8 to 9 percent of the population known as “the elite” is taken into account, it appears most persons in Haiti get by on little more than \$100 a year—and yet a chicken purchased in Port-au-Prince can cost as much as \$5.

“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.

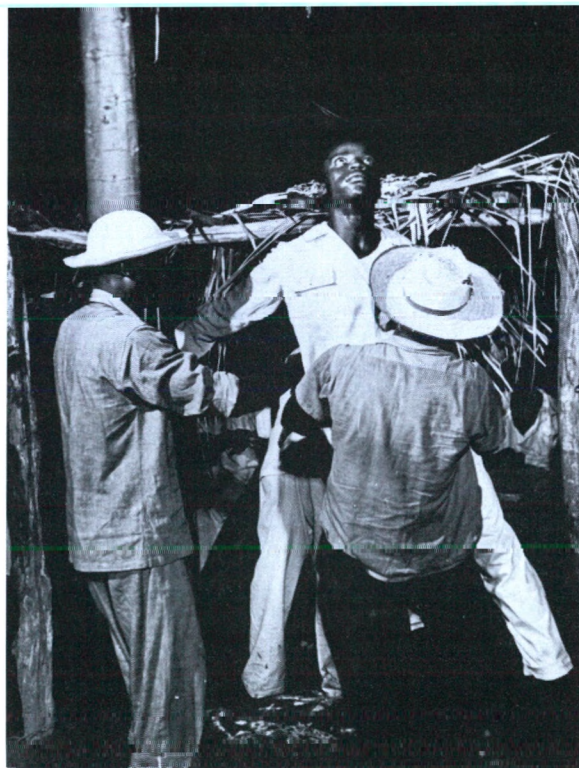
The Centrality of Family

For the slaves taken from Africa, the loss of extended family was so great that they apparently made efforts to recreate that family before they had even set foot on the shores of the New World. It is reported that some slaves recognized an incest prohibition as existing between males and females who had undergone the Middle Passage on the same ship. We know almost nothing about the interactions among slaves in the early part of the eighteenth century, when large numbers of them arrived in Haiti to work the plantations. However, knowledge of the crucial role of the extended family throughout West Africa easily leads to the conclusion that whatever blending among Fon, Yoruba, and Kongo cultures took place during that period must have been compelled in large part by the need for family. In the early stages this need would have been met through fictive kinship structures in which putative “mothers” and “fathers,” “aunts” and “uncles,” and “cousins” provided the individual with both identity (a place in society) and protection. Since the contributing African cultures defined family as including the ancestors and the spirits, the need for family was both a social and a spiritual need.

The slaves’ loss of access to family land in Africa was as great as their loss of the African family itself.

Indeed, from one perspective family and land were inseparable. Prevented from visiting family graves and from leaving food offerings and pouring libations at ancestral shrines, the enslaved African had also been denied the means of ensuring the spiritual blessing and protection of the ancestors. Thus when slaves could bring no other possessions with them, some nevertheless managed to carry away small sacks of the soil of their motherland. This connection of family, land, and religion persists in rural Haiti today.

Unlike most of the other Caribbean nations Haiti is predominantly a country of peasant farmers, many of whom own their own land. Where the social structures have not been decimated by the combined pressures of overpopulation, depleted soil, and corrupt politics, rural people in Haiti tend to live in large, patriarchal, extended families. Even moderately successful men in the countryside may enter into multiple *plasaj* or common-law unions with women. Each of these women is set up in a house of her own in which she raises the children born of their union. Thus a multigenerational extended family can swell to considerable size even when counting only the blood kin. Such families, however, are not defined solely by blood ties. Large rural families in variably include adopted "godmothers," "godfathers," and "cousins," as well as a number of "maids" and other workers who exchange their labor for a place to sleep and for meager rations. Included in this latter group are the *restavèk* (literally, the "stay-withs"), children whose parents could not afford to feed them and so either sold



At a Vodou ceremony, participants support a man during the trance that marks possession by a spirit.

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“Moun fèt pou mouri” (People are born to die), Haitians are fond of saying with a shrug of the shoulders.

them or gave them away to slightly more prosperous families. Social hierarchy is relentless in Haiti. There is always someone poorer than oneself. Even the most minimal rural household with only one or two able-bodied adults to work an unproductive square of earth manages to have a servant.

The patriarch of the extended family functions as the *oungan* or priest when that family serves the spirits. He is often the one who treats family members when they become ill, although an outsider may be called in for such treatments if there is someone in the vicinity who has a reputation as one who “knows leaves.” However, it is necessarily the patriarch who presides at the *gwo sèvis*, the big dancing and drumming events that include animal sacrifice. These ceremonies are held annually if family resources permit. More commonly they are held at longer intervals and then only in response to crises within the group. The purpose of the elaborate ritualizing is to honor, entertain, and feed the ancestors and the Vodou spirits which those ancestors served.

The family dead are buried on the family land and the cemetery is a major center for religious activity. In addition, a cult house for the ritual objects of the family is often built on a small, separate plot of land. Thus, to inherit land is also to inherit the bones of the ancestors and the duty to honor those ancestors as well as to serve the spirits represented in the cult house. Conversely, to be separated from the land is also to risk one’s access to the power and protection that these spirit entities provide.

Separation from land and family is, however, an increasingly frequent experience for the younger generations of Haiti’s rural poor. Inheritance laws in Haiti work to divide the land into smaller and smaller plots. This pressure, combined with that of the multiple problems cited earlier, has pushed large numbers of young people off the land and toward the elusive promise of a better life in the cities.

For young men urban life is often cruel. In the countryside they are reared to the expectations of male privilege and power. (Even the female-headed households that are prevalent in the cities perpetuate this ideology to a degree.) Yet some experts estimate unemployment among young urban males at 60 percent and others argue that the figure should be much higher. Women fare somewhat better in the urban environment. Most of the factory jobs available are of the piecework variety, and European and American employers seem to favor women for these repetitive tasks. Urban women also have a market tradition bequeathed to them by their rural sisters. In the country it is the women who take the excess produce to market, along with bread, candy, herbal teas, baskets, and other things they make with their own hands. The urban woman spun away from the rural extended family frequently ends up not only in charge of her house and her children—as she might well have been in the country—but also solely responsible for their financial support. In the countryside her market money would have been the “rainy-day savings” for times of drought and hunger or the means to fulfill a

private dream for herself or her children. In the cities she must rely on the old market skills more centrally. The poor urban woman is constantly engaged in small-scale commerce, often in several such enterprises simultaneously. For example, even if she has a regular job, she may sell peanut candy at the door of her home or work as a seamstress or beautician in the evenings and on weekends.

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 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 sajan* (midwives), nowhere in the countryside do they effectively challenge the spiritual hege-

mony 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.

The urban Vodou temples run by men tend to mimic the patriarchal structure of the rural extended families. The urban *oungan* is notorious for fathering many children and recruiting desirable young women to be among his *ounsi*, brides of the gods, the ritual chorus and general workforce of a Vodou temple.³ He thus creates a highly visible father role which he then operates out of in relation to those who serve the spirits under his tutelage. While the female *manbo* who heads a temple is not necessarily more democratic in all of her relationships with those that serve the spirits in her house, she does tend to be so in the ways that a mother’s role is normally less authoritarian than that of a father. For example, many temples headed by women function as day-care centers for the working mothers associated with them. In sum, the woman-headed temple tends to reiterate the tone and atmosphere inside the home, a place where women have usually been in charge. This is an atmosphere that allows for more flexibility in human relationships than is found in the male-headed temple, which recalls the more public and therefore more rigid social rules of the entire extended family. This shift toward greater authority for women in urban Vodou has undoubtedly had an effect on the nature of the care given to individuals who turn to traditional religion to solve the many problems that urban life in Haiti can bring.

For the slaves taken from Africa, the loss of extended family was so great that they apparently made efforts to recreate that family before they had even set foot on the shores of the New World.



Decoratively carved gourds are used to hold offerings—especially food—for the spirit etched on the gourd. The drawing on this gourd depicts Baron Samedi, god of the cemetery—also called Guede, god of the dead.

Courtesy of Nicole Gallery: The Art of Haiti, Chicago

Whether the temple is headed by a man or a woman, it is clear that its appeal to the urban population is rooted in its ability to recreate family. A song sung at the beginning of Vodou ceremonies in Port-au-Prince illustrates this:

*Lafanmi semble,
Semble nan.
Se Kreyòl nou yè,
Pa genyen Gine enkò.*

The family is assembled,
Gathered in.
We are Creoles,
Who have Africa no longer.

The Vodou View of Person

In Vodou, persons are said to possess several “souls.” In fact, there is no generic term in the Haitian Creole language that includes all of these spiritual entities or energies, even though each possesses some of the characteristics of what Westerners call soul. Furthermore, the word *nam*, derivative of the French word for soul, is only one of the complex of forces that constitute a person. A person’s *nam* is usually understood as the animating force of the body. The most immediate effect of death is the departure of the *nam*, which is sometimes said to linger for a short period of time around the corpse or grave. The *nam* is an evanescent thing that disappears soon after death.

By contrast the *gwo bonanj*, the big guardian angel, is capable of sustained existence apart from the body it inhabits. One of the situations in which the person is separated from his or her *gwo bonanj* occurs during the possession trance, which is central to Vodou ritualizing. The struggle that marks the onset of possession is understood as a struggle between a person's *gwo bonanj* and the Vodou *lwa* (spirit), who desires to "ride" that person and to use his or her body and voice to communicate with the faithful. One who is thus ridden by the spirit is known as a *chwal* (horse) of the spirit. Those who are possessed report that they lose consciousness after this initial struggle. The loss of consciousness and the resulting amnesia about what the spirit said and did while riding the *chwal* is explained as due to the departure of the *gwo bonanj*.

Similarly, it is the *gwo bonanj* that wanders from the body during sleep, even into the land of the dead, thus allowing deceased persons or those living at a great distance to appear in dreams. The wanderings of the big guardian angel during sleep are sometimes useful for information-gathering. For example, a mother in Haiti said she learned from a dream that her daughter in New York had met with an accident and broken her arm. In like fashion, when a person is uneasy, she may say that her *gwo bonanj* is agitated. This is an undesirable state mainly because it robs the person of sound sleep and therefore of dreams, which are an important vehicle for communication with the dispersed family, the ancestors, and the spirits.

Finally, it is the *gwo bonanj* that must be ritually removed "from the head" of a person shortly after death. The big guardian angel is then sent "under the water" to dwell for a period of time until it (now referred to as a *mò*, one of the dead) is "called up from the water," installed in a clay pot known as a *govi*, and placed on the family altar. The Vodou ceremony known as *rele mò nan dlo*, calling the dead from the water, calls them from Gine, Africa, a watery land said to exist below the earth. The ceremony ideally takes place a year and a day following the death. Because it is an elaborate and expensive ceremony, however, in practice families wait until there are several of their dead whom they may retrieve at once. As a result the dead frequently emerge complaining of cold, dampness, and neglect. In this ceremony, the dead speak through a kind of ventriloquism possession and genuinely sound as if they come from both far away and underwater. Their identity is confirmed by the intimate knowledge of family life which they display. The spirits called up from the waters of Africa inquire about family members and comment on problems within the group. Given these various understandings of the nature and activity of the *gwo bonanj*, it seems fair to conclude that this dimension of soul is both the consciousness and essential personality of the individual.

The *ti bonanj* (little guardian angel), which each person also possesses, is much more difficult to define. One urban *manbo*, or priestess, gave me two interesting responses to questions about the nature of the *ti bonanj*.

The family dead are buried on the family land and the cemetery is a major center for religious activity.

“When you look at your shadow,” she said, “you will see that sometimes it has a dark center. That is the *gwo bonanj*, but the paler shadow around the dark center is the *ti bonanj*.” When asked what the little guardian angel does, she gave another concrete illustration: “When you are walking a long way or carrying something very heavy and feel so tired that you know you are not going to make it, it is the *ti bonanj* that takes over so you can do what you have to do.” The *ti bonanj* is thus perhaps best described as a spiritual reserve tank. It is an energy or presence within the person that is dimmer or deeper than consciousness, but it is nevertheless there to be called upon in situations of stress and depletion.

Much less routinely, Vodou *oungan* and *manbo* speak of another dimension of the person called the *zetwal* or star. This is not an inner presence so much as it is a kind of celestial parallel self. The concept of the *zetwal* is rooted in the belief that each person is born with his or her fate already foreknown and unchangeable. The regular movements of the stars and their recurring patterns mimic, perhaps even direct, the larger contours of life in the human community. Whatever control an individual has over his or her life thus comes in specific moments and short-run situations. *Mizè* (suffering) may be held at bay only for a short time and *chans* (luck) only marginally enhanced. The overall shape and direction of a life are determined by fate.

The *nam*, the *gwo bonanj*, the *ti bonanj*, and the *zetwal* are the constitutive parts of a Haitian view of personhood that is clearly derivative of what ethnographers

call the “multiple soul complex” in West Africa. The fact that Vodou contains European elements as well as African is also hinted at in this formulation. In addition to their Catholicism, the French planter class of Haiti was known for its participation in a variety of forms of marginal spirituality including Freemasonry and spiritualism. It seems likely that the astrological flavor of the *zetwal* concept also owes its parentage to this line of influence, even though the notion that individual persons are born with their fate already cast by the gods was a belief held by the Fon and to some extent also by the Yoruba.⁴

While Vodou devotees understand the dead body (*kòr kadav*) of a person to be a material substance separable from these various animating spiritual entities and therefore subject to decay and ultimate dissolution, the body/soul or material/spiritual split is not central to their understanding of personhood. As an indication of this it is worth noting that there is no division within the Vodou view of person between drives or appetites that come from the body—for example, hunger and sexuality—and those that come from the spirit or mind. In fact, sexuality is perhaps the central animating force in all of life. Much of Vodou ritualizing suggests that sexual and spiritual energy come from the same source.

What complicates the understanding of personhood is the realization that individuals are not comprehensible apart from the Vodou spirits associated with them. It is easiest to discuss this in the urban setting, which I know best. Here, each person is said to

have a *mèt tet*, master of the head. This is the main spirit served by that person, and if the person is one who serves as a “horse” of the spirits, it will be the *mèt tet* who most often possesses that person. To a certain extent the personality of the individual human being mirrors that of his or her *mèt tet*. For example, a man who has Ogou as his *mèt tet* will be expected to exhibit some of the warrior spirit’s anger, strictness, and perseverance in his everyday behavior. Yet he will also have been told that Ogou is “too hot” to be served alone. The spirit of war and anger must be balanced by others, for example, by a strong “sweet” spirit such as the ancient and venerable snake spirit, Dambala.

In addition to a *mèt tet* each individual has a smaller number of other spirits, usually two or three, from whom he or she receives special protection. This complex of spirits, which may consist of some that are known only in that family and others that are recognized throughout Haiti, differs from individual to individual. It is partly because of this that Vodou, though centrally concerned with morality, could never produce a codified moral law that would apply equally to all persons. In Vodou, an individual lives a moral life by faithfully serving the particular configuration of spirits that “love” or “protect” that person. This includes following their advice, advice that will be consistent with the personalities of the spirits. Thus it might be said that the Vodou ethic is an intensely contextual one.

It is the urban devotee’s particular grouping of protective spirits that determines the nature of ritual as well

as moral obligations. Furthermore, it is important to note that the choice of this penumbra of protective spirits is not for “the living” to make; Vodou devotees insist that it is the spirits who choose the persons they love or protect. Yet, priests and priestesses do determine the choices the spirits have made, often through divination.

A question may well be raised as to whether the Vodou spirits are truly distinct and separate from the persons who serve them. This question is answered in paradoxical ways within Vodou ritualizing. Beliefs surrounding possession trance and the struggle of the *gwo bonanj* with the possessing spirit, as well as the insistence that the person is chosen by the spirit and not vice versa, point to a clear distinction between spirit and person. However, from the perspective of certain rituals such as those that occur during initiation and after death, the individual person cannot be separated from the spirits that reside “in the head” or “on” the person, these being equally common expressions among Vodou devotees. Initiation rituals simultaneously “feed the spirits in the head” and establish a repository for them outside the person. This repository is called a *pò tet* (head pot). After initiation it is placed on the Vodou family altar and becomes the focus of rituals designed to cool, soothe, and strengthen the person. Furthermore, when the spirit is removed from a person’s head at death, this spirit is sometimes treated as if it were the *gwo bonanj* and sometimes as if it were the *lwa*, the Vodou spirit, who was the *mèt tet* of the dead person.

The urban Vodou temples are currently the closest thing to a social welfare system that exists in Haiti.

Similarly, when the ancestor is called up from the waters and established on the family altar, the spirit is called both by the name of the ancestor and by the name of the *lwa*. For example, reference may be made to “Marie’s Ogou” or to “Pierre’s Dambala.” Thus there is also a sense in which at least the head spirit is identified with the *gwo bonanj*, if not with the individual in a larger sense.

In fifteen years of work on Haitian traditional religion, I have learned that paradoxes of this sort are to be cherished rather than resolved, for it is invariably such paradoxical statements that provide the greatest insight into the religious system we call Vodou. If it is understood that within the Vodou worldview the individual is both a separate self and an inseparable part of a family, then it can be grasped how the spirits who are part of that extended family can be *both* other than and merged with those who serve them.

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.

* * * *

Treatment in the Vodou System

Vodou priests and priestesses treat a wide variety of *pwoblèm*, “problems.” Clients come to them for help with love, work, and family problems as well as with sickness. The first determination that a Vodou healer must make is whether the problem “comes from God.” If a problem is determined to have been sent by God, it is then seen as “natural” in the sense of that which is meant to be, that which is unavoidable.

When Catholicism blended with African religious traditions to create Vodou, the great West African sky gods, progenitors of human and divine beings alike, were absorbed into Bondyè (God). Bondyè (literally, the “good god”) is the one and only god and is clearly distinguishable from the *lwa*, who are sometimes said to be his “angels.” A popular Haitian proverb emphasizes the message that is contained in the name of god itself: “Bondyè bon” (God is good). As a result, if a problem, usually a physical illness in this case, is understood as coming from Bondyè, then it works to the greater good, even though this fact is unlikely to be apparent to the sufferer. No priest or priestess will interfere in such a case.

However, if a problem is determined to come from what some Haitians call “supernatural” causes, it is

then thought to be appropriate for treatment within the Vodou system. It is important to remember that Haitians do not live in a two-story universe. God and the spirits are an intersecting dimension of life; they are not denizens of a separate realm. When they call a problem “supernatural,” it means two things: the problem is not part of the natural order, meaning part of what is fated to be, and it is likely to have been caused by the spirits. Health problems that have a history of being resistant to scientific medical treatment often end up in the Vodou temple, where that very resistance is taken as a sign of the spirit-connected nature of the ailment. In fact, most problems are diagnosed as supernatural in origin or, if not specifically caused by the spirits, then at least falling within the province of their curative powers.

Once the preliminary determination is made that a particular problem is suitable for treatment, the *manbo* or *oungan* sets out to discover more about its nature and origins. Clients do not present themselves to Vodou healers with a detailed list of their symptoms. According to tradition, nothing more is required than a statement such as: “M’pa bon. M’pa genyen chans” (“I’m not well. I don’t have any luck”). From this point, it is up to the priest or priestess to determine the nature of the problem, as well as its cause and cure. This is usually accomplished through divination.

The most popular form of divination used in Port-au-Prince is card reading. However, gazing into a candle flame may be used or other more exotic techniques, such as pouring a small amount of alcohol into the top



On this flag of Grand Bois—the god of the forest, who makes the trees grow and provides humanity with food and medicinal herbs—the figure of Grand Bois is surrounded by common Vodou symbols, or veves, which consecrate and empower the flag: the tree—reminding humanity of its dependence on nature; the heartshaped leaves—symbols of the affinity between humanity and nature; the fire of purification; the cup of initiation; the ason—symbol of priestly power; the conch shell—symbol of femininity and fertility; the cross—symbol of Guede, god of death and regeneration; the cross-hatch—symbol of Ogou, god of force, courage, fire, weapons, and the army.

Courtesy of Nicole Gallery: The Art of Haiti, Chicago

What complicates the understanding of personhood is that individuals are not comprehensible apart from the Vodou spirits associated with them.

of a human skull and then reading the patterns made by the liquid moving along the cranial grooves—a very graphic appeal to the wisdom of the ancestors! For card divination, an ordinary deck is used with all cards below the seven removed. After lighting a candle and praying, the *manbo* or *oungan* offers the cards to the client for cutting. These are then laid out in four rows of eight in front of the healer. The whole process is repeated twice, once to determine the best description of the problem and once to track down its supernatural connections. After the first spread, the healer begins tapping the cards in patterns dictated by his or her own inner perceptions. Occasionally a question will be raised or a statement made. For example: “There is trouble in your house. I see fighting.” The client is free to say yes or no without prejudice. Gradually, through a series of such statements and responses, the contours of the problem reveal themselves. It should be emphasized that while this is clearly not a miraculous procedure or even one requiring extrasensory perception, it nevertheless calls on the intuitive skills of the practitioner and represents an important step in the curing. When the problem is articulated through this gradual dialectical process, its definition may well surprise even the client. I once witnessed a session in which a mother brought her young daughter for help because the child would not eat, was losing her hair, and had run away from home. In the course of settling on the appropriate description of the problem, the *manbo* uncovered something that was unknown to the mother and unspoken

before by the daughter: the girl’s stepfather was sexually abusing her.

Once a full picture of the problem emerges, the healer then lays out the cards once more to determine its cause or origin: “I see the spirits love you a lot. Ezili especially. Did you promise you were going to do something for her and then not do it?” By this means a complete diagnosis is made.

Diagnoses point to disruptions in relationships. Often the relation in question is with the spirits themselves. Broken promises, lax or insufficient offerings, or refusal of the spiritual vocation the *lwa* have chosen for a person can all be reasons for trouble. Many *manbo* and *oungan* have dramatic stories to tell about their own efforts to resist the desire of the *lwa* that they take the *asson*, that is, undergo initiation to the priesthood. One woman was hospitalized three times and given last rites on two occasions for an intestinal disorder, the cause of which medical doctors could never determine. (Eventually she obeyed the *lwa*, and thereafter she reported that she experienced no further health problems.) Obligations incurred or promises broken by family members generations back can emerge as the cause of the contemporary individual’s troubles.

However, as was seen in the case of the sexually abused child, it is not always the spirits who cause a problem. For example, the cards often reveal that someone is suffering because of the “jealousy” of other persons. Jealousy is understood to be such a strong emotion that the lives of its targets can be seriously

disrupted. Within the Vodou system the object of jealousy rarely escapes at least part of the burden of blame. Such an attitude reflects a society in which it is expected that anyone who has much should give much. Thus, a wealthy person is almost by definition thought to be stingy, and a very lucky person is suspected of having done “work with the left hand.” A less serious but related diagnosis is that someone is suffering from “eyes.” This mildly unsettling condition comes from the fact that too many people are paying attention to that individual. It may be that there is gossip circulating. With both jealousy and eyes, as with several other diagnostic categories, the troubled relationships are among the living. In such situations the spirits are called on for help, but there is no sense in which they are seen as causing the problem.

Sorcery and Ethics

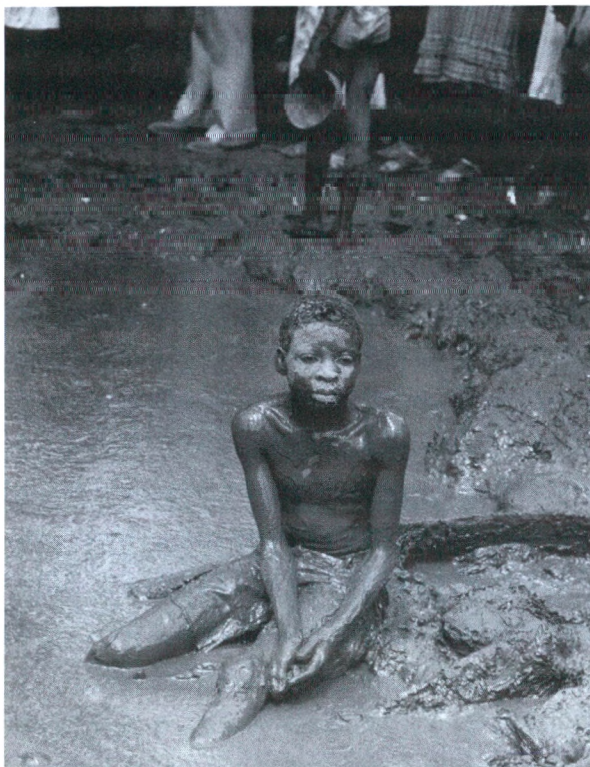
Disruptions in relations with the spirits cause serious problems, yet in many ways it is an even more serious situation if, in the course of a “treatment,” it is discovered that a person’s problems arise from the fact that another human being has done “work” against them. The range of magical actions that fall under the category of “work” is considerable. It may only be that a rejected lover has gone to the *manbo* or *oungan* for a love charm, or it may be something more serious, such as an act of sorcery performed by a vengeful neighbor.

For example, sorcery is frequently implicated when

a diagnosis is made that a woman has “fallen into perdition.” “Perdition” is a condition that befalls a pregnant woman in which the child in her womb is “held” or “tied” to prevent it from growing. When a woman who has missed one or more menstrual periods and assumes herself to be pregnant experiences a discharge of blood, she suspects that she may have “fallen into perdition.” In all pregnancies it is believed that the menstrual blood that would ordinarily exit from the body each month is held in the womb where it serves as nourishment for the child. In a state of perdition the nourishing blood bypasses the fetus. The fetus, however, is not expelled but held inside the mother. Fetuses are believed to be able to stay in a state of arrested growth for years until something is done to “cut off” the perdition or “untie” the child. When that is accomplished the monthly blood flow stops, and the child begins to do its “work” within the womb. The infant born nine months later is the one who was conceived before the state of perdition began. Falling into perdition can be caused by several things. It can be caused if “cold” is allowed to enter the womb. It can be caused by restive *lwa* or ancestral spirits. However, work of the left hand, specifically sorcery, is the most frequent diagnosis. All children, but especially the unborn, are said to be susceptible to being “caught” by a work of sorcery directed against a family.⁵

There is an underlying belief in what might be called an economy of energy in Haitian attitudes toward sorcery or the work of the left hand. A rather flat-footed

***Broken promises, lax or insufficient offerings, or refusal of the spiritual vocation
can all be reasons for trouble.***



Devotees seek healing of body and soul in mud mixed with food for St. Jacques (Ogou) and the blood of sacrificed animals. The ceremony is held in Plain-du-Nord, Haiti.

Photo by Harold Brown, OMS International, Inc.

way of articulating the content of this belief would be to say: nothing comes for free. For example, there is a significant distinction made in the types of powers that a person can call on for help in this life. There are first of all *espri fumi* (family spirits), and then there are *pwechte* (literally, "points that have been purchased"). Most often residing in some tangible object such as a stone or bottle (the "point"), these spirits are either the souls of persons who died without family, ceremony, or burial, or they are the free-floating spirits of another, often malevolent, sort.

Serving family spirits entails obligations that may strain resources and energy; however, the demands of family spirits theoretically never escalate beyond reason. Within a given family the living and the spirits are interdependent in a way that makes both parties exercise restraint. Powers that have been purchased are another matter. While it is understood that they may be extremely effective, they have neither history nor loyalty to curb their rapacious appetites. Consequently, working with the left hand leads all too easily to an ascending spiral of obligations. Stories are frequently told of *manbo* and *oungan* who turned to sorcery in a desperate moment and then found it impossible to extricate themselves. First they lost members of their family; finally they lost their own lives. This belief that a person ultimately pays for what is gained through illegitimate means is one moral force within Vodou that curbs the wanton practice of sorcery.

Another moral force is the belief that only in ex-

treme circumstances may one use sorcery to harm another, and only if one is absolutely just in doing so. For example, there was a *manbo* who lost her home through the deception of a woman friend who stole the title papers. The former friend actually went to court in an effort to claim the house for herself. The *manbo* performed a very simple act of magic (there is a widespread belief that the simplest ritual acts are the most powerful)⁶ that involved dropping a “point” or charm into a latrine. As a result of this, three people either fell sick or died: the judge, the lawyer, and the erstwhile friend. When this incident was discussed within the family, someone invariably noted that the *manbo* could do this with no fear of reprisal from humans or spirits because she was so clearly in the right. The house was hers.

Yet another belief that acts to curb destructive uses of spiritual power centers on that part of Vodou associated with cemeteries. Although a version of this system operates within the cities, the pattern is clearest in the rural areas where cemeteries are still family property. The first male to be buried in a cemetery is known as the Baron Simityè, Baron of the Cemetery. When a wrong has been done to an individual or family by someone from outside that group, a simple ritual performed in the cemetery calls on Baron to send a *mò*, one of the souls of the dead, to avenge that wrong. The Baron’s power can never be used, by definition, by one family member against another.

What complicates this discussion of morality and the uses of power within Vodou is the fact that it is not

always possible to keep the categories clear and distinct. What is sorcery from one person’s perspective is no more than what was required for an effective treatment from another’s point of view. For example, love magic may heal a broken heart or soothe wounded pride, but it also necessarily involves the manipulation of the will of another. Cemeteries in Haiti are littered with the evidence of this common sort of “work.” Small male and female rag dolls bound face to face and stood on their heads (inversion creates change) in a jar or drinking glass are evidence of a work designed to bring about a reunion. The same dolls bound back to back indicate that the dissolution of a troublesome relationship was the desired result. One bound with its face to the back of the other is said to be in a position to “eat” the other, that is, to take revenge. Such routine magic is within the repertoire of most Vodou healers and does not involve trafficking with suspect or “purchased” spirits.

Understandably, most priests and priestesses claim to eschew the work of the left hand. Equally understandably, rumors circulate that this one or that one “serves with both hands.” It is not unlikely that most sorcery rumors can be attributed to individuals or groups in conflict wherein each party, knowing their own spirituality to be rooted in family and tradition, can only assume that the practices of their enemies are not so rooted.

* * * *

Conclusion

“Moun fèt pou mouri,” people are born to die—the saying reveals the Haitian’s sense that life is both short and painful. This verdict cannot change; it can only be accepted. Yet in the midst of the struggle that is life it is possible to enhance one’s *chans* (luck) and minimize the *mizè* (suffering). This is accomplished in two ways: first, by respectful attention to the web of sustaining human relationships that defines family, and second, through conscientious service to the spirits who are after all members of one’s own extended family, even—from one perspective, at least—parts of oneself. The spirits are served by the parent (fictive or actual) in the name of the family. In order to serve the family well in this role, the priest or priestess must have *konesans*: knowledge, intuition, insight into human and spiritual affairs. Such

knowledge is most often rooted in the *oungan*’s or *manbo*’s own experience of suffering. To *kouche* (lie down, sleep, give birth, die, and, specifically, to be initiated) is to take the risk necessary to be healed oneself and through that process to enhance and focus one’s power and knowledge in order to heal others. Once gained, *konesans* carries with it a moral obligation that it be used justly and respectfully. Thus, the *manbo* or *oungan* is one who knows how to *eshofe*, to raise the life energy in individuals and groups, human and divine. Power thus mobilized can then be concentrated in *pwe* (points) which are the concrete embodiments of relationships human and divine. Problems properly articulated in the concrete can be healed. One can pick up the *pwe*, turn it upside down, and bring about change that heals. ☸

NOTES

1. Claude Lévi-Strauss, *The Savage Mind* (Chicago, 1966), pp. 1–33 (Chap. 1, “The Science of the Concrete”).
2. As will be seen below, there is a sense in which the dead continue to exist; however, none of the living would consider this existence superior to his or her own. Thus immortality does not function as a reward for sacrifices made in the present life.
3. A partial qualification to this characterization exists in the large numbers of homosexual priests who have genuine power and prestige within Vodou. This is somewhat surprising given the extreme homophobia in Haitian culture. However, it is only a partial qualification because many of these priests are more accurately described as bisexuals. They often have traditional families.
4. See William Bascom, *The Yoruba of Southwestern Nigeria* (New York, 1969); also Melville Herskovits, *Dahomey: An Ancient West African Kingdom*, 2 vols. (Evanston, IL, 1967).

5. Gerald F. Murray, "Women in Perdition: Ritual Fertility Control in Haiti," in *Culture, Natality and Family Planning*, eds. John F. Marshall and Steven Polgar (Chapel Hill, NC, 1976), pp. 59–78.

Murray points out that the socially useful part of this explanatory scheme is that, in providing the possibility of a pregnancy much longer than nine months, a woman can claim the father of her child to be almost anyone with whom she has ever had sexual relations. This in turn allows her to choose among fathers the one who is most likely to be able to give meaningful support. Given the current social instability all over Haiti, finding men with the means and temperament to be responsible fathers is one of the major problems faced by women.

6. See Serge Larose, "The Meaning of Africa in Haitian Vodou," in *Symbols and Sentiments: Cross-Cultural Studies in Symbolism*, ed. Joan Lewis (New York, 1977), pp. 85–116.



When alcoholism was viewed largely as a moral problem rather than an illness, suasion was the tool of reformers. The series *The Bottle* (by George Cruikshank, 1847) chronicles the destruction of a family by alcoholism. Plate III (above) shows the parents seeking solace in drink as their furniture is carried away.

Bill W. and Dr. Bob tells of the founding of Alcoholics Anonymous in the mid-1930s. It sheds fresh light on a baffling disease while celebrating the healing possibilities present when one alcoholic talks to another. Clearly we still need help with the problems that gave rise to AA. A 1988 issue of *Public Health Reports* notes that in the U.S. each year 4.6 million adolescents and as many as half of our homeless have serious alcohol problems, and almost 50 percent of emergency room admissions are alcohol related. If AA can help people caught in a problem of this magnitude, we should take a closer look at a most unconventional therapy and ask why it works.

The playwrights merit special notice also. Both psychiatrist Samuel Shem and clinical psychologist Janet Surrey have helped clients with problems of addiction for many years.

Excerpts from

Bill W. and Dr. Bob

*A Historical Drama on the Founding
of Alcoholics Anonymous*

Samuel Shem and Janet Surrey

**Scene 8. 1934, late November.
182 Clinton Street, Brooklyn Heights**

Bill W. at kitchen table, drinking. A pitcher rests on the table. He looks bad—haggard, with head bandaged—and is dressed sloppily. In a bitter mood, he's writing a letter:

Bill W.

"November 25, 1934. Dear President Franklin Delano Roosevelt: I'm an American, I've fought for freedom, I've worked both labor and management, and in *my* opinion, this New Deal of yours is the most cockamamy idea in the history of—"

[Knock on door. Bill yells, "Come in!" Ebby Thatcher enters, totally transformed. Now he's dressed neatly; he's sober, clear-eyed, and alert, glowing with confidence and health]

Ebby? Ebby Thatcher? I don't believe it—you look A-1!

Ebby. Evening, Bill—how are you?

Bill W. Pretty good.

Ebby. That bad, eh?

[They laugh]

Bill W. Slipped on the ice. What's it been—five years? Sit down. Last I heard you'd been committed to the Brattleboro Asylum.

Ebby. "Alcoholic insanity," right. I went to court—

Bill W. And you beat it! Let's celebrate! Gin and pineapple juice—not that I like the pineapple juice, but it'd be less upsetting to Lois, in case she gets home early from work.

Ebby. No, thanks, I don't drink.

Bill W. Right—the pineapple juice spoils it. I'll get the gin—

Ebby. Don't bother, Bill. I don't drink.

Bill W. What the hell are you talkin' about?

Ebby. I got religion. I don't find it necessary to take a drink today.

[Bill stares at him, astonished]

Bill, something incredible's happened. You're like a brother to me. I've come to tell you about it. OK?

Bill W. Maybe and maybe not. You sure you won't. . .

Ebby. No. Maybe I'll come back . . . some other time?

Bill W. Stop stalling, sit down, and spit it out.

Ebby. Two years ago I got kicked out of Albany, and I holed up in our camp in the Green Mountains. An old buddy named Rowland came to see me. He'd heard that one more arrest and I'd be put away. Now Rowland was the worst drunk I ever saw, but when he showed up he was sober. Seems he'd gone to Switzerland to see some psychiatrist named Carl Jung—ever hear of him?

Bill W. Sure. Famous man, Carl Jung.

Ebby. Rowland was treated by Dr. Carl Jung for a year, but soon as he left, he got drunk. When he went back, Jung said: "It would be useless. The only thing that can help free you is a vital spiritual awakening. Ally yourself with a spiritual movement." So Rowland comes back to Vermont, joins the Oxford Group.¹ He teaches me to sit in silence, ask for guidance—

Bill W. Uh-oh! I'm having a funny feeling, Ebby. Those little hairs on the back of my neck are standing up straight—

Ebby. *I know!* That's how I felt too! Rowland left—next thing I know, I'm in court, about to be thrown into Brattleboro. But there, standing beside me, is Rowland! He gets me off, brings me down here to live at the Oxford Group house—they run the Calvary Mission on 23rd. The other day I hear about you—

Bill W. What'd you hear?

Ebby. That you're in desperate straits.

Bill W. You heard wrong. Just look at me—I'm terrific. Terrific.

Ebby. Bill, I've been sober ever since that day in court—two whole months! It's a miracle. I want to talk to you about prayer.

Bill W. Holy shit! You? The kid who missed more chapel than—

Ebby. I know, I know—but will you just listen?

[Bill rolls his eyes, mutters]

I tried to pray, not really believing—just as an experiment—and suddenly I was released from my desire to drink—in a flash!

Bill W. Look, I'm not an atheist. This world didn't begin in a cipher, and it isn't aimlessly going nowhere. Scientists say that vast forces are at work. I believe in a Spirit of the Universe, OK?

[Full of bitterness]

But! But with preachers and religions I part company. When they talk of a God personal to me, my mind snaps *shut!* What about the wars fought in God's name? What about that, Eb?

Ebby. That's how I felt, too—but I'm *sober!*

Bill W. *How?* Where'd you get the power to do it?

Ebby. That's just it, Bill—it wasn't *my* power. There was nothing left in me—I was powerless, and I admitted it. This came about through a power greater than myself.

Bill W. God? The old man in the white beard and bathrobe? One day the Big Guy spotted you, reached down those huge white hands?

Ebby. Bill, why don't you use your *own* conception of God?

Bill W. What?

Ebby. What's the big deal? You said you believed in *something*, right?

[Pause. Bill pours another drink]

Bill W. Dunno why you ever bothered to come over here tonight, Eb.

Ebby. I agree—the “God” concept’s tearing the world apart. The human race may’ve taken a wrong turn there. But this is *not* “God.” This is cutting through religion to reality, to spirit.

Bill W. You say that, but then you join this Oxford church group.

Ebby. It’s not a church. The meetings are held in people’s homes—

Bill W. How does it keep me away from a drink?

Ebby. If you’re willing to surrender—

Bill W. *Surrender?* Jesus Christ! I may not be in good shape, but one thing I got left is my self-respect: I take responsibility for myself! All of history—especially *this* century—shows what happens when people *stop* taking—

Ebby. Can you not take that drink? I know you can’t, ‘cause I was there.

Bill W. Right, before you “got God.”

Ebby. Dammit, Bill, you don’t have to believe in God. You just have to admit that *you’re not God*—so that something new, outside that prickly, stubborn Vermont self of yours can take hold!

Bill W. Don’t talk ragtime to me, pal.

Ebby. My friend, you want to drink more than you want to live.

[Pause]

Bill W. What the hell’s this country coming to? We’re a democracy, but we got a socialist president. My best friend’s turned into a religious nut and hunts me

down in my kitchen with his God-talk—which he says is anything *but* talk about God. Then he says I’m using my notion of God to keep away from God, so I can drink! Is that it? Have I got it now, Eb?

Ebby. [Laughing]

You forgot the surrender, Bill.

Bill W. Friend, if I didn’t *know* you—if I weren’t seeing right before my eyes the fact that you’re sober, ‘n I’m not—I’d throw you out on your ass! I’m listening cause you’re a *drunk*, not ‘cause you’ve got religion.

[Pause]

Look, you make some sense, but you’re not in my world. I’m holed up in my cave and you’re lifting the shades, but the light hurts my eyes. You’re telling me it’s a soft sunny day out there, but that just makes me feel worse, stuck inside! Even if I do want to come out into your world, I can’t, ‘cause I don’t share your belief.

Ebby. Good.

Bill W. [Coughing up his drink]

Good?

Ebby. It’s *good* that you’re willing, but that you don’t believe.

Bill W. How the hell can that be good?

Ebby. Rowland didn’t believe Carl Jung, *I* didn’t believe Rowland. This damn thing works *in spite of* any belief.

Bill W. Don’t you have to believe to surrender?

Ebby. No. It's surrender without belief.

Bill W. Doesn't make sense.

Ebby. I suppose everything in *your* world makes sense? Look, I can't argue logic with you—you're a helluva lot smarter than me. In fact, if a man like *you* were to put his mind to this puzzle, to try and get at the root of this spiritual thing—hell, *anything* could happen!

Bill W. Yeah, yeah, but how d'ya know this is gonna last, or if . . .
[They keep talking, to blackout]

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.

[*Groans in pain*]

Oh, my head!

Ebby. Least you made it into Town’s Hospital, didn’t you?

Bill W. Been here a lotta times before. Great menu—barbiturates, belladonna, and castor oil. Christ, I’m tired, Ebby.

Ebby. I’ll let you rest. I’ll be back tomorrow, Bill.

Bill W. [*Desperately*]

I *want* what you got, Ebby, but I can’t get it! It’s like what happened at the mission never happened at all! Nothing lasts. I try everything, try hard—nothing takes, nothing *works*! It’s hopeless!

Ebby. No, it isn’t. My friend, be grateful things seem so bad. It means they’re getting better.

[*Bill groans; brief pause; tentatively*]

Let’s pray, Bill. Just you and me, right now, together?

[*Bill struggles with it. A pause*]

Bill W. No. Just leave me alone for now.

[Ebby exits. Bill, in despair, mutters, groans, and then sits up, waving a clenched fist angrily]

Dammit, I've had it! I'll do anything, anything at all! If there's a God, show yourself! C'mon, c'mon! If you're really Number 1, let's see it! Right now!

[Stops still, in silence, staring straight ahead. Long pause, pure silence. Bill unclenches fist, opens his palm, stunned; bows head and then looks back up. Pause.]

Silkworth!

[Silkworth enters]

Doc—Something unbelievable happened!

Dr. Silkworth. What was it?

Bill W. I . . . no, never mind. It'd be impossible, I mean, to put into words—it's crazy, anyway.

Dr. Silkworth. Please, Bill, I really want to hear.

Bill W. I was feeling so desperate—but then I got mad! I'd damn well had *enough*! I found myself screaming, challenging this damn universe to stop playing games, and then . . . something happened. The room lit up with a hot white light, and I was seized with a feeling—every joy I'd ever known seemed like nothing in comparison. Then I felt myself standing on the top of a mountain, and a wind blew—not air, no, something else, lighter maybe. It blew strong, clean, right through me—and a thought came: "You are a free man."

[Pause]

But this is mad! You must think I've gone mad!

Dr. Silkworth. No, no, go on! Finish—before it fades!

Bill W. I don't know how long I was in that state, but when I came back to this room, a great peace came over me, and I was aware of a . . . a Presence. And I knew then that no matter how wrong things seemed to be, there could no longer be any question of the ultimate rightness of God's universe. For the first time in my life, I felt I really *belonged*.

[Pause]

Doc, is this . . . is this real? I mean, have I gone insane?

Dr. Silkworth. No! You've had a powerful psychic occurrence. I've read about these things, but I've never had one, or seen one, myself.

Bill W. [Overcome with doubt]

I dunno, doc, it seems pretty crazy. Bill had a hot flash—so what? Big deal.

Dr. Silkworth. See that? The *old* Bill's trying to tear it down already! Listen to me: whatever happened, you're already a different person. Whatever you've got now, hang onto it—it's a lot better than *what had you*, half an hour ago.

[Blackout]

**Scene 14. 1935, May 11. Late Saturday afternoon.
Lobby of the Mayflower Hotel, Akron. Music**

[On one side: entrance to bar, from which comes music, laughter, sounds of happy drinkers.

On other side: propped up on a metal stand, a "Church Directory," listing names of Akron churches.

Downstage center: phone booth.]

Bill W. enters. He is drawn toward the bar, takes a few steps, stops, in agony; walks to church directory, glances at it, turns back to bar; desperate, he searches directory, finds name and number, goes to phone, dials. Rev. Tunks answers.

Bill W. Hello, is this Reverend Walter F. Tunks?

Rev. Tunks. It is.

Bill W. You don't know me—my name's Bill. I'm a stockbroker from New York and I'm standing here in the lobby of the Mayflower Hotel and I . . . well, I need help.

Rev. Tunks. How can I help?

Bill W. Yesterday my business deal fell through, and my partners went back to New York, leaving me to pick up the pieces. It's a colossal disappointment and . . . well, I'm an alcoholic, and I keep being *pulled* like a magnet toward the bar. If I go in there, I'm done for! I don't know anybody in Akron, I've been sober five months, in the Oxford Group—and I'm feeling desperate! I need to talk to another drunk. So I went to the church directory and picked out your name.

Rev. Tunks. You think *I'm* a drunk?

Bill W. No, no, I thought maybe you could give me the number of another drunk—I mean a drunk. I’m not crazy—this is *humiliating*, but believe me, it’s a matter of life or death!

Rev. Tunks. No need, no need to feel—I have my book here—these people may be able to help—got a pencil? Here are their numbers.

[Bill notes them. Music, bar noise drowns out their voices]

How many is that, Bill?

Bill W. Ten. I should be able to find someone—thanks!

Rev. Tunks. By the way—how did you choose to call *me*?

Bill W. Why, I don’t know.

Rev. Tunks. Was it because I’m Episcopal? Are you an Episcopalian?

Bill W. No, why?

Rev. Tunks. Well, I don’t know how you managed to do it, but out of fifty or so names on that list, you picked the one clergyman in Akron who’s active in the Oxford Group.

Bill W. Oh my God! Maybe I’m on the right track after all!

[Bill dials first number: no answer. He dials second number]

Hello, is Alphonso Mork there?

Man’s voice. No. Who’s calling?

Bill W. Never mind.

[He dials third number]

Hello, I'm looking for Jack Mack.

Man's voice. You got him.

Bill W. My name's Bill, I'm an alcoholic from—

[Phone goes dead. Frustrated, Bill tries again and again—noise drowns him out. He gets to tenth name on list]

Norman Shepard? Norman, you don't know me, my name's Bill, I'm from New York, I've been given your number by Reverend Tunks. This is going to sound very strange, Norman, but I'm an alcoholic, on the wagon with the Oxford Group five months, and I'm in danger right now of slipping off, and that would be a disaster!

Man's voice. I'm sure it would, Bill, but how can I help?

Bill W. You, um . . . you're not a . . . um . . . a drunk yourself, are you?

Man's voice. Sorry, no.

Bill W. What I need is another drunk to talk to. Can you put me in touch with someone?

Man's voice. Not now—I'm just catching the Zephyr to New York, myself.

[Bill groans in disappointment]

Did the Reverend Tunks give you other names to call?

Bill W. He gave me ten, and you're the tenth—you're my last chance! Aren't there *any* drunks in Akron?

Man's voice. Wait, a friend of mine's active in the Oxford Group. For years she's had this pet project, trying to help a prominent doctor in town stop drinking—you call Henrietta Sieberling.

Bill W. Sieberling? Wife of Frank? Goodyear Rubber? I've met him—I could never call up his wife—not about *this*—

Man's voice. Not his wife, his daughter-in-law. You call her. She's the one! It's Ulster 5-2265. Good luck.

[Bill agonizes, then dials. Henrietta answers]

Bill W. Henrietta Sieberling?

Henrietta. This is she, yes.

Bill W. My name's Bill, I'm from the Oxford Group, and I'm a rumhound from New York.

Henrietta. [Covering receiver, astonished]

Oh my God!—this is really manna from heaven!

Bill W. Hello? Hello? Don't hang up on me, *please!*

Henrietta. I'm right here, Bill—go on.

Bill W. I been sober five months. I'm about to take that first drink, and the only thing that'll stop me is to talk to another drunk. The Reverend Tunks put me in touch with Norman Shepard, who said you know someone who might fit the bill.

Henrietta. Yes, Bill, you come right out here—I know just the man! Tell the taxi to bring you to Stan Hywet Hall—H-Y-W-E-T—it's Welsh, for "rock is found here." The cabbie will know where it is—it's just around the corner—mere minutes away!

Bill W. Thank God! I'm on my way!

Henrietta. Meanwhile I shall make the call to my friend!

[Bill exits; Henrietta dials]

[Lights up on Dr. Bob's house: Anne and their son Smitty, now age seventeen, sit at kitchen table. Dr. Bob enters, carrying large potted plant, totally drunk. He wobbles under plant, dumps it on table.]

Dr. Bob. Tomorrow's Mother's Day, so 'ere's a potted plant—habby Mother's Day tomorrow, Ab. . . Ab. . . Abercrombie.

[He collapses, rolls under table, stuporous. They stare.]

Anne. All right, Smitty, let's get him upstairs to bed.

[They try. Bob, belligerent, tussles. Phone rings]

Henrietta. Hello, Anne, it's Henrietta.

Anne. Oh, hello, Henrietta. Could you call back a bit later?

[Bob hears the name, thrashes around, cursing]

Henrietta. I'm afraid not. I have a request, Anne. Could you and Bob come over and meet a friend of mine, a sober drinking man named Bill, who might be of help to Bob?

Anne. No, it won't be possible for us to come over tonight.

Henrietta. You *must* come over, Anne—I *know* he'll be helpful. I'd never ask you on such short notice, except that this is an incredible opportunity—like the answer to our prayers!

Anne. The truth is, Bob just came home as drunk as I've ever seen—

Smitty. Tell her he's totally bagged! Tell her that.

Anne. Smitty says Bob's "totally bagged"—unable to walk, and even if he could, there's no way he'd listen to anyone, even if you had Will Rogers himself over there, dying to meet Bob—

Dr. Bob. Will Rogers? Dyin' t'meet *me*? 'Bout time! Sure, why not? Le's go! Lasso tricks—

Henrietta. But this new man has come all the way from New York City—

Anne. Sorry, Henrietta, but it's impossible—

Dr. Bob. Tomorrow—tell Will Rogers we'll come tomorrow.

Anne. Tomorrow—Bob has promised to come over tomorrow.

Henrietta. Yes, do. At five? Smashing. Bye-bye, and God bless.
[Pause. Bill enters, relieved, happy, safe, full of energy.]

Bill W. Henrietta?

Henrietta. Bill. You made it! Welcome.
[Takes his hand]

You're shaking! And white as a sheet—sit down! Are you all right?

Bill W. Maybe. Close call. I've never felt so... like I needed someone, you know? Good to be here, sober.

Henrietta. Yes, and you're safe here. There's no drink in the house, and now that my husband's moved out, no drinkers either. You're perfectly safe now. I'll make some coffee.

Bill W. But this is all so incredible. I didn't realize you live here alone.
[Deeply moved]

What an act of faith, for you to invite me, a total stranger, into your home.

Henrietta. Yes, yes, but there's been a slight hitch—I called my friend, a surgeon in town named Bob—talked to his wife, actually—and, well, to be truthful, he sort of can't come out here tonight because apparently he's, as his son put it, "totally bagged"—something about Mother's Day and a large potted plant. At this very moment his dear wife and son are trying to drag him upstairs to bed! I'm so sorry, Bill—

Bill W. [delighted; excitedly]

Sorry? Don't be sorry—he sounds *perfect*! Henrietta, he sounds like just the man I need!

[Blackout]

**Scene 15. 1935, Sunday, May 12, Mother's Day.
5 p.m. Henrietta's house. Music**

Bill W. and Henrietta sitting, waiting. Dr. Bob, Anne, Smitty at door.

Dr. Bob. [Bad case of "the shakes"; irritated]

It's 5 o'clock. Remember: we're staying only fifteen minutes.

Anne. Darn it, Bob—this is just *it*, for me, for us!

Dr. Bob. Anne, I don't ever remember feeling worse, an' I don' wanna talk to this mug or anybody else—I'm doing you'n Henrietta a big favor—fifteen minutes—at *most* fifteen—you promised me, Anne.

[Enter]

Henrietta. So good of you to come, Bob. Bob, Anne, Smitty—meet Bill.

Dr. Bob. 'Fraid we can only stay about fifteen minutes.

Bill W. Looks to me like you could use a drink.

Dr. Bob. Yeah. How'd you guess.

[Pause]

Henrietta. Yes, well, grand! Now—since time is so short, why don't you men retire to the library, while I make some coffee.

[Bill and Bob to library; Henrietta makes coffee]

Bill W. You're probably wondering what the hell's going on, Henrietta dragging you over here to listen to me.

Dr. Bob. Accent sounds familiar—wouldn't be Vermont, would it?

Bill W. Sure would—East Dorset—it's a small village up near Man—

Dr. Bob. Manchester, I know. I'm St. Johnsbury, myself—quite a coincidence.

Bill W. Maybe, maybe not. That's how things've been going lately, in my life. You see, I'm a drunk, sober five months. Last night I was about to take a drink, so I had to find another drunk to talk to. We got, um, twelve minutes— I'll give y'the *Reader's Digest* version—condensed. Are you game?

Dr. Bob. Fire away.

Bill W. My grandfather and father were drunks, so I vowed never to touch the stuff. In 1918, waiting to go off to war, I was bivouacked in Newport, Rhode Island. The wealthy families insisted on entertaining us. It was the first time I'd been out in society. I was so shy, I could hardly say two words! The dinner table

was a helluva trial! One night I was offered a Bronx cocktail, and despite everything—all the warnings, my training, my fear—I took that first drink, and another, and then . . . it was a miracle! That strange barrier between me and all men and women seemed instantly to go down. I felt like I belonged—I was part of things at last! The magic of those first drinks! I became the life of the party! I fell into a whole series of dates. Of course, that first night I got thoroughly drunk, and after that I did pass out, but I was off to the races! Doc, I went from the highest peak of the financial world right down to the gutter. Flunked out of law school, flew a plane drunk—lies, jail, hiding booze, stealing from my wife—can you imagine?

Dr. Bob. Don't have to—I did it. How old are ya?

Bill W. Thirty-nine.

Dr. Bob. I'm fifty-five—got sixteen years on ya. Keep firin'.

Bill W. I ended up in Town's Hospital. My doctor, William Silkworth, told me that alcoholism is a disease, so I figure that—

Dr. Bob. "Alcohol-*ism*"? A medical disease?

Bill W. Yeah. Silkworth says it may be genetic.

Dr. Bob. Betcha five to one it is! Now why couldn't *I* see that?

Bill W. Most doctors can't. So I figure this is *it*—self-knowledge, right? Didn't work. Now the next piece of the puzzle is spiritual: one afternoon an old pal, a hard drinker named Ebby, shows up—sober—he'd joined the Oxford Group.

Dr. Bob. Amazin'! M'wife 'n I've been goin' to Oxford Group meetings for years! Another coincidence!

-
- Bill W.** Maybe, maybe not. Ebby told me I was powerless over alcohol and had to turn my will and my life over to a power greater than myself. Now I'd gotten pretty cynical about God, so I just played along, going to meetings, still getting loaded. But then one day, back in Town's, I hit bottom, and . . . well . . . *something else* happened to me—but in the interest of time—
- Dr. Bob.** No, no—go on.
- Bill W.** Let's just say I had a kinda "hot flash," and from then on I never doubted the existence of a higher power in my life.
- Dr. Bob.** You had a "conversion" experience?
- Bill W.** You've read William James?
- Dr. Bob.** I've read *everything*. Keep talkin'.
- Bill W.** So then what'd I do? Tried to convert all the drunks in New York! Know how many I got? None! Not *one*! 'Cause something's been missing. Now maybe I'm crazy but maybe not, 'cause what I think's missing is this: what's happening right here, right now—this meeting—*our* meeting, especially in the light of all these so-called "coincidences" leading up to it.
- [*He pauses to let it sink in*]
- In that hotel lobby last night, I *knew*—Doc Silkworth, the Oxford Group, my friends, my wife, my prayers—none of 'em could help me.
- Dr. Bob.** But why not? I've been askin' myself that for years.
- Bill W.** *Because they're not drunks!* They don't know what it's like to wake up, your head bloody and a golf bag in your arms and a woman standing over you who maybe is your wife but maybe not and the veins in your temples pounding on bone and you don't even know what *year* it is, much less where you are or

how you got there! They don't know what it's like, every cell of your body dry as sand, thirsting after the one thing in the world that you *know* will destroy you—and not being able to turn away! *They* don't know—we do, right?

[Dr. Bob *nods*]

Now I don't want to get too far out here, Bob, because we're both men of the world, *rational* men who've witnessed the birth of the great scientific events of this grand and terrible twentieth century—*rational, sensible, practical* men—but I have this funny feeling that we've been brought together for a reason, maybe even a purpose.

[*Pause*]

Y'see, in that hotel lobby, I *knew*: the only thing that could keep me sober was telling my story to another drunk. Matter of fact, the exact words I heard were: "Bill, you need another drunk to talk to, *just as much as he needs you.*"

[*Checks watch, rises*]

Sorry, friend, I went a few minutes over—we'd best get—

Dr. Bob. What's your rush? If it works for you, maybe it'll work for me.

Bill W. Maybe. . . I'm listening.

Dr. Bob. I dunno. . . what you said—with no horse manure thrown in—it's like listenin' to myself. I did all that—an' I mean *all* of it. I flunked outa med school—twice, my father the judge dragged me home to Vermont, I used pills and booze every day. Sometimes in the operating room I was high as a kite—lucky I didn't kill somebody!

[*Pause*]

1918, eh? Prohibition was murder, wasn't it?

Bill W. The worst thing you can do to a drunk is pass a law to try and stop him—he gets *very serious* about it then.

[*They laugh*]

Dr. Bob. Bill, I'm tryin' my best to stop, to find that spirituality, but I can't. I got fed too much God as a kid—I swore off it for good. The lid's on tight. I want to believe, but I can't.

Bill W. Good.

Dr. Bob. Good? How can that be good?

Bill W. This thing seems to really *work* with fellas like us, who want it, but who can't bring ourselves to believe—the damn thing works *in spite of* ourselves. But leave God out of it—I want to hear about you and booze.

Dr. Bob. It's hell. If I don't drink, I'm a monster. I need it to function—to be a doctor, a husband, a father. Without it, I'm so afraid, I can't function at all. Booze is the glue that holds me together, the only thing I can count on in the world.

[*Pause. A leap of faith, a cry for help*]

Can you understand that? Can you, Bill?

Bill W. [*Connecting with him, from his heart*]

My friend, *I have lived* it. Every day, for seventeen years.

Dr. Bob. And now, the goddamn stuff doesn't even work anymore. With or without it, I'm a monster!

Bill W. The *monster* is your disease.

Dr. Bob. [A plea, a challenge]

You really *believe* that, Bill?

Bill W. [With great power]

I *know* it.

[Pause. Dr. Bob is overwhelmed by the sense that here, at last, is another person who understands what he's gone through, from his own experience. Tears come to his eyes; he can't speak. A few seconds of silence]

Dr. Bob. Christ!

[Pause]

I always figgered a drunk was a bum under a bridge—not folks like us. Here I am, a physician, pillar of the community. I got to wishin' I could be that bum under that bridge. But you're sayin' that what I needed all along was to come clean to a hard-core, nose-in-the-gutter drunk?

Bill W. You found him, Bob. Fire away.

Dr. Bob. It all began in 1898, when I first left home for college in New Hampshire. At that time it had a reputation as a "Wilderness college sporting an unaccountable degree of immorality and vice"—otherwise known as Dartmouth. I'll never forget that feeling—finally I was free! Drink soon cured my shyness. I had an enormous capacity for the stuff, and when I was loaded, I sang, and danced, and played the . . .

[Light has intensified into a spot, a golden glow. The two men sit on the edges of their chairs, leaning in toward each other, totally absorbed in talking, listening, and responding, their hands and faces revealing the intensity of their shared energy. The "feel" is of a tremendous sense of peace. Spot out.]

Lights up: Anne and Henrietta sitting; Smitty asleep on couch]

Henrietta. How's the time, Anne?

Anne. It's after eleven—they've been in there *six hours!* Smitty has school tomorrow. Come on, Smitty, get up.

Henrietta. [*Calling*]

Bill? Bob? I'm afraid you'll have to adjourn.

[Lights up: Bill and Bob sit, talking. The light is brighter, crisper. The "feel" is of fresh new energy, unleashed, filling the words and actions of both men]

Dr. Bob. [*Calling*]

Be right down.

[To Bill, excitedly, with real zest]

But *what* is? We alcoholics have had people tryin' to *tell* us what's wrong with us all our lives—just gets our backs up, makes us dig in our heels—y'can't *fix* us, telling us stories.

Bill W. [*Revved up, carried away*]

But telling *our* stories to each other—making a simple, honest statement of who we are and what happened to us, well, that's *real*. It has a ring of truth to it—like when a coin falls on a table, faster and faster, giving off that ringing sound, you know? And when *we're* telling it, some *quality* of that truth makes its way across the gap between one drunk and another—like sound waves or light rays—and maybe, when nobody's looking, it slips in under the ribs and hits the other fella's heart? It's a mystery *how* it works, but it *does work!* Truth does move people—right?

Dr. Bob. You're gettin' kinda complicated about it, Bill. I mean, you're puttin' in a lotta fireworks and miracles and—

Henrietta. [*Calling*]

Bill! Bob! It's very late! Anne needs to go!

Bill W. [*Calling*]

Be right there!

[*In awe of the magnitude of the discovery*]

I can see the shape of the whole thing emerging! All we've got to do is whittle it down! This could be one of the greatest discoveries of the century!

Dr. Bob. Whatever it is, if this treatment works, we got no choice but to take it to others.

Bill W. Together!

[*He pauses, sensing Bob's concern*]

Don't worry, I'll go easy on the fireworks. Hell, maybe the main importance of that hot flash of mine was just to move me along to the next stop—this meeting with you. If there is any miracle, partner, this is it!

Dr. Bob. [*Embarrassed; rising*]

Yeah, well, I dunno about things like that.

[*With a twinkle in his eye*]

Looks like it wasn't God after all! It's just God working through other drunks.

Bill W. We'll save hundreds, thousands, millions!

Dr. Bob. Hey, let's just get one more. C'mon, we gotta face the music.
[Exit; lights down. Pause. Enter living room. Dr. Bob, walking in, seems transformed—no "shakes," no hunched back]

Anne. [Surprised]
Well then, Bob!

Smitty. Mom! Let's go home! I'm tired of waiting for him!

Anne. [Calmly, sensing something has changed]
We all are, Smitty, but I have a feeling we're ready now. When are you going back to New York City, Bill?

Bill W. I'll be staying in Akron awhile.
[Pauses, embarrassed]
Don't know where, though—truth is, I'm broke.

Henrietta. The Portage Country Club's just down the road—perfect for an avid golfer like you—and a strategic location: halfway between my house and Bob's.

Bill W. Sounds about right to me.

Henrietta. Quite a long meeting you two had.

Bill W. Takes a while, Henrietta, to draw up a plan to save ourselves—and while we were at it, the rest of the world too.

Henrietta. Is that what you were up to?

Dr. Bob. So long, Bill, and thanks.

Bill W. Thank *you*. See you tomorrow. I can't wait to start!

Dr. Bob. [Putting his arm around his son]
C'mon, son, let's go home.
[Starts to walk out, stops, turns to Henrietta]
Henri, you'll be pleased to know that . . .
[Pause]
The Divinity came through.

Henrietta. Quite a coincidence, isn't it?

Dr. Bob. Maybe . . . maybe not.
[Pause]
Henrietta, good night.
[They walk out as light fades to blackout]

Editor's note: *Two months have passed. Bob has had a relapse, which Bill has helped him through, using the Town's Hospital treatment (featuring, among other things, tomatoes). Bill and Bob have tried twice to take their "program" to a third alcoholic and have failed: once, comically, with one of Bob's fellow surgeons, and once, almost tragically, with an atheist of good breeding who wound up chasing Bob's wife, Anne, around the house with a butcher knife. They have persisted, however, and in Akron City Hospital they have contacted Billy, a Kentucky lawyer and former deacon of his church who for years has been in and out of hospitals for alcoholism and who has reached a new low. The previous day Bill and Bob asked Billy if he could surrender his will and his life to a power greater than himself. Billy said he doubted that he could, but he agreed to have them return the next day for his answer.*

Scene 22. Next morning, Akron City Hospital

Billy asleep; Bill and Bob enter and awaken him

Dr. Bob. Hey, wake up, Billy. I'm just as tired as you are. Move over.

Billy. Huh? On yeah, sure, sure—

Dr. Bob. No, no, just joking. How'd ya sleep?

Billy. Didn't think I slept a wink, but I guess I did!

Bill W. Well, what's it to be? You want to quit?

Billy. Yeah, I do. I'm sure of it now.

[Pause]

Yeah—for at least five, six, maybe eight months—until I get things straightened up, start to be respected again.

[Bill and Bob laugh]

Hey, what's so funny about that?

Dr. Bob. Whether you quit for five days, five months, or five years, if you start again you'll end up right back here, tied down six ways from Sunday. You've got a disease, and it's progressive. If you go back to it, you pick it up even further down the line.

Billy. How'd I get it?

Dr. Bob. Nobody knows. We all might've been born with it.

Billy. Will y'tell the wife that, too?

Bill W. You bet. Next question: can you quit for twenty-four hours?

Billy. Sure—anybody can quit for twenty-four hours.

Dr. Bob. That's all we're talkin' about—one day at a time. After that, it's up to you.

Billy. That's good. I can do that.

Dr. Bob. For a while you'll need to be on a strict diet. You might not like it much—tomatoes, sauerkraut, Karo corn syrup?

Billy. Won't bother me—I like 'em all.

Dr. Bob. You're a real American, Billy.

Billy. Thanks, but you know, I—

Bill W. At some point we'll ask you to make a moral inventory of yourself, make amends to people you've harmed.

Billy. Yeah, I can do that, too, but I got to tell you—

Bill W. *[Picking up on something new in Billy]*
Bob, we may have something here. Now, Billy, what about asking for help from—

Dr. Bob. Maybe we should stop talking, Bill, and listen a while?

Bill W. Good idea. Go ahead.

Billy. Well, since you already know everything else about me, you may as well know this. Y'see, after you left last night, I couldn't sleep. I kept thinkin' what liquor had done to me and my family, the utter devastation of my life. I saw, then, just what I'd become: scum.

[Pause; with fierce self-loathing]

Scum. Y’know that feeling?

Dr. Bob. [Touched, with a glance at Bill, who is also moved.]

We sure do.

Billy. I’d hit bottom. I’d got ahold of somethin’ I couldn’t handle by myself. I *wanted* to go to my God, ask for help like you said, but truth is, I couldn’t.

[Pause. Bill and Bob look at each other, crestfallen]

Dr. Bob. So that’s it?

Billy. Say, this don’t seem right, lyin’ on this bed. Would you boys mind if I got up, and we all set down together?

Bill W. Of course not, Billy.

[Billy tries to get up but can’t—a pitiful sight. He tries again, almost falls out of bed. Bill and Bob rush to him]

Billy. Christ, I’m weak! Bring on the tomatoes! Boys, I reckon I need some help.

[Bill and Bob help him up. Putting his arms around their shoulders, they try to walk him, but he collapses, and they have to hold him up]

Billy. Damn! My legs are all watery!

Dr. Bob. Ease off—let yourself go limp, Billy—we’ll carry you.

Billy. Ow! Not so fast! You’re jostlin’ my giblets!

[With painful slowness, gently, they carry him to three chairs downstage (same location onstage as in the meeting of Bill and Bob in scene 15— what follows should echo it.)]

Billy sits in middle chair, with Bill and Bob on either side. Light is single spot, on all three]

Billy. Thank y'kindly. So there I was, stuck for the longest time. But then, in my mind's eye, I saw you two, the way you looked, the way you looked at me when you came back into my room last night, remember?

Bill W. [Excitedly]

Sure do, don't we, Bob?

Billy. And, I dunno, but somethin' about the way you two boys were, you know, *together*, really hit me.

Bill W. Right! Go on!

Billy. I'm a country lawyer, made a good livin' bein' able to divine what's up with folk. You two *got* somethin', and it's funny—it's not the one or the other, it's somethin' *between* you. Last night I saw that, and—like when you pass a good card game and want in?—well, *I wanted in*. You'd been through a lot, together—known each other a long time. Am I right?

Dr. Bob. Well, in fact, Billy—

Bill W. Long time—been through a lot, Bob'n me, yes!

Billy. Did I know it? Like you're pioneers, goin' someplace I'd never been, and just by makin' it here into my room sober, you showed me it was *possible*, y'know?

Bill W. [Absolutely amazed at what he's hearing]

Exactly! Hear that, Bob?

Dr. Bob. Keep firin', Billy.

Billy. Yeah! And I—this'll sound corny—but I saw Bill here as a man of the sky, and Doc, well, you was of the earth, and the place you found is where earth and sky meet. And I felt I'd give *anything* to be there with you, and almost in spite of myself I found myself sayin' out loud: "If they can do it, I can do it"—over and over again. And then I felt somethin' break free. Y'know the feelin'?

Bill W. [Thrilled at all this, as is Bob]

Sure do, don't we, Bob?

Dr. Bob. [Showing his excitement for the first time]

Exactly! Then what?

[Light has intensified into a spot, a golden glow, as in the meeting of Bill and Bob, scene 15. The three men sit on the edges of their chairs, leaning in toward each other, totally absorbed in talking, listening, and responding, their hands and faces revealing their excitement. The "feel" is of a tremendous sense of shared "spirit." Light starts a slow fade]

Billy. Well, all at once, I knew I *could*. Things came clear, like a breeze was blowin'—not really in me or outside me, but all around and in between, like on a farm on a summer's day you kin actually *see* the breeze, rufflin' wheat—ever seen that?

Dr. Bob. Beautiful sight!

Billy. Beautiful!

[Pause; amazed]

And now I know that *with your help*, I *can* go to this Higher Power, yes.

Bill W. [Softly]

Bob, this is it.

Dr. Bob. So you *are* willing, with us, to ask for help?

Billy. Yes, friends, I am.

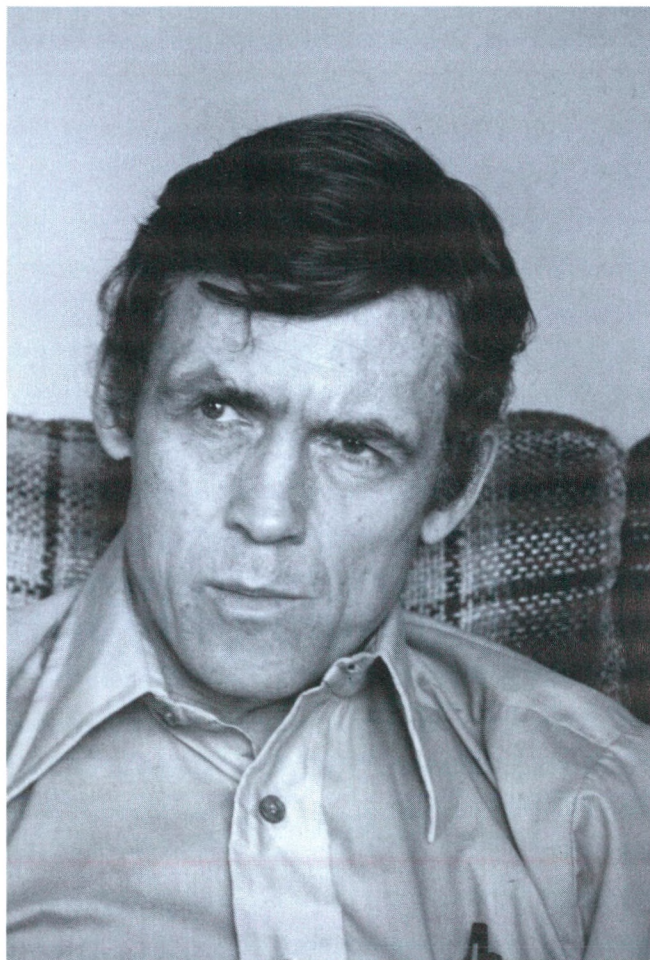
[Light has faded to blackout]

NOTE

1. The Oxford Group: a nondenominational evangelical movement founded by a Lutheran minister named Frank Buchman. Originally known as the First Century Christian Fellowship, it became the Oxford Group in 1928. Members were encouraged to try to live by the principles of Christ's life, to practice four absolutes (honesty, purity, unselfishness, and love), to engage in confession to each other (at meetings held not in churches but in homes), to make amends to those they had harmed, and daily to practice sitting in silent meditation, seeking guidance from God.

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“Among the very poor there is not the same covering over of brokenness. Part of our suburban way of life is the unspoken norm: ‘Don’t let anybody know how much trouble we’re in.’ Well, when you’re in as much trouble as my patients are, there’s no hiding it anymore. So I’m freer to work with my own suffering.”



Facing Brokenness

An Interview with David Hilfiker

Dr. David Hilfiker, for seven years a family practitioner in Grand Marais, Minnesota, first came to public notice when he published “Facing Our Mistakes” in the January 12, 1984, issue of the *New England Journal of Medicine*. In that article he bravely admitted making several medical mistakes, most prominent of which was an unintentional abortion. His virtually unprecedented admissions, first to his colleagues in his profession’s preeminent journal and then to the larger public via *Harper’s* magazine, sparked considerable discussion both within and beyond medicine. The articles were followed by a book that further explored the private burdens of the modern physician: *Healing the Wounds: A Physician Looks at His Work* (Pantheon, 1985).

Hilfiker’s searching of his own experience progressed from early questions about his own competence to more radical doubts about the way modern medicine is practiced, at least in rural settings. The crushing weight of patients’ limitless expectations, along with emergency situations frequently requiring work at the edge of professional expertise, led him to feel caught in an intolerable situation not entirely of his making. In 1983 Hilfiker began working with the poor in Washington D.C.; he later became staff physician at Christ House, a center that provides medical care for homeless men. On May 4, 1989, Dr. Hilfiker discussed his earlier experience and his new medical world with *Second Opinion*. His unusual candor about an intense and ongoing struggle to discern his professional direction reminds us of the powerful but often hidden personal side of modern medicine.

Second Opinion: In 1982 you experienced a personal crisis. Was the “missed abortion” the precipitating factor?

David Hilfiker: It was not a single event. It was that terrible mistake in addition to eight or ten other stressors that I couldn’t explain to nonphysicians because the pressures don’t sound the same to nonphysicians. And I couldn’t share the pain with physicians because in most cases it’s too scary, and they couldn’t listen to me.

Second Opinion: Is there some sort of taboo surrounding physician mistakes?

David Hilfiker: I think so. It’s a taboo we have throughout American life, but most strongly within the profession because of the role physicians have either been placed in, or placed themselves in. The role is, as an extreme, the God-role. But even if you don’t take it to that extreme, the role is “the one who knows.” What we want for our personal physician is somebody who knows what he is doing and is a top-notch expert in whatever field we’ve

got our problem in. Faced with that pressure, it takes enormous courage to say, “I’m not what you want. If you want somebody infallible, you’re going to have to go someplace else, because these are the mistakes I’ve made, and I’m going to continue to make them. You might be the next one.”

I don’t like being on call. I’ll do it because it’s part of the job, but phone calls at 3:00 in the morning are not my idea of the way to spend a nice, happy life. We physicians complain a lot to each other, but we’re not allowed to come out and be honest about what’s the matter.

Second Opinion: When you decided you had to talk, how did you begin?

David Hilfiker: I knew I had to write, but I had no real designs about a book or an article. I just took the year off, deciding not to work, not to do anything. I felt that in order to work it through for myself, I needed to spend a couple hours a day writing down what had happened. I wasn’t sure what had happened to me. I was still under the illusion that my crisis was just my personal weakness, *my* problem,

and I needed to work it through, but it wasn’t going to be of particular interest to other people because their problems were different.

But as I started to write and discovered what the problems were, it became clear that this at least needed to be tested to see if this was true for other people. I sent two chapters to the *New England Journal of Medicine*, and they were published. Especially the article on mistakes, that’s what I am known for.

Second Opinion: Clearly you hit a nerve.

David Hilfiker: I got about 150 letters, all but two basically saying, “Thank you for publishing this.” A number told me their own stories. I had ten or twelve people relate people they’d killed, their own suffering through mistakes and how they’d been burdened, some people actually saying “I’ve been living with this X number of years, I’ve left the practice because of this,” and that the article was important to them. Other people had worked it through and wanted to share with me in hopes that their experiences would be helpful to me.

Second Opinion: So at the individual level you got responses saying, "That rings true, I'm glad somebody's finally talking about it." What about your profession? How did the profession as a whole deal with the problem you put on the table?

David Hilfiker: There were two responses that I think were about equal. One was, "If you don't know what you're doing any better than that, you should not be delivering babies. Anybody would know that you should X, Y, Z." Some people even wrote pleasant letters back, telling me that if I would just do X, Y, and Z, I could prevent this the next time.

Second Opinion: "Be sure to do ultrasound," for example.

David Hilfiker: Yes, or, "I go to this wonderful course up in Maine every year and that prepares me for this." Or, "There is something that you can do to put you in control of the situation again. You haven't done that, but if you just do it, you're a good person, I'm sure you're a good doctor." One of the profession's responses to mistakes is to tighten up

the education process, to make sure that family practitioners don't have access to hospitals or to the critical care unit, to make sure that we're all as highly trained as possible.

So the actual response professionally has been to ignore the article. All sorts of individuals tell me how wonderful it is, but the last time I counted there were three articles in the entire medical literature dealing with mistakes, none of which was written by a physician.

Second Opinion: In the article on mistakes, there are some very powerful sentences about how physicians are cut off from healing because there's no place to talk about this aspect of being a doctor. Six years later, do you see any professional group prepared to confront this need?

David Hilfiker: There may be, but I haven't seen any. There's a lot happening in the medical schools. There are these Balant groups (where medical people are encouraged to share what is really happening inside them). First- and second-year students are terribly interested. So are the people who work with them.

"Primary care doctors need to be able to feel their patients' pain. And the only way to feel a patient's pain is by being willing to face your own."



Almost none of this exists at the residency level. Even where people are interested, they have not done anything to change the structure. I don't know of a residency that will say, "Okay, it doesn't matter what rotation you're on, neurosurgery, cardiology, whatever, you get 8:00 to 10:00 p.m. Friday every week free to come into this."

Second Opinion: Let's clarify your diagnosis. What's wrong with the way we're practicing medicine right now?

David Hilfiker: The question is too broad for me. I'll respond, but I'm very much aware of practicing on the fringes of medicine. An isolated rural GP, that's on the fringes. Now I practice in a situation in which I'm far more isolated than I was in rural Minnesota.

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 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.

Second Opinion: The burden you describe is that people make demands in so many dimensions of life upon you. Why do you think we look to you physicians for so much?

David Hilfiker: I don't know for sure. Part is archetypal. We always look to shamans for magical healing, we always look to priests, the medical priesthood. There's the tendency to look at healing as a divine art, so there's something within people that expects divinity from

our healers. But the profession has also encouraged them. That's not true in other countries. Go to Finland, and the physician does not hold the same place in the society. You tell people here you're a doctor and it's, "Oooh, aaah." [chuckles] You go over to Finland and you say you're a doctor and they say, "Oh, that's nice, what's your wife do?"

Second Opinion: Part of the reason you write, and part of the reason you came here, is to witness to your profession, to call them to something different. How would you like to see the practice of medicine change?

David Hilfiker: We need to bring ourselves more into the process of healing, not just our expertise. We need to be there as real people. Maybe it's helpful to talk about primary care and specialist care. There are technical needs out there. And maybe it's not important that my vascular surgeon really listen to me deeply. He has to be able to understand my symptoms and all that, but I probably don't need for my vascular surgeon to be able to "feel my pain" and to struggle with

me in that way. So when you're talking about technical medicine, the needs are probably different.

But when you're talking about a relationship with a physician who's going to help you make life-and-death decisions and decide whether to go to the vascular surgeon to have an operation which has a 50 percent chance of helping you and a 50 percent chance of making you worse, those primary care doctors need to know how to really be able to feel their patients' pain. And the only way to be able to feel a patient's pain is by being willing to face your own. So those of us who work with people at that level need to get out of our technical selves and be able to share our own pain and move into their pain.

Second Opinion: What is it about Christ House that makes this a better place to you to practice medicine?

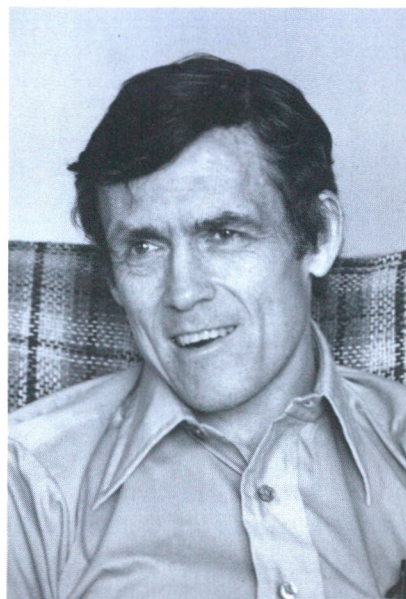
David Hilfiker: There are many different things. On a technical level, I'm having to do about 5 percent of what I used to do in Minnesota. And the 95 percent I don't do is what gave me trouble. I don't deliver babies now. I don't do any ER work.

I don't do any hospital work. I rarely move to the limits of my competence in terms of technical expertise. If I get to that limit, I send the patient someplace else. I'm on call here, but nobody calls, it's telephone calls only. People here are used to going to the ER. When somebody calls who is sick, I send them to the ER.

Second, there's a community of people that I'm now part of. I'm not an individual doing an individual doctor's work. I am part of the larger community, a much larger Church of the Savior community, which has a certain purpose, and I'm part of a smaller community, which is Christ House, that sees itself as working together. So I don't have to make those hard individual decisions by myself. Since I'm not working at the top medical level, I can share—I'm no longer alone making a decision about where to put the next stitch in an appendectomy. I'm working on social problems where the nurse, the director, and others have as much expertise as I do, so we can bounce it back and forth.

And third, and this is just for me personally, to work with people who are so very broken gives me

"One of the true marks of call is that you're having a good time at it, even if other people think it looks like suffering."



permission to work with my brokenness in a way that I didn't experience working with middle-class people. Among the very poor there is not the same covering over of the brokenness. Part of our suburban way of life is the unspoken norm: "Don't let anybody know how much trouble we're in." Well, when you're in as much trouble as my patients are, there's no hiding it anymore. There isn't the same pretense.

So I'm freer to work with my own suffering. And, for instance, when it turns out that I have to say, "No, I can't see you at five o'clock because I'm *finished* for the day. That's my own limitation. I wish I were freer. I wish I could be kinder and more responsive to your needs, but—because of who I am—I'm not able to do that." I have more freedom, an inner freedom to say something like that here because the people I'm working with have shown me how to be broken better than the people I was working with before. And ultimately that might be the biggest difference.

Second Opinion: Aren't you implying that there is something radically wrong with the way modern medi-

cine is practiced? Are you proposing a reshaping of our paradigm of the good physician?

David Hilfiker: Biblical scholar Walter Brueggeman claims that people need to begin to articulate their grief and their despair. Coming in at any level, saying this and this and this are what's wrong with the profession, is not only not very helpful, but in some sense it leads to too simplistic a diagnosis. What I'm encouraging physicians to do is to get in touch with their own pain, despair, and grief. Out of that will come the appropriate local healing. In other words, rather than prescribe on the basis of my own experience, what I'm really doing is inviting people to pay attention to their own experience. What is your pain? Can you dare to share it with your patients? Then out of that perhaps will come the newness. Again, as Brueggeman said, "out of grief," because only out of grief comes newness.

What I'm really saying is that I am not the critic, each individual should be. And you will be the more appropriate critic of yourself if you get in touch with your own pain and

grief. So I invite you to do that. And then not only the diagnosis, but the treatment will probably be more appropriate.

Second Opinion: Are there certain settings in which that is more likely to happen?

David Hilfiker: I'm not sure. I think it could have happened in Minnesota. I lived in a very special community and I think it would have been possible there. Part of my grief is that it didn't.

I think in that community there are a lot of broken people. In lots of small communities, there's a lot of pain. People are willing to share that with doctors. I think I was invited by some people to share it, and I think it could have happened there. Now, whether it can happen in Potomac, or in a rich suburb in Chicago—I've got serious questions about that. In other words, I'm not sure it can happen outside a community and in places where there is no community, where we meet each other as experts. If I want a doctor, I look in the phone book and find the best physician. My physician is my physician, he's not my neighbor. He's not my

son's volleyball coach, he's my physician. It's much, much, much more difficult.

I don't know how you respond to it as a vascular surgeon. But it's certainly not only in this environment that it is possible. I think the issue is community. Maybe it's possible in those places where there really is community, where your practice is small enough that you can know each other on another level.

Second Opinion: You've said that there are a lot of myths about poor people that you've had to dispense with or go beyond. What have you learned here about poverty and poor people?

David Hilfiker: I can't talk about "poor people" in general. I work with only one very small segment of poor people. They're terribly, terribly broken. Most poor people aren't alcoholics. But most of the poor people I work with *are* alcoholics. Among the homeless men, 80 percent are alcoholic.

My images have been shaped by the working experiences I have had. If I were working with Salvadoran refugees, or with Appalachian

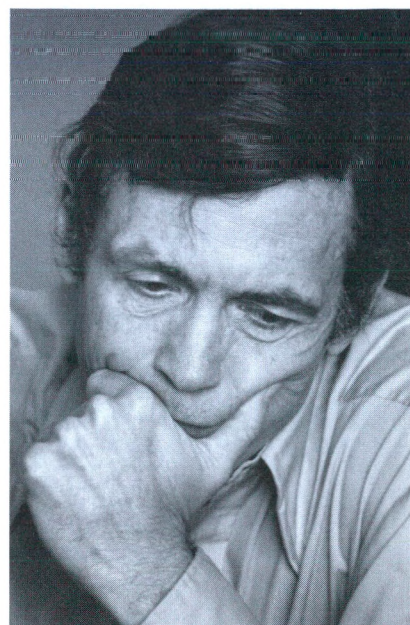
whites, or with working class people who work all the time but just don't have enough money to pull through, I would have very different images.

Second Opinion: What preconceptions about the poor did you have to revise in light of your experience?

David Hilfiker: One is the "liberation theology" preconception, that poor people are really beautiful, integrated people who have been oppressed politically and socially and economically, and if you'd just get the oppressors off their backs they would do just fine. They would have their little base communities and they would restructure society and life would be better. That may be true in rural Latin America—although I keep asking missionaries about that, and they say, "Well, your experience sounds a lot like my experience."

To digress a little, I did talk with an American missionary to Africa who's written about the beautiful poor. And I asked him, "What's wrong with me?" because that's not what I'm seeing. And he said "Well, to be honest, when I go into the

"We are rearing people in the cities for whom there will be no cure."



cities in Africa, I see the same kind of brokenness you see."

The poor who are oppressed and just need to get the oppressors off their backs—those are the rural communities that are stable, that have histories, that have families, where you've got people sitting on them economically, or with an army. And all you need to do for those folks is to get the oppressors off their backs.

But when those folks have been in the city for a generation—even this missionary was saying—we're talking about a whole different thing. So I came to the city with the idea of "Blessed are the poor," you know. And I'm faced with a man who takes \$250 from my receptionist's purse—and he's a *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." God 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.

Then the second big change—and it's related—is to discover the incredible depth of the damage that's been done to people. We have this fantasy in this country, the myth of the meritocracy that Michael Lerner writes about in *Surplus Powerlessness*. There is this fantasy that we all start off on this level playing field, that we are all born equal, that our internal experiences are the same. We have this unarticulated assumption that *my* struggle with, say, self-discipline is about the same as the struggle of a person who has known no consistent parenting, has lived in the streets, has attended schools where he or she has been

ignored. Well, the reality is that what we call "self-discipline" is not as available to this person as to a middle-class, well-educated product of a two-parent family, someone whose parents loved him.

Let me use myself as an example. I am currently in therapy. There is certain damage that has been done to me, and it is taking me years of twice-weekly, one-hour therapy sessions to deal with it. I was loved by my parents. They were limited in certain ways, so they did a certain amount of damage to me, but I was loved, I was cared for, I was given food, I was told I was a good boy. I grew up with what most would consider a wonderful family—and it's still taking me years to get over the damage.

Well, I have a one-and-a-half-year-old patient born to a fourteen-year-old child whose own mother was a heroin addict. So the baby's mother grew up as the daughter of a woman whose prime concern was to get heroin, and who was fourteen or fifteen when she had *her* daughter. That daughter, the one who's a mother now, was conceived either as an absolute accident, absolutely unwanted, or out of the need of the

mother to have somebody take care of *her*. And once she started as a child doing anything that didn't take care of the mother the response was either "b-a-a-a-d child" or being ignored, and that is passed on from mother to child. What kind of damage is done to those people who are not loved as children?

What I am realizing—and I believe this—is, there but for the grace of God go I. I would be the same way if I had been reared that way. I have often told the story about John Turnell, who's still a close friend of mine. His mother's mentally ill. He didn't even know her. She was in the hospital. The times she was home she must have done crazy things to her kid. Father was an alcoholic. The best thing he said to his child was, "You're just like your mother, you're crazy." By the time he was four and five, John was literally going from relative to relative to find a place to stay in this small southern town where he grew up. He discovered alcohol, finally, to get away from this, at ten or eleven. He's been drinking since then. When we talk about what John is capable of, when I say, "Why don't you stop drinking?", we're not talk-

ing about the same internal reality. I don't even know what responsibility means in a context like that. I'm sure it means something, but I couldn't tell you what.

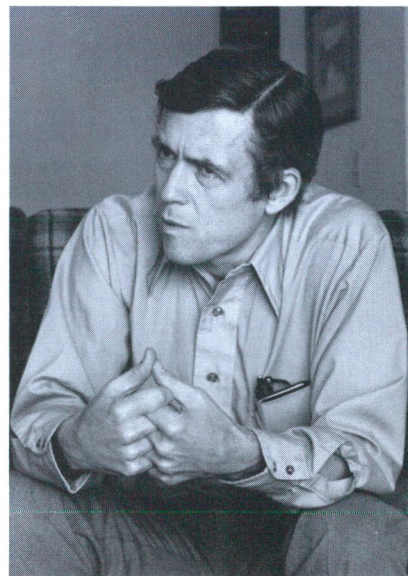
I'm not saying that we should condone the bad behavior, that we shouldn't have prisons or send them to jail or hold them responsible. But I don't know anymore what it *means* to hold this person responsible for shooting another person.

I come away with a sense of awe around these people. And my own sense is that the good things they do are absolute miracles. The healings that occur are just phenomenal.

The heroin addict grandmother I was just talking about has been clean for a year. Did it basically on her own! She'd gone through a number of programs and it didn't work. She kept coming into the office, trying time after time to get clean, and finally she did it. And now she's started to speak up in Narcotics Anonymous meetings and started to help other people. And that is a miracle!

The fact that Mabel can do what she's done is the equivalent in my mind of Jesus doing what he did. I mean, she's gone from nothing to

***"I really do feel like Jeremiah
—seeing very clearly the
coming destruction of our
culture. The judgment's been
rendered."***



being a decent person. Relatively, that's the same movement that Jesus made. And then I start seeing the face of Jesus.

At times I can't stand her. She's not a saint. She comes in late or not at all for her appointments and she's got complaints and she's neurotic. I have to say, "Mabel, go away." So it's not that she's a saint. But what she's done with what she's had, it's just phenomenal.

Second Opinion: What have your encounters with the Mabels and the Johns of this world taught you about the rest of us?

David Hilfiker: Somebody said the value of a society can be discovered in the way it treats the marginal ones. The way we treat the marginal ones is a sign of our attitude toward life.

Well, we treat our poor like they're not people. And there's one part of me that just gets real angry about that. But that's only one part of the story. The other part is the suffering that goes on out there, in suburbia, in "normal" society because of the need people have to deny their own grief and suffering. What we do in

psychological terms is, we project our evil onto black ghetto people. We're not in touch with our darkness. We run away from our grief and despair. We put old people away so we don't have to see them die, we put ghetto people away so we don't have to see them suffer. We create "community" with our therapists so that we don't really have to be responsible to other human beings. I'm not against therapy, but that's not *community*. You know, we're all Willy Loman, living with a kind of incredible suffering that we just will not name. It's too painful. So it's all kept inside.

So a lot of what we complain about—the consumerism, the militarism, the ecological insanity—are symptoms of not knowing where real life is. Those are primary problems—but they are also symptoms. People put the poor in ghettos because they think they've got to keep evil away from themselves. And that's not what you do with evil. You embrace it because it's your own.

We consume as a way of satiating ourselves, as a way of anesthetizing ourselves. But much of the need to consume, much of the need to anes-

thetize myself drops away of its own accord when I embrace my own pain and the pain around me. If I can feel John's or Mabel's suffering, if I can be aware of and not need to deny my own suffering, it turns out that there are a lot more valuable things to do with my money than to buy an extra video or to take a vacation in Spain. Working at a lower salary than I could get on the open market, for instance, becomes not a sacrifice but a joy, because the pain around me, and thus my own pain, is relieved. As I can embrace a community of suffering people, I don't need to anesthetize myself with an escape into trifles.

Second Opinion: You speak a lot about numbness, about both our personal and cultural numbness. Is there something fundamentally wrong with the way we live?

David Hilfiker: 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.

Second Opinion: That doesn't sound like judgment coming. It sounds like judgment's here.

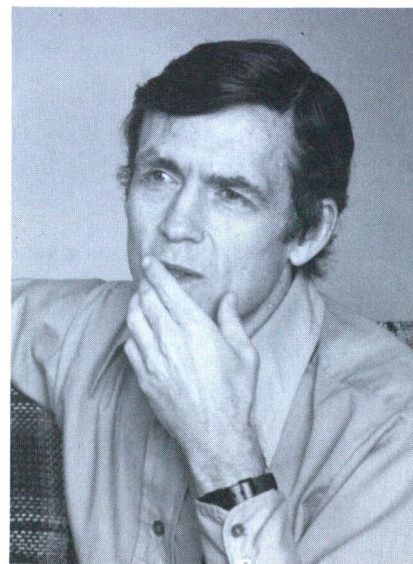
David Hilfiker: Absolutely. All you have to do is look around. We've destroyed large segments of our culture, and we're seeing the first fruits of it. There's no way to reverse that. I think the judgment's been rendered.

Second Opinion: What about the churches? Are they numb, too?

David Hilfiker: By and large, we are not even allowed to talk about brokenness in there. There is a certain kind of spiritual humility which is encouraged, but it's "I was a sinner *last week*. Now I've seen the light." That's encouraged in the church. Not, "I am a sinner now and for the foreseeable future this is what I've got." There may be room for the recovering alcoholic in some churches, but there's no room for the practicing alcoholic. "You're better; now come join us." There's room for the poor person who can come in and be not poor any more, or at least not shake things up. But there's no room in the church for people who are still broken.

Let me give you an example. Our pastor in Minnesota really struggled to help our congregation begin dealing with alcoholism in our church. We were just fine on people who were recovering but not if they were still drinking. There wasn't room for those people. In the church, we're not yet to the level of the AA groups, who can say "I don't have power over this alcohol, it's one day

"There may be room for the recovering alcoholic in some churches, but there's no room for the practicing alcoholic. 'You're better; now come join us.' "



“God 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.”



at a time.” Maybe AA is as close as we get within middle-class society.

As an example, in Minnesota the issue was convincing people that they were alcoholics. That’s generally not the issue in the inner city. We may have a problem getting people to *do* something about it, but I don’t often have to talk people into the diagnosis. People here know, are more willing to look at what their sin is.

Part of the problem with the church is that we look at ourselves and seem to have to condemn ourselves for our sinfulness. There’s no place in the church for accepting our sinfulness, for saying, “Yes, that’s right, that’s who I am.” This is different from the “whatever-I-am-is-okay” school of psychotherapy. What I am is *sinful*, and I’m a child of God anyway, and God loves me anyway.

Second Opinion: You are suggesting that healing is found in the encounter with human suffering. Is it only found here?

David Hilfiker: A middle-class family can go through this same kind of hell in their own encounter with

alcoholism. So it’s not just here among the homeless. But if you want to go to the best place, if you want to structure it into your life, instead of waiting for it to happen, here’s one place.

Second Opinion: Return for a moment to your physician colleagues. What difference would encounter with the poor make for them?

David Hilfiker: I’m not sure how much simple exposure, without the proper kind of interpretation and support, can accomplish. There’s a way in which it can just really turn you off—for instance, when poor people don’t show up for their appointments. You’re a neurologist and you have to schedule people an hour and a half apart. You’ve got your office sitting there, all the staff sitting there, and the person doesn’t show up. And that happens in my practice half the time. The result of such frustrations is that not a lot has happened in terms of your coming to grips with your own brokenness—just a lot of anger.

So my guess is that simply taking poor people into your practice will either turn into a kind of martyrdom

or simply will not last long. I think that taking poor people into practice needs to be done for other reasons—and in tandem with some theological understanding of what’s going on. There has to be some interpretation of the experience.

Second Opinion: *Healing the Wounds* asserts that in the medical profession there is no place to talk about and face certain things, in particular the mistakes and the burdens of rural practice. You’ve also suggested that there doesn’t seem to be a place for sharing certain things in our churches. Now you’re suggesting that it is possible to create a place for this kind of conversation. What have you learned about creating such spaces?

David Hilfiker: The mission has to be sacrificed.

Second Opinion: Would you translate? Fewer patients seen?

David Hilfiker: Fewer patients seen, more money spent. And worrying how to justify that.

Second Opinion: Many of our sophisticated high-gloss hospitals have no rooms that lend themselves to real conversation. And the pressures of patient care make it very difficult to gather high-powered professionals to talk in a serious way about the ethical issues in a case.

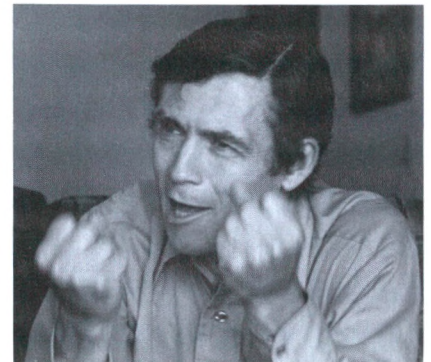
David Hilfiker: Right. They don’t have the time. Or there’s no space. And it’s just as true here. Christ House is going on a retreat next Tuesday with a staff of 40 people—paying them to go on a retreat while hiring others to substitute. That’s only one day a year. We have to fight like mad to get that even here, because it’s “money taken away from the poor.” The patients’ needs are so overwhelming. How do we on the staff justify taking *our* needs as human beings seriously? Even within our structure we have to fight for it. And the mission, at least in the short term, maybe even the long term, suffers because of it. And we have to be willing to do this. In other words, you have decreased productivity, decreased efficiency—which is another way of saying that the workers are as important as the product regardless of the type of work.

Second Opinion: In many ways your work here in Washington seems harder than it was in Minnesota. Clearly people under such pressure can take it for only so long. What keeps a person going, so that even though it’s arduous, burdensome, and frustrating, you’re not done in by it?

David Hilfiker: I’m sure the work does seem harder to you and to some other people than my work in Minnesota. And it might be harder work for someone else. It’s much easier for me. I didn’t do well in the rural practice environment. I do much better here where expectations are different. I am personally more comfortable here, which is a way of talking about my “call”—the notion that we do what we do not because there’s good work that needs to be done but because I as an individual am called by God to be doing this work. My pastor keeps saying that one of the true marks of call is that you’re having a good time at it, even if other people think it looks like suffering.

A person who is following his call is not bound by either the expectations of the immediate people or the

“Working with our darkness, working with our light, doing what we can to create community among people, trying to right injustice. These are the things the Bible talks about as being the Kingdom of God. And it’s not for after we’re dead. It’s right here, and it’s possible, and everybody’s invited.”



needs that are around. They take those things into account and move the way God draws. That process of finding one’s own way is a description of what “call” is. One of the things we need to do is to encourage people to get involved in that process.

Second Opinion: “Call” can sound very self-centered.

David Hilfiker: Yes, it really can. That’s one of the reasons community is so important. Call is always validated by community. You can work by yourself, but it’s got to be validated by other people who say,

“Yes, we agree, that’s what you need to be doing.” In order for my call really to be a call it has to be affirmed by the community.

Second Opinion: What would you say to people who are really moved by your message and your experience, but who aren’t quite ready to make the kind of bold move that you made?

David Hilfiker: Get into a one-to-one relationship with at least one very poor person. I don’t care how you do it. It doesn’t matter whether it’s a helping relationship or what. And have a way to reflect upon it.

That’s a way to start, and then be open to where that leads you.

Second Opinion: When we were talking before about the culture as a whole, the message was dark. As you think about where we are as a people and the kinds of problems we’re up against, do you still have reason to hope?

David Hilfiker: The preconception in our culture is that real life is found in comfort. Even though all the evidence is against it, we have this fantasy that the goal of life is to become comfortable. When we get

uncomfortable we assume that something's wrong.

Christ House is not fun a lot of the time, there are days when none of this makes sense to me, and yet there's incredible hope. This is who

we're supposed to be. This kind of life, working with our darkness, working with our light, doing what we can to create community among people, trying to right injustice. These are the things that the Bible

talks about as being the Kingdom of God. And it's not for after we're dead. It's right here, and it's possible, and everybody's invited. ☸



The Christ of the Breadlines, by P. Eichenberg (1950), hangs in the entryway at Christ House.



Defense Mechanism (1955), by sculptor Paul T. Granlund, sculptor-in-residence, Gustavus Adolphus College, Saint Peter, Minnesota

Victims of Victims

The Unending Chain of Poverty

David Hilfiker

IT WAS THE CHILDREN, I think, who first began to teach me a deeper understanding of the brokenness I saw around me and a deeper compassion for its victims. Initially unable to understand why so many of my patients seemed incapable of taking their medications as directed, of showing up for appointments, of doing the day-to-day tasks that would bring about their recovery, I nevertheless bristled at the suggestion that the poverty I saw around me might be the fault of its victims.

Still, I found it hard to argue. “If they would only. . .” became a daily refrain. I knew that my patients were an oppressed people, but it began to seem that the real problem was the behavior of the victims themselves. Was I becoming racist, too? Did my wealth and

security blind me to something more important? But then I began watching the children and hearing the tales, and a deeper understanding emerged.

Sarah Moseby brings in her two children, six-year-old Derwin and his younger sister, Shawneen. Sarah wants to show me that Derwin is “hyperactive” so I will prescribe some medicine to cure his behavior problems. According to Sarah, Derwin is “bad”: He won’t pay attention in his first-grade class and is probably going to be kept back a year. He goes around assaulting other children, getting into fights. His teacher can’t control him either. The younger sister, Shawneen, however, is “good” and causes “no problems.”

I like Derwin as soon as he comes into the room. His irrepressible energy is evident. He immediately

Dr. Hilfiker is medical director of Community of Hope Health Services in Washington, D.C. He describes his work in the interview beginning on page 92. The above article is part of a manuscript in progress tentatively titled *Not All of Us Are Saints*.

I knew that my patients were an oppressed people, but it began to seem that the real problem was the behavior of the victims themselves.

climbs up on the examining table and begins tugging at the stethoscope hanging around my neck. As I listen to Sarah tell me about his problems, Derwin takes the stethoscope from me and listens first to my chest and then to his own. Sarah grabs the stethoscope in mid-sentence. “Put that down,” she yells. “That belongs to the doctor.” She turns back to me and continues her story.

Derwin sits still on the exam table for perhaps twenty seconds and then crawls off in search of something else to do. As Sarah finishes her story, I lean down and hoist Derwin back onto the table and ask him what he thinks the problem in school is. “I’m bad,” he says matter-of-factly. “I beat the other kids up.” Four-year-old Shawneen sits passively at her mother’s side.

“Why do you beat the kids up?” I ask Derwin.

“Because I’m bad,” he says, reaching for the stethoscope and listening to his chest again. “I can beat them all up.” There is a hint of pride in his otherwise emotionless voice.

“Hyperactivity” is a very specific medical condition of childhood comprising an overabundance of physical movement, the inability to maintain an attention span, and certain evidence of organic brain injury. It is not a common disorder, but most of us parents at one time or another are certain—if only to explain their behavior to ourselves—that our misbehaving children are hyperactive. Such is Sarah’s understandable perception. She and the first-grade teacher are unable to control Derwin’s behavior, he seems unable to sit still in one place,

he is constantly into things, so a diagnosis of hyperactivity seems obvious.

Derwin may be a behavior problem, but my observations and brief examination quickly confirm that he is not hyperactive. I tell Sarah there will be no magic medicines for her child.

“Well, what can you do for him then?” she asks.

I don’t know. I do suspect that Derwin isn’t the real problem. Sarah has been my patient for about a year, and I am aware of the chaos in her own life. I believe that her boyfriend beats her regularly, although she refers to it only obliquely and denies it when I ask directly. Sarah is a very dependent, passive person with little sense for her own powers and responsibilities. As I have tried to respond to her own medical problems, I have noticed that the disorder of her life has left her unable to follow even the simplest medical instructions without intensive outside support from social workers, nurses, counselors, and others.

Derwin’s father had abused Sarah until she left him. She is still in relationship with Shawneen’s father. Sarah has lost her apartment and was in the city shelter for homeless families before she came to Community of Hope, where our transitional housing program has offered her temporary respite and help. Sarah is undoubtedly so overwhelmed by the chaos of her own life that she is unable to provide the consistent support that both Derwin and Shawneen need.

I suspect that Derwin is mostly the scapegoat for a very difficult situation. He becomes “the problem”

within a family system that cannot cope. Hoping to find some help for Sarah someplace, I refer the family to a psychologist for testing.

The psychologist agrees with my assessment and adds more. 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?

Child psychologist Alice Miller (1981:79) writes that all children have a time early in their lives during which they need to experience the parent as completely devoted to their welfare. During this “narcissistic phase” the child needs to know the world as an extension of himself. When a child is born into a world where either parent or, too frequently among the very poor, the single mother does not have the time, energy, or emotional maturity to allow this narcissistic phase of childhood, then the child almost invariably spends the rest of his life arrested in that stage, looking for that completely devoted parent figure. And when the child herself becomes a parent and there is finally a person (this time a newborn baby) who can fulfill the teenage mother’s needs for love and attention, that new baby is deprived of its own narcissistic phase, as it must learn to attend to the needs of the parent. The vicious circle is established.

Who is going to help Sarah, Shawneen, and Derwin become a functioning family? Who will break the circle? The family shelters in the District of Columbia don’t have enough social workers even to enroll the families in the appropriate entitlement programs, much less to begin the intensive process of helping people make sense of their lives or come to terms with the emotional trauma of homelessness. There is little continuing

The very young children can still hold onto their dreams, still see themselves as potential police, firefighters, doctors, and teachers. The older ones have learned better. They know their future.

health care. Certainly there is no one who will really address the deeper problems in Sarah's life.

The school Derwin has been attending since September is crowded with children who have much worse problems than he. Half of the kids in the school are refugees from Central America and speak Spanish as their primary language. The vast majority of the rest of the children come from single-parent, impoverished homes like Derwin's. When our social workers visit the school, they find the teachers and staff so overwhelmed by combat conditions that even the best teachers can do little more than punish unruly behavior and try to make it through the day. Certainly Derwin has little chance of finding the long-term, sympathetic counseling and support he needs. Whom will we blame when he becomes a juvenile delinquent?

Mary Curran, a pastor and social worker at Community of Hope who works with the Families in Transition (FIT) program, tells of watching children's make-believe games on the front steps of the building. Up until the age of six or so, the kids play at being police, firefighters, doctors, teachers—all the usual roles children choose. But Mary notices that about the age of six, things begin to change. In their games the children now begin to play dope addict, dope seller, and undercover agent. They play drunk, play out fights between man and woman, parent and child. It is as if the very young children can still hold onto their dreams, still see themselves as potential police, firefighters, doctors, and teachers. The older ones have already learned better.

They know their future. They have begun to see the real options available to them. Hope has already been crushed.

But damage lies sometimes even deeper.

Jenny was three years old when she was first brought in to see our pediatrician because of a discharge from the vagina. Routine cultures determined that Jenny had gonorrhea. Testing of other family members revealed that Jenny's father also had gonorrhea. He vehemently denied there was any connection. The pediatrician immediately reported her findings to the local authorities, but no charges were brought and no legal determination of what had happened was entered into the record. Jenny was placed with her alcoholic mother, who was separated from Jenny's father. Within months, however, she was back again with her father.

Twice over the next three years different caregivers again brought her in with vaginal discharges (a very uncommon complaint in prepubertal girls), but at these visits we were unable to culture out the specific germ responsible. (Cultures for these organisms are not completely reliable; there are, unfortunately, frequent "false negatives.") Each time we suspected sexual abuse and reported our findings to the responsible authorities. Each time we were told that without documentation (such as culture-proven venereal disease) there was little the authorities could do.

When Jenny was six, she was brought to the clinic with a burn on the inside of her thigh close to the groin. Her stepmother, also an alcoholic, reported that “Jenny pulled an iron down on herself.” Examining the burn, the nurse practitioner who works with me discovered an exactly symmetric, evenly burnt triangular area about three inches across, quite consistent with a burn from the tip of an iron. We did not believe, however, that such an evenly shaped burn high up on the inside of the thigh could have been caused by an iron falling randomly on a moving target; it seemed much more likely to have been intentional.

We reported the situation to the proper authorities, this time to a department dealing with the physical abuse of children. The team was reluctant to visit, since they felt they could not disprove her stepmother’s story, but at our insistence they examined Jenny in the clinic and interviewed her father and step-mother. They told us, however, they couldn’t do anything more. Without further evidence they couldn’t prove that the step-mother’s story was not accurate. Since this was the first time the child had been reported, all they could do was make a notation in their files. We emphasized to them that we had reported the family at least three times previously for sexual abuse, one episode fully documented. Their response was that sexual abuse was not their area. Without previous reports of *physical* abuse, they could do nothing.

Jenny still lives with her father and stepmother, both active alcoholics.

Others in our inner-city neighborhood—born to teenage single mothers, exposed to alcohol and drugs both in utero and at an early age, lacking any opportunity for education, without adequate role models, abused, abandoned, and without reason for hope—rarely escape from the despair and degradation of poverty, alcohol, and drugs. If they have hope, as some do, it is against all the data. Even if our society someday decides it is going to spend the resources needed to help them, the chances of healing the brokenness will be small. And our society is currently limiting its efforts to heal the wounds.

The brokenness we find is often so deep, it seems futile to attempt to apportion blame. Diane Baxter and her two girls were residents at the Pitts Hotel, the city shelter for homeless families just up the street from Community of Hope. Because of a lapse in medical care provided by the city at the shelter, Diane came frequently with her children to the clinic in order to catch up on much needed health care. She seemed to have some serious psychosomatic health problems herself (not unusual for parents under the stress of homelessness), so she came in often. Soon she was coming in almost every day, sometimes to be seen by one of the medical team, sometimes just to sit in the waiting room and chat with staff or other patients. She told anyone and everyone how difficult it was to take care of her older

These children believe at an early age the lie that America is a meritocracy.

daughter, Maureen, three years old, especially since her younger daughter by herself seemed to strain Diane's caretaking resources.

And, at the beginning, we in the clinic noticed how Maureen *was* all over the place, playing with toys, interrupting our conversations for attention, grabbing things from her younger sister. Her mother's response varied between two opposite extremes. Most of the time Diane seemed to pay almost no attention to her, as if she were someone else's child tearing up the place. But when she did discipline her, Diane yelled at her as if she were an adult intentionally disrupting her peace and quiet. Other times she just gave her a punch to the body or to the head. She seemed to have little understanding of how three-year-old children normally act and treated every disruption as willful and premeditated.

While caring for the family, we noticed that Maureen never went voluntarily to her mother: for help, for consolation, or—as far as we could tell—for anything. One weekend Diane asked Teresa, one of the young mothers staying in the Community of Hope building as part of the FIT program, to babysit for Maureen while Diane was away. Teresa found it exhausting because of the child's high level of activity, but with the proper attention to her, she became quite fond of Maureen, as had many of us at the clinic.

After the weekend, Teresa brought her to our waiting room so that Diane could pick her up. When Maureen saw her mother coming, she ran and hid behind Teresa, refusing to let go of her clothes, holding

on for dear life. Ultimately we had to distract Maureen with a toy so that Teresa could sneak out of the waiting room. When she noticed she was gone, Maureen was almost beside herself with rage.

As we talked about the issue in a staff meeting, the receptionists mentioned that Diane would frequently come into the waiting room and ask someone to hold the younger baby or to watch Maureen "just for a minute." She would then disappear for several hours while the staff tried to entertain the children. On a number of occasions—without asking anyone to take responsibility—she had just left both Maureen and her one-year-old sister in the waiting room and gone.

There had been reports that Diane's physical punishment of Maureen was excessive. Various members of the staff noticed Diane punching Maureen with her fist, often about the head, for some real or imagined misbehavior. Her verbal threats were almost worse: "If you don't stop that, I'm going to break your arm!" When Maureen would cry, Diane would yell at her, "Why are you crying? Nothin' happened to you," refusing to acknowledge that she had even struck Maureen. Diane would then look at us in exasperation, "She's always like this, cryin' for no reason." When we confronted her about her abuse, Diane would refuse to talk about it and then stalk out of the clinic.

We did call Protective Services. The worker there asked whether there were any bruises or broken bones, any physical proof that Maureen had been abused. When we said there were none, the worker repeated the

familiar refrain: there was nothing they could do without proof. We reminded the worker that several people in the clinic had seen Diane hitting Maureen about the head with her fists, but we were told that they would still need proof in order to take any action.

My first responses to Jenny's sexual abuse and to Maureen's physical abuse were anger and rage. How could parents do such things to children? But once again the children themselves were to teach me a deeper understanding. This time it was the thirteen- and fourteen-year-old girls whom I had watched growing up under conditions of abuse very similar to Jenny's and Maureen's.

Margine was a youngster we had known for many years. Her mother was a severe alcoholic who had left the state without Margine several years earlier, so Margine was moved from one relative to the next, living in constant chaos. She had become sexually active by the time she was twelve, and all our attempts to provide her with either counseling or birth control were futile. She even hinted from time to time that she wouldn't mind having a child, so she could have someone who loved her, so she could be important in the community, so that people would pay attention to her, too. Her wish was not long in fulfillment, and I was soon watching fourteen-year-old Margine berating her one-year-old son for not sitting still for my ear exam, spanking him

for "messin' those toys up," and neglecting to bring him in for crucial medical attention.

But who could I be angry at now? Was fourteen-year-old Margine to blame, herself the product of an environment so chaotic I could hardly imagine it? Or was it her mother, pitifully addicted to alcohol during Margine's entire childhood? Sure, Jenny's father was responsible for his behavior and society could expect him to behave differently, but did I know what *his* history was? Could I be sure that I would act differently under such circumstances? Certainly Diane Baxter had to be held accountable for the way she was rearing Maureen, but could I blame her for treating her daughter in the same way she herself had probably been treated? I could hardly expect anything better from Margine: I knew her history, and I knew a fourteen-year-old would have trouble being a parent under the best of circumstances. Life in our neighborhood was very much a Shakespearean tragedy: everyone caught in an ugly web for which no one was really to blame.

What is it like to grow up the child of such abuse? What is it like to suspect almost from birth that you are really not loved? What is it like to grow up in a neighborhood where so many of the male role models are alcoholics and drug addicts, where so many of the female role models are pregnant by the time they are fifteen? What is it like to grow up in a neighborhood where those who struggle against all odds and manage to stay off welfare and maintain honest jobs are consigned to a lifetime of working two jobs at minimal

Understanding that at the deepest level their poverty is not the fault of the victims is changing me internally.

wages just to eke out a subsistence living, where “success” is the flashy car and designer clothes of the drug sellers, where there is otherwise little hope for a future any different from the intolerable present? What is it like to grow up where few kids graduate from high school, where the expectation of a persistent, degrading poverty pervades?

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 (1988), 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.

And as I begin to understand what has happened to these children, the answer to the question of who is

responsible for it all becomes murky. Responsibility seems to fade into generations of ancestors, into distant days of segregation and then into slavery. It seems to diffuse into the cultural landscape, into the ways our society compounds the problems of people who—for one reason or another—simply can’t make it. It becomes apparent that the notion of individual blame is not going to be useful in understanding or responding to what I see daily. To the extent that we are part of society, all of us share responsibility for what is happening to the poor of our society. And that seems to demand some kind of response from me.

Understanding that at the deepest level their poverty is not the fault of the victims is changing me internally. I find myself identifying more and more with the needs of my patients. I read the morning paper from the point of view of a homeless man: What does this federal budget cut mean for him? How does such-and-such extravagance look from the point of view of those who have nothing? I have not become poor in any real sense, but I begin to feel more and more that these are “my people.”

My gradual identification with them creates its own problems. Immense feelings of frustration remain and are intensified. I find myself often angry at my patients, impatient with the parents, disliking some of the people I am to care for. I find myself crossing the street or slipping out a side door to avoid them. I find myself exhausted at the end of even four hours of patient care, exhausted by the tragedy of these lives, yet unable to feel

OK about limiting the time and energy I invest in my work. If these are actually oppressed people, on whom am I to vent my frustrations when their brokenness makes me angry? If my patients are so broken, how can I justify my own withdrawal after just a few hours with them? How can I justify my own wealth, my own comfort in the face of their suffering?

My hope in coming to Washington was that if I opened myself to the pain of the poor and did what I could to be in solidarity with them, then the alienation, the cynicism, the tension of being among the wealthy

which I had experienced earlier would be relieved. I would rest more easily, I would feel more integrated, less selfish. But it seems not to be happening.

The closer I get to the pain of the poor, the more I become aware of my limitations and of the privileged position which allows me to withdraw when it feels necessary. Now that I have felt their pain I am no longer numb. But now some of their pain is my own, and my own needs for money, comfort, private time, free space seem less and less justifiable in the face of their misery. ☸

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Sixth in a series

On James F. Childress

*Answering
Every Person*



B. J. St. blente, University of Virginia

*“Pluralism goes hand-in-hand with procedural morality.
When the gods are silent, or their voices are ambiguous,
procedures are necessary.”*

—Who Should Decide? Paternalism in Health Care, p. 119

Courtney S. Campbell

MANY THEOLOGIANs IN THE FIELD of medical ethics believe that their primary vocational responsibility is to be faithful to a theological tradition and responsive to particular religious communities. This requires that the religious dimensions and theological perspectives on ethical issues be articulated explicitly and forcefully. Not to do so is to risk forfeiting theological integrity and even professional credibility.¹

The medical ethics of James F. Childress makes it clear that the boundaries of the community of ethical responsibility should not be drawn too narrowly. The prominent theological theme in Quaker thought (Childress's tradition) of “answering that of God in every person” carries a universalistic impulse, requiring the ethicist to take account of and be accountable to non-

theologically informed positions. The responsibility to answer to a community constituted by “every person” may entail a less explicit, background role for theological convictions in moral discourse. As in Childress's case, there may be *theological* reasons for not doing medical ethics theologically.

For Childress the metaphor of “answering” nevertheless clarifies the role of justification in ethics, the relation of God to the world, and the nature of moral agency. In this article, I will bring such theological considerations into the foreground, indicate their relevance, and draw out their implications for Childress's ethical method. We will then examine how this method works in four topics in medical ethics in which Childress has been a prominent figure: paternalism, the

forgoing of medical nutrition and hydration for terminally ill patients, the rationing of scarce lifesaving medical resources, and policies for organ procurement.

I. Answering: Moral Responsibility and Justification

A major theme in recent theological and philosophical ethics is responsibility.² The key questions for such an ethic are responsibility *to whom* and *for what*. In his work in both medical and social ethics, Childress uses the concept of “moral justification” to develop the idea of responsibility. Justification, an integral part of any account of responsibility, involves “the appeal to moral principles, rules, and values to defeat charges of moral liability” (1983a:276, 278; 1982b). Indeed, part of what it means to be a moral agent is to assume responsibility to others for justifying one’s actions. The claims of conscience, other persons, and God are answered by giving reasons to validate conduct.

Childress’s interpretation of moral justification is both shaped by and critiques theological perspectives. In particular, the metaphor of “answering,” articulated in the ethics of seventeenth-century Quaker thinker, George Fox, is a principal theological source of Childress’s account. Fox’s idea of “answering that of God in every person” emphasizes responsiveness to the directions of the Spirit. This view may seem initially at odds with a stress on justification of one’s action *to others*.

However, Childress contends that the Quaker understanding is much more complex than a simple recommendation of theological intuitionism: The content of “that of God” includes norms such as the unity of mankind, natural affections, the primitive order, humanity, and ordering to the glory of God (1974:2–41). For Fox, these provide standards to which every person must answer; “answering” is thus compatible with moral reasoning.

Childress incorporates and modifies Fox’s account with nontheological sources such as legal models of answering to suggest several elements of a concept of moral justification. First, answering, as a response that evokes a response from the other, conveys continuity and dialogue in moral discourse. Second, the evoked response will confirm or invalidate one’s answer depending on the appropriateness of the reasons advanced (1974:13, 30). Finally, “answering. . . every person” implies that the process of moral justification is universal, embracing both its participants and its audience. In this respect moral justification reflects a fundamental claim about our common humanity and expresses part of what it means to be *social* beings (1971:167).

This interpretation of moral justification is developed *against* other theological perspectives, in particular the traditional Protestant suspicion of the language of “moral justification.” Protestants claim that God justifies human beings, that is, accepts them as righteous, even though they are not righteous. Hence justification

as an activity that *we* engage in may be viewed as encroaching on the sovereignty and freedom of God. For moral justification could be construed as a form of “works-righteousness,” in which the decisive criterion of the “righteousness” of a moral agent is the conformity of his or her conduct to prescribed rules and requirements. The freedom of the believer to act with creativity and imagination under the command of God seems infringed when “standards and consequences” are imposed by us for moral judgment (1971:165, 166; 1983a:278). A model of ethics that gives primacy to moral justification, then, may risk “legalism,” in which adherence to rules and laws is the center of the moral life.

However, recognizing analogies with law in the moral life, Childress argues, does not necessarily lead to legalism. Nor is he convinced that theological suspicion of moral justification is entirely substantiated. There may be continuity between moral and religious justification, and the importance of moral justification “does not eliminate the need for God’s grace or limit God’s freedom” (1983a:278; 1986e:332–33).

If moral justification means that we answer to others for our actions relative to certain standards, the question becomes, What might these standards be? Childress’s ethical method identifies five major principles comprising an “embedded common morality” (1989a:88), which may be defended and accepted on several grounds, theological or nontheological.³

1. The principle of *nonmaleficence* prohibits the infliction of harm, injury, or death upon others. This princi-

ple is closely associated with the maxim *primum non nocere* (above all, or at least, do no harm) in the Hippocratic medical tradition. Nonmaleficence is a necessary, even if minimal, component of *agape* or love of neighbor, and overlaps with the concept of “sanctity of life.” However, Childress also contends that nonmaleficence is a “bedrock of social morality” and “human interaction.” Its status therefore does not depend on theological premises (1986g:425).

2. This principle must be supplemented, however, since we are also positively engaged in seeking to promote the welfare of others. The principle of *beneficence* includes actions that prevent and remove harm from others as well as doing good toward them. In the Hippocratic tradition, the principle of “patient benefit” reflects beneficence. Indeed, it is the fundamental rationale for medical care.

Beneficence also overlaps with *agape*, but does not exhaust its meaning. For example, many philosophical positions maintain that a duty to assist is morally mandatory only when such actions carry minimal inconvenience or risk to the agent, whereas *agape* is usually understood to involve some sacrifice of the agent’s interests. For Childress, *agape* may require more but certainly never less than beneficence (1982c:34–37).

3. Since it is not always possible to avoid inflicting harm while doing good, we frequently must balance the benefits and harm of an action. The principle of *utility*, Childress holds, requires us to seek the action that will produce the greatest benefit over harm. While the most

*"The ethicist is compelled by
Scripture to be a 'trouble-maker'
as well as a 'trouble-shooter.'
Thus, the ethicist has a
responsibility within the
Christian community to direct
attention to principles and rules
that constitute obligations
that may otherwise be
overlooked or neglected."*

*—"Scripture and Christian Ethics,"
pp. 285—86*

philosophically refined defenses of this principle are found in utilitarian moral theories, Childress believes that its moral meaning can be expressed theologically in the principle of proportionality, or proportionate good (1986k:512).

The principles of nonmaleficence, beneficence, and utility are oriented by a moral concern for acting in ways that achieve the optimal consequences, ends, or results. Their moral validity can be defended on professional or philosophical grounds, and can also be rooted theologically in *agape*.

4 and 5. Two other fundamental principles, *justice* and *respect for persons*, by contrast, place moral constraints on the means used to achieve desired results and have independent standing; in certain circumstances they can conflict with *agape*. On this latter point, Childress disagrees with the late Protestant ethicist Paul Ramsey, who maintained that justice (as well as all other moral norms) is a second-order principle that derives from love.⁴

While the principle of utility has to do with the aggregate balance of benefits and burdens, justice concerns how these are distributed among various social groups and individuals. Justice requires fairness in allocating benefits and burdens. If a proposed policy appears to have enormous aggregate benefits, but would impose a disproportionate share of burdens on identifiable groups or individuals, it violates justice.

The fundamental meaning Childress ascribes to the principle of respect for persons follows the German

philosopher Immanuel Kant's second formulation of his categorical imperative: "Act so that you treat humanity, whether in your own person or in that of another, always as an end and never as a means only" (Kant 1969:54; Childress 1987a:28). This principle also draws on theological and philosophical traditions of reflection on respect for conscience (1979a:315–35; Beauchamp and Childress 1983:268–76). The moral requirement to respect the wishes, choices, and actions of other persons may, in Childress's view, conflict with *agape* and the obligations of health professionals to benefit their patients.

Childress illustrates this conflict in contemporary medical ethics using the parable of the good Samaritan, the scriptural narrative often considered the paradigm case of neighbor-love (Luke 10:30–37). If, when the Samaritan came upon the wounded traveler, the injured person had indicated a desire to die and had refused assistance, what should the Samaritan have done? By analogy, how should medical professionals respond when patients choose to forgo medical treatment? Even though love might require the kinds of actions related in the parable, respect might entail accepting the person's request (Childress 1985:225–26).

While respect for persons is independent of *agape*, it does not always "win" in cases of conflict, nor is it "the single, exclusive or overriding principle of biomedical ethics" (1984a:31). Childress argues that while love without respect is demeaning, absolute priority of respect for persons over beneficence or *agape* risks apathy

and indifference. We are obliged to seek a proper balance between care and concern and respect to avoid the alternative "temptations" of indignity and indifference (1982c:ix; 1986j:451).

These principles and derivative rules such as confidentiality, veracity, and fidelity command widespread acceptance. How do such norms function in moral justification? Childress rejects three alternatives that have been influential in Christian theological ethics: (1) one principle (for example, love) is superordinate and absolute; (2) several principles are arranged in order of priority; (3) moral principles illuminate but do not prescribe; they are maxims without normative force. Childress instead advocates a pluralist method: each principle is obligatory, but none possesses a pre-assigned priority. In a concrete case of moral conflict any principle can be overridden by competing principles (1986h:425–27).⁵

How, then, in a case of conflict, can a person decide which principle "wins"? In part, Childress's response would invoke "a logic of prima facie duties": When fundamental principles conflict, moral reasoning must satisfy a series of conditions about authorization, cause, alternatives, due proportion, and expectations to justify setting aside one moral duty in favor of another. Even so, the overridden principle retains its moral significance by setting limits on how much it can be infringed.⁶ In addition, "the practical application of principles and rules," Childress asserts, "is not mechanical since it presupposes discernment and prudence"

(1986h:427; 1989b:41). However, he has not developed a concept of practical reasoning that shows how to distinguish adequately between discernment or prudence and arbitrary intuitions or personal preferences.

This suggests a significant limitation to the pluralistic approach. Childress's rationale for adopting this method, along with the procedural moral logic that reduces but does not eliminate its intuitional elements, requires that we attend to its theological and anthropological underpinnings.

II. That of God: Theology and Ethics

Childress concurs with neoorthodox theologian H. Richard Niebuhr that a determination of "what is going on" in a situation of moral conflict can be and often is shaped by theological convictions about the doctrine of God (1981:102-4). Interpretation of a situation may then be expressed theologically in the question, "What is God doing?" (H. R. Niebuhr 1942:630; 1963:60-65, 126).

For Childress, the metaphor of "answering" structures our understanding of what God is doing in the world and how we are to respond. In our capacity to "answer" to claims upon us, we are responsive to "that of God in every person." What is God doing to which we as moral selves are accountable? In his social ethics, Childress has followed Paul Ramsey (and thus H. Richard Niebuhr) in contending that an adequate Christian ethics requires the "whole idea" of God. That is, divine purposive activity can and theologically must be

understood in terms of creating, ordering (including both sustaining and restraining), and redeeming. While these purposes are finally inseparable, they and human responses to them can be differentiated (1971:101, 102). Theological ethics is challenged not only to affirm all three aspects of divine purpose, but to balance them.

This approach to the doctrine of God, Childress claims, supports a pluralist model for ethical reflection. "[A] pluralist approach is most consistent with an adequate, balanced understanding of God's creative, ruling, and redeeming will" (1971:103). His claim has two implications that need particular emphasis. First, the plurality of the divine nature correlates with an ethical method that draws on a multiplicity of moral principles. Second, the absence of any interpretive priority in the doctrine of God informs Childress's position on the status and weight of ethical principles. In a theologically qualified pluralism, "no single principle or value receives exclusive attention" (1971:103, 104).

This relation of theological affirmation and ethical method is one of correlation rather than derivation. Theological convictions do not, in Childress's view, constitute obligations, that is, they do not furnish the premises from which moral conclusions are then derived, nor is faith a necessary condition of morality. The significance of theology for ethics is that it can provide an interpretive framework or perspective that enhances recognition of relevant moral obligations (1981:102-4; 1983a:279, 285-86), obligations that may already be accepted by nonbelievers on nontheological grounds. For

example, an understanding of God's impartial loving care for human beings can illuminate the moral priority of equality in the allocation of resources.

There are also important limits to this theological-ethical correlativity. The ultimate inseparability of the triune divine nature has no analogical counterpart at the level of Childress's practical ethics. Unlike Ramsey, for example, Childress does not hold that all moral principles can be derived from one supreme principle, such as love. Because the fundamental principles of Childress's ethics are independent rather than derivative, they come into conflict. Childress's ethical method therefore at least theoretically accommodates genuine moral dilemmas and moral tragedy, irresolvable conflicts of moral obligations, which could not be the case were it derived logically or analogically from theological convictions.

III. In Every Person: Anthropology and Ethics

God's activity, expressed theologically as creating, ordering, and redeeming, according to Childress, may also be expressed in correlative anthropological terms. Human beings may be understood as created, fallen, and redeemed. A coherent ethics must account for these dimensions of human nature and attempt to hold them in balance and tension. Two themes with deep roots in theological ethics, the *imago dei* (image of God)

"[A] pluralist approach is most consistent with an adequate, balanced interpretation of God's creative, ruling and redeeming will. ... No single principle or value receives exclusive attention."

—Civil Disobedience and Political
Obligation, pp. 103–4

and sin, have important implications for Childress's ethical method.

That human beings are part of nature, Childress contends, is reflected in their earthly creatureliness and in their status as created beings. But human beings are also a unique part of nature, as illumined in Scripture, created in the image of God (1981:103, 104). For Childress (following Reinhold Niebuhr), *imago dei* means in part that human beings possess the capacity for self-transcendence, that we can consider more than a narrow pursuit of our own self-interest (1986c:292-93). This capacity is a necessary condition for moral discourse. If persons as moral agents are to answer to each other, they must recognize and respect the interests and ends of others.

The *imago dei* also means that human beings have "dominion over nature," understood as "stewardship, trusteeship, or administration" (1986d:18, 27). Yet however elevated human beings may be relative to the rest of creation, we still remain only an image of the divine nature. Our created status implies ontological limits to our powers and capacities. These are experienced frequently in our limited capabilities to predict, control, and assess our actions (in contrast to divine omniscience, omnipotence, and infallibility). Finitude and moral fallibility are as much a part of the human condition as self-transcendence (1981:118; 1982b:57-61).

Human sinfulness imposes additional limits of moral significance; we exhibit a notorious tendency for self-interestedness, for seeking our own good at the ex-

pense of others. Our problem, according to Childress, is not simply that finitude inhibits reflection, but also that our predictions, capacity for control, and moral assessments persistently favor our particular interests and needs. Self-interestedness infects our judgments, diminishing the efficacy of moral reasoning, persuasion, and answering.

These background beliefs about human nature⁷ inform Childress's ethics in important ways. The theme of *imago dei*, for example, theologically grounds several important moral principles, including respect for persons. As beings created in the image of God, persons deserve and demand respect from others. They are not to be treated merely as means to ends, and the reasons they give for actions should be taken seriously.

Childress connects the respect-for-persons principle with this theological claim to distinguish it from the principle of autonomy. Respect for persons "cannot be reduced to the modern liberal conception of autonomy, because its religious context includes embodiment, not merely personal choices, and also limits set by God" (1986d:18; 1986a:51). The language of autonomy is too easily identified with an ideology of unfettered individualism and moral minimalism. Thus, while the political ideology of Anglo-American liberalism may identify autonomy with self-determination limited only by equal self-determination for others, from a theological perspective autonomy must be qualified by considerations of dependence, sociality, and finitude.

The theme of *imago dei*, which expresses "that of

God in every person,” presents furthermore a fundamental moral claim that all persons be treated as equals. In addition, “beliefs about God’s creation and redemption of human life (e.g., God created human beings in his image) are claims about humanity that can support a right to life” (1986f:131; 1986d:19).

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 (1983:74–75) 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 performing 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 (1986l:586–88).

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 (1984b:59; 1989b:42–43).

This claim takes on added significance against the backdrop of current debates in theological and philosophical ethics. It has become fashionable to affirm the importance of community over against the individualism of a liberal societal ethos. According to such views, community is based on trust and shared substantive values, while liberal individualism supports only the most minimal culture whose members, if they interact at all, relate only as “strangers.”

While Childress does not deny the moral significance of community, he believes that the dichotomy of community versus individual is misleading. If proponents of the dichotomy were consistent, they would ultimately be forced to claim that moral discourse between members of different communities and traditions is an illusion. Childress is not willing to concede that moral discourse at the societal level is meaningless; even in a pluralistic society, there can be shared commitment to certain procedural values. Pluralism does not preclude meaningful moral relations between “friendly

*“Limited paternalism is a
procedural solution to conflict
about the good life: it allows
each competent person to decide
for himself or herself.”*

—“Paternalism,” p. 451

strangers,” whose bond may be a commitment, expressed in support for fair procedures, to treat others as equals (1980:38).

This contextual argument for procedures is supplemented by one that roots procedures in human nature. Procedures enable decisionmakers to respond more adequately to human limitations. Because of our limited predictive capabilities, there are no guarantees that the results of our actions will be fair and just (1981:118). We can, however, establish and implement fair procedures. Thus, for example, in a situation where scarce resources must be rationed and we can neither predict the outcome nor agree on how to achieve it, we can at least affirm a fundamental equality among prospective recipients by establishing a procedural method of randomness.

Furthermore, procedures, while they do not eradicate sin from the moral life, minimize its impact (1981: 103). 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” (1986j:450). 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.

IV. Paternalism

The principle of beneficence (as well as the Hippocratic notion of patient benefit and the religious notion of *agape*) requires that health care professionals provide care that promotes the welfare of their patients. When patient welfare is emphasized to the exclusion of patient choices, the moral conflict of paternalism arises. As Childress defines it, paternalism is a “refusal to acquiesce in a person’s wishes, choices or actions for that person’s own benefit” (1982c:vii). Paternalistic actions may include withholding information from a patient; disclosure of information to third parties without patient consent; invasion of a person’s body without their consent, such as the provision of life-sustaining treatment; refusal to carry out a patient request for a medical procedure, such as sterilization or abortion; or provision of unwanted services. Paternalism also may take the form of lying, deception, or even coercion, as in cases of involuntary commitment (1982c:113).

Paternalism is morally interesting because it is based on an appeal to the welfare, needs, or best interests of the patient. However, to the extent that it overrides patient choices and actions it is *prima facie* wrong, because acts on the patient’s behalf are performed without or against his or her behest. Under certain circumstances, ordinarily beneficent actions can be demeaning and insulting. In Childress’s view, therefore, it is morally necessary for beneficent action to be constrained by the principle of respect for persons. The

choices of patients who are competent and able to make autonomous decisions regarding disclosure or non-disclosure of information, refusal of lifesaving medical treatment, or personal life-style should be respected.

The moral logic of paternalism is, according to Childress, suspect for several reasons. A necessary assumption of paternalistic action, that it will enhance patient welfare, is vulnerable to the same critique Childress applies to ends-oriented morality generally: “the necessity for prediction and assessment of outcomes. . .tends to undermine paternalism on its own grounds without appeal to other principles of morality” (1982c:44). The constraints imposed by finitude and fallibility are sufficient nonmoral grounds to reject paternalism.

Paternalism also raises a question about what constitutes patient welfare or need, or more fundamentally, health. Theological perspectives can support narrow interpretations of these concepts, and consequently, of professional control. Many interpretations of the commandment to love, Childress notes, assume an objective or unitary understanding of the neighbor’s interests and needs, while the doctrine of sin warrants suspicion of the patient’s own interpretation of his or her interests (1982c:35–39; 1986j:450, 451). In practice, professionals and patients will differ in their interpretations of patient welfare, as will patients among themselves.

The exclusion of the patient’s perspective renders paternalism deficient on moral grounds. In cases where paternalistic action violates the principle of respect for

persons, the patient will experience an assault on his or her dignity:

[A] professional's refusal to acquiesce in a person's wishes, choices and actions, where no one else is harmed, and merely because the professional disagrees with the values of the patient's life plan and risk budget, is a profound affront to dignity and independence. . . . Paternalism is insulting because it treats the patient as a child, that is, as one who has not yet freely and competently, and with adequate information, formed a conception of good and evil, of benefits and harms, or is not able to act on that conception in these circumstances. (1982c:68, 69)

Paternalism is thus sufficiently problematic for Childress because of its inattention both to the decisions of patients and to the values that inform such decisions (1982a:49–51). While professionals may be tempted by self-righteousness and the “arrogance of benevolence,” however, critics of paternalism may be tempted by “sloth and indifference.” The ethical challenge, Childress argues, is to maintain “a tension between the principles of beneficence and respect” (1982c:ix).

This moral tension is expressed in the “principle of limited paternalism,” which Childress describes as a “procedural solution to [substantive] conflict about the good” (1986j:450). Limited paternalism both counters the prevalent medical ethos of paternalism and morally allows paternalism under certain circumstances

(1980:34–35). It specifies actions by which “agents meet the needs of other persons without insulting them” (1982c:103).

Paternalistic interventions can be justified if five conditions are satisfied: (1) The patient's capacity to express wishes or to act on them must be limited to the extent that his or her competence is questionable; (2) there must be a probability of harm to the patient without paternalistic intervention; (3) the probable benefit to be achieved by intervention must be greater than the probable harm of nonintervention; (4) there must be a reasonable chance that the intervention will achieve the benefit; (5) the mode of paternalistic intervention should be the least restrictive and least humiliating of possible alternatives. If these conditions are satisfied, paternalistic interventions “even against [a] person's express wishes do not signify disrespect or constitute an indignity” (1982c:102–13).

The principle of limited paternalism illustrates the moral logic of *prima facie* duties in Childress's method. Several conditions must be satisfied to justify infringing respect for persons, but the moral force of the principle of limited paternalism is acknowledged. The “least restrictive” alternative, for example, would entail that temporary restriction of action is morally preferable to long-term confinement.

Paternalism and the principles of beneficence and respect for persons set the moral parameters within which Childress addresses the very controversial question of withdrawing one form of medical treatment, arti-

ficial nutrition and hydration. His position has been influential not only among academic bioethicists, but also for the formulation of public policy, having been cited in early cases on this issue in Massachusetts and New Jersey.

V. Forgoing Medical Nutrition and Hydration

Childress holds that the principles of beneficence and respect for persons establish a presumption in favor of providing all medical treatments that prolong life, since prolonging life is typically considered in a patient's interest and also desired by the patient (1986m:69). However, under certain circumstances, this obligation may be overridden by either principle—for example, when competent patients refuse medical treatment.

But many decisions about terminating medical treatment are made on behalf of incompetent patients who never expressed their treatment preferences. In such cases, the principle of limited paternalism becomes relevant. Childress contends that proxies for the patient should make decisions based on a standard of best interests, a patient-centered standard based on beneficence that favors provision of treatment when it has a reasonable chance of success and when successful treatment will realize proportionately greater benefits than burdens. However, there may be situations when these conditions are not satisfied and the patient's in-

terests are better served by discontinuing medical treatment. According to Childress, no medical treatment as such is obligatory; the underlying principles of beneficence and respect for persons can entail that provision of treatment is morally required, discretionary, or even wrong (1986m:77).

Childress's position on whether there is a moral obligation to provide nutrition and hydration to patients reflects this general framework. Competent patients have a right, grounded in respect for persons, to accept or refuse insertion or implantation of a feeding tube. Similarly, proxy decisionmakers may be morally justified in concluding that continuing medical nutrition and hydration is in the best interests of an incompetent patient. There are, however, three kinds of cases where the conditions for limited paternalism may not be satisfied.

First, it can be useless or futile to provide such treatment when a patient is dying and when death, no matter what actions are taken, is imminent. Medical nutrition and hydration may also be withdrawn or withheld from patients whose condition, though presumably irreversible but not imminently terminal, nevertheless rules out any possibility of benefit to the patient. Such patients include those born with anencephaly (lacking all or part of the brain), those who are permanently unconscious, or those in a preterminal coma or persistent vegetative state. In any of these situations, the provision of any medical treatment does not satisfy the condition of reasonable hope of success.

Finally, when treatment may improve a patient's nutritional status, but only at great burden, particularly in the form of increased patient suffering, treatment may be considered futile in a broad sense. Provision of nutrition and hydration would then fail to meet the condition of proportionate benefit (Lynn and Childress 1983:18–19). However, while the duty to prolong life may be justifiably infringed by decisions of either patients or proxies, the extent of infringement is limited by principles of both beneficence and respect. The refusal of medical treatment does not preclude expressions of compassion or acts of caring, such as moistening lips or massaging the body, by caregivers.

Childress's conclusions, as contrasted with some more permissive interpretations, hold for a quite limited set of conditions and patients. The patient-centered approach he advocates imposes serious constraints on decisionmakers. Medical ambiguity, conditioned in part by our propensity for fallibility, is a key consideration in assessing the burdens and benefits of treatment and should dispose decisionmakers to err (if they are to err) on the side of prolonging life. Moreover, the priority of patient interests should prevent external considerations, such as economic rationality and costs of treatment to others, from entering into, let alone controlling, the moral decision about terminating treatment.

Some difficult questions remain. It is not always clear whether Childress's argument against the provision of medical nutrition and hydration is primarily an objection to the treatment itself or to the medical pro-

cedures required to provide it, all of which involve some degree of invasiveness or constraint. This distinction may well invoke the fifth condition for limited paternalism, which requires providing benefits by the least intrusive means. In any case, Childress's position relies on a conceptual claim that "medical procedures to provide nutrition and hydration are more similar to other medical procedures than to typical human ways of providing nutrition and hydration, for example, a sip of water" (Lynn and Childress 1983:20–21). If so, then the underlying issue is the appropriate use of technology, not a recommendation regarding "starvation."

Childress's views have undergone a noticeable evolution. Originally he maintained that his argument did not establish an "obligation to withhold or withdraw such procedures," but only a moral permission. More recently he has moved to a view that it can be morally obligatory not to provide artificial nutrition and hydration because such provision *violates* patient interests (1986m:77–81). This stronger claim seems required by the moral logic of his argument: If the contemplated intervention fails to satisfy the necessary conditions of limited paternalism, it is not clear why the provision of treatment would be a matter of moral discretion rather than prohibition. One could uphold the discretionary stance out of respect for the interests of the patient's family (as Childress does), but this moves away from a *patient-centered* treatment standard.

Childress is willing to concede that the interests of others besides the patient morally count in a decisive

way. However, these others are not family members but patients in need of scarce resources that might otherwise be “wasted.” Childress carefully distinguishes decisions to forgo treatment based on the morally dubious economic interests of a family or health care institution, from the claims of other patients to needed care. This latter claim, underwritten by the principle of justice, is particularly compelling in debates over how to allocate scarce resources.

VI. Rationing Medical Treatment

How should resources for medical care be distributed when there are more patients in need than available supplies? Childress’s first foray into medical ethics addressed this question in the context of a shortage of kidney dialysis machines. The arguments presented in his now-classic article, “Who Should Live When Not All Can Live?” (1970:339–55), remain compelling today as our society confronts scarcities of organs, artificial hearts, or drugs for AIDS patients. Childress draws upon both theological and nontheological considerations to argue that a randomizing procedure (such as queuing or a lottery) ought to be used to decide how to ration scarce, indispensable medical resources.

The ethical task, Childress contends, is to identify the most satisfactory criteria and procedures for determining who should live when all cannot. The selection of ethically acceptable criteria for rationing conditions the adoption of an appropriate procedure. However, the

“There are many levels of responsibility in society, and not everyone should act in terms of the same standards at every level. The physician is not a policy maker. His or her primary responsibility is to the patient, and society has good reasons for insisting on the primacy of this responsibility of personal care.”

—Principles of Biomedical Ethics, p. 213

choice of criteria will itself be constrained by the pluralism of contemporary society as well as by basic anthropological convictions (1970:342).

A first set of criteria concerns rules of exclusion that determine an initial group of medically acceptable candidates. The relevant considerations at this stage are medical need and probability of benefit, minimum standards that at least preclude wasting already scarce resources. The medical nature of these criteria determines how the procedure is implemented; health care professionals are best suited to make such judgments. Public accountability and justification by professionals is essential, however, lest *medical* need and benefit be expended to encompass psychosocial considerations, allowing assessments about the social worth of a particular patient to be incorporated into exclusion decisions. To guard against unjustifiable exclusion of some patients on grounds of social worth, Childress maintains that the rules of exclusion should be applied as if the scarce resource were unlimited (1981:92; 1978:1415).

The use of social worth criteria to determine acceptable candidates mistakenly assumes a consensus on what is valuable; the fact of pluralism argues against a selection method based on social worth. Such criteria would also require the establishment of a socially representative committee to determine who receives resources. Not only is it unlikely in theory that such a committee could adequately reflect all of society's values and determine how to rank them accurately, but in past practice, the use of "God squads" at various institutions

has produced notoriously arbitrary decisions (1978:1416; Ramsey 1970:242–52).

Social worth judgments also reflect utilitarian assessments of past and future contributions to society. Proposing that patients receive scarce resources according to their anticipated contributions to societal well-being overlooks the facts of human finitude and fallibility. It is, Childress argues, "rarely easy to predict what our needs will be in a few years and what the consequences of present actions will be. Furthermore, it is difficult to predict which persons will fulfill their potential function in society. . . . We simply lack the capacity to predict very accurately the consequences which we then must evaluate. Our incapacity is never more evident than when we think in societal terms" (1970:345, 346).

There is another fundamental objection to rationing resources on grounds of social worth. A selection method that requires comparative evaluations of a mother, a minister, and an attorney, for example, reduces the value of the individual to his or her social role and function. It "dulls and perhaps even eliminates the sense of the person's transcendence, his dignity as a person" (1970:346). The *imago dei* underlies Childress's argument. From a theological perspective, social worth criteria simply do not adequately account for "that of God in every person."

Respect for personal dignity, Childress maintains, can best be affirmed through random selection of recipients. Whether a natural (first-come, first-served) or

artificial (lottery) method is used, such a procedure maintains “a significant degree of personal dignity by providing equality of opportunity” (1970:348). Each individual has an equal right to be saved when not all can be saved.

Random selection can also sustain and extend trust, which Childress considers an essential aspect of human dignity (1970:349). Patients would not be the objects of interpersonal comparisons of worth by those to whom they have entrusted their care; nor would they be treated merely as means to the social good; at the same time, physicians could continue their commitment to seek their patient’s best interests without moral compromise through involvement in a selection committee.

Childress’s argument for a random method is strengthened by both anthropological and theological considerations. Choosing a procedure for selecting recipients without knowing the consequences to oneself as well as to the society of this choice both acknowledges and mitigates the factor of self-interestedness in human action. In addition, Childress reflects the views of Paul Ramsey in holding that the experience of God’s indiscriminate love for human beings provides a morally significant analogy that favors equality in rationing decisions and rules out social worth assessments (1981:94).

In our pluralistic society, Childress assumes cultural agreement on one fundamental value, equality of opportunity. This seems a plausible claim, but what seems

less certain is that different methods of random selection equally guarantee equal opportunity. A “natural” rationing method of first-come, first-served may exclude some individuals who cannot make their need for scarce resources known soon enough because of income stratification or proximity to a medically underserved locale. Some persons may not be able to get on a waiting list for an organ transplant, for example, because they lack access to medical care.

An “artificial” method of random selection like a lottery may be morally preferable, and can be supported theologically. In particular, Childress points to situations in Scripture, such as the Jonah narrative (Jonah 1:4-7) or the selection of Matthias as one of the twelve apostles after the resurrection of Jesus (Acts 1:23-26), in which the divine will is revealed through the casting of lots: “The lot is cast into the lap; but the whole disposing thereof is of the Lord” (Proverbs 16:33). These examples illustrate how Scripture functions in Childress’s ethical method to illuminate our obligations.

Whether a lottery or queuing is preferable finally for Childress seems to turn on practicality. If, for example, shipwreck survivors were required to swim for a lifeboat, those who arrive first would have good grounds to dismiss appeals to a lottery by those who arrive later. In this respect, Childress holds that background constraints and injustices are equally applicable to both methods. The morally critical point is that either form of randomization is preferable to an ethically unacceptable social worth approach.⁸

The scarcities that might deprive individual patients of needed or desired resources on moral grounds of fairness and equality of opportunity do not occur in isolation from much broader societal questions about how to allocate health resources. Macroallocation issues—how much a society spends on health care relative to other social goods; how it divides health expenditures among preventive, chronic, and acute care medicine; how it assigns priorities to different diseases and technologies—all affect the amount of available resources to be distributed among individual patients with different and competing needs, and thus can determine the extent of the problem of scarcity (1979b:256–69). For example, some state legislatures recently have decided to limit funds for transplantable organs in order to enhance prenatal care programs. A limited supply of organs for transplant not only creates agonizing choices at the microdecision level (which patient should receive an available organ), but also poses important questions about society’s policy priorities (1987b:85–110).

VII. “Gifts of Life”: Organ Procurement

The scarcity of transplantable organs is at least theoretically avoidable. Estimates indicate there are more than enough deaths each year in the U.S. of the kinds that would provide “a surfeit of organs” (1986b:133). However, our society has yet to identify and implement a

morally acceptable method of organ procurement that would effectively alleviate shortages.

Religious beliefs contribute measureably to this scarcity. Opinion surveys reveal that people’s reluctance to donate organs stems from concern about the integrity of the body in the “resurrection or afterlife” among 12 percent of respondents and from “religious prohibitions” in 9 percent (Report 1986:37–39, 142). Such beliefs are not as significant in creating shortages as is pervasive distrust of medical professionals, but the percentage of objections to organ donation on religious grounds has increased in recent surveys and raises questions about how religious convictions may affect societal efforts to procure a sufficient supply.

Childress indicates that the theme of *imago dei* has significant implications for this issue, since it supports a concept of human stewardship over creation and over the use and disposal of one’s body and body parts. “As stewards and trustees, human beings do not have unlimited power. God has set limits on what human beings may do with and to their own bodies and those of others” (1986d:4). This model of stewardship imposes obligations toward the body, living or dead, especially respect for the cadaver; demands justification for invasions of the body, including for purposes of organ procurement; and establishes a presumption in favor of respecting the wishes of persons regarding organ donation (1986d:18).

Our current procurement system, according to Childress, can be characterized as “encouraged altru-

ism,” structured by the model and language of “gifts.” In organ donation, “gifts of life” are typically offered to unknown, unidentified strangers in critical need. Such a model is not obviously incompatible with religious perspectives concerning the body’s sanctity and the requirement for justification. For example, Childress notes that the strong prohibitions in Jewish traditions against desecration of the corpse, based on God’s creation of human beings in *imago dei*, like “any prohibition in Jewish law, except for murder, incest and idolatry, may be overridden in order to save human life” (1986d:6). Moreover, procurement methods structured by the notions of altruism, gift, and generosity may provide an occasion for the expression of *agape* and concern for the neighbor’s welfare. “It may be an act of love to donate one’s organs before or after death, or a deceased relative’s organs, in order to meet a neighbor’s needs” (1986h:441). The closer procurement policies conform to a “gift model,” the less likely they are to risk infringing the boundaries of the *imago dei*.

Childress, who served as vice-chairman of the National Task Force on Organ Transplantation, agrees with many that the predominant method of the last two decades, encouraging voluntary gifts of organs through public education and distribution of donor cards, has simply failed to furnish a sufficient number of suitable organs for transplant. While Childress holds that a variety of policies—including express or presumed donation or commercial sales—may be ethically permissible, the challenge for policymakers is to identify

morally preferable and politically feasible alternatives (1989a:89).

As an expression of the principle of respect for persons, Childress contends, primacy should be given to the known wishes of the individual regarding donation. This would preclude “expropriation” in which cadaver organs would be “harvested” irrespective of or even against the expressed wishes of the decedent. The *imago dei* and stewardship themes provide religious grounds to reject such a policy because of its implicit disrespect for the cadaver. Moreover, expropriation is contrary to the altruism that supports current practices and may even be counterproductive over time by heightening distrust (such as fears over premature declaration of death) about the procurement system and about the lengths to which a society will go to save lives. Thus, though expropriation may theoretically be a very efficient way to increase the supply of organs, moral, theological, and political objections exclude it as a viable policy option (1989a:98–99).

Commercial sales of transplantable organs may be ethically acceptable, based on respect for a donor’s freedom of choice, although there are important moral concerns about the voluntariness of the choice and the potential for exploitation in a market system where demand is great. However, Childress does not view an “organ market” as significantly more effective than alternatives for increasing the supply of organs. Nor would such a method express altruism or support the practice of gift-giving. The *imago dei* and stewardship themes

"Both paternalists and their critics are susceptible to various temptations. Paternalists are tempted by pride and self-righteousness. ... Critics of paternalism are often tempted by sloth and even indifference."

—Who Should Decide? Paternalism in Health Care, p. 9

also sanction reluctance to endorse this policy option, for a commercial market in organs may encourage viewing human bodies and their parts as commodities. For several reasons, then, Childress contends: "It would be ethically and politically unwise to convert the system of donation into a system of sales until [alternative] policies have been given a chance to work, in part because transfer of organs by sales would be costly, would probably drive out many donations, and could have serious effects on our conception of personhood and embodiment by promoting commodification" (1989a:101-2).

A policy based on "presumed consent" to organ donation is held by Childress to be ethically permissible to the extent that personal choices are the controlling factor (1986b:138). However, it is subject to scrutiny at several points. The element of consent, for example, may be substantially diminished if organs are removed routinely from cadavers only because donors do not dissent. The failure to dissent cannot be automatically construed as consent; silence may instead indicate that donors do not know about or understand the procurement process.

While Childress believes that "a policy of presumed donation rests on passive altruism, and it does not preclude active altruism," he also contends that "a policy of express consent is ethically preferable, because it promotes active generosity and community" (1986i: 442). The moral priority of express consent—for example, by declaring oneself a willing donor on a donor card—has its practical limits for increasing the supply of

organs. However, there may be alternatives. The proposal that Childress believes promises to balance best the needs to enhance organ procurement efforts, preserve gift-giving, and respect personal and bodily integrity, has been termed "required request." The key element in this mechanism is the development of "institutional [e.g., hospital] protocols for approaching the family of a dead person who is a potential source of organs" (1989a:94). Health care professionals may ask family members about the wishes of the decedent with respect to organ donation and if these are unknown could inform the family of their moral and legal right to donate. Indeed, informing the family about a donation option can allow the family to exercise "responsive generosity or charity." And while in some instances this may entail moving the locus of consent from the individual to the family, Childress contends that "it is appropriate to view the family as entrusted with the corpse and thus as stewards and trustees, who should act on the decedent's wishes where they are known, but who may make their own decisions about donation if those wishes are not known" (1986d:21). Acknowledgment of the ethical and theological significance of gifts, stewardship, and respect for the body as a symbol of the image of God, then, seem to play an informing role in Childress's advocacy of express consent and required request as preferred policies regarding organ procurement.

VIII. The Community of Ethical Responsibility

Childress has called for "more careful analytical and constructive" attention to moral norms, such as love and justice, invoked in bioethics discourse as a way of clarifying and resolving some controversial issues, while noting "the impossibility of either clarifying or resolving these disputes without attention to [the] broader theological, metaphysical and anthropological contexts" of these norms (1985:225). These broader premoral presuppositions clearly inform Childress's own ethical method, and this method may be applied to clarify and resolve some of the perplexing issues in biomedical ethics. Still, we might ask Childress to heed his own call and articulate his own constructive position in certain areas.

Childress's appeal to "discernment" and "prudence" to determine the morally fitting principle for a situation, for example, looks suspiciously like reliance on intuitionism. This limitation is made even more serious by his moral anthropology. If finitude, fallibility, and sin infect moral decision making to the extent Childress claims, the capacity of persons to discern the "winning" principle in cases of conflict would seem similarly suspect. Philosophers and theologians since Aristotle and Aquinas have warned against expecting undue precision in ethics, acknowledging that uncertainty increases the more concrete moral decision making

becomes. Nevertheless, without a theory of discernment and prudence in moral reasoning, it is not clear that Childress's method provides solid grounds for any decision made in a situation where two principles conflict.

One possible remedy is the specification of a theory of value, particularly regarding the substantive goods that constitute human flourishing and well-being. Childress's interpretation of the "nature" of human beings is in my view existentially and theologically sound. But we are told very little about the "destiny" of human beings—the goods toward which we are naturally inclined or which we ought to be pursuing. Perhaps finitude and fallibility inhibit or prevent apprehension of an ultimate human end; but the central challenge that developing a concept of human destiny may pose for Childress's ethics is whether it is possible to articulate a substantive theory of human well-being without risking the imperialism of paternalism.

The concern about human destiny has been central for theological traditions and religious communities. One clear implication of Childress's view that the mean-

ing and weight of moral norms is connected with broader metaphysical convictions is that the theological claims of particular communities can change the moral meaning and significance of principles such as love of neighbor or respect for persons. In this regard, attention to distinctive theological traditions or, more generally, to particular cultures, may suggest limits to the scope of Childress's ethical method.

This point notwithstanding, a medical ethics that is tradition-specific risks silencing theological perspectives in the broader world of moral discourse and leaving the details of fashioning ethically sound health policies for society to those who are not theologically informed. Childress's ethics indicates the need for accountability, for *theological* reasons, to claims and interests beyond those of particular religious communities. The ethicist is directed and called to reflect on social and policy concerns out of the responsibility of "answering...every person." In this very fundamental mode of engagement with rather than withdrawal from vexing policy issues, theological convictions may have their most profound impact on the dilemmas of medical ethics. ☸

NOTES

1. I have briefly summarized the central objections forcefully articulated by James M. Gustafson (1978:386–92) to religious ethicists who fail to make explicit the religious dimensions of their positions. According to Gustafson, the choice for such persons is clear: “They will have either to become moral philosophers with a special interest in ‘religious’ texts and arguments, or become theologians,” developing their positions out of and in response to “historically identifiable religious communities.”
2. The classic exposition of an “ethics of responsibility” was articulated by Max Weber in his essay “Politics as a Vocation” (1958:77–128). More recently, such prominent figures as H. Richard Niebuhr (1963) and Hans Jonas (1984) have developed their ethical positions around the concept of *responsibility*.
3. Childress’s claim that these principles are “embedded in various policies and practices” and “are widely accepted (with only slight variations) in the policy area” implies methodological sensitivity to human experience and the need for a *dialectical and corrective* relationship between ethical theory and ordinary moral judgments. The criticism of Childress’s approach to ethics as abstract and alien to the concrete, lived-in world is simply mistaken.
4. David Smith (1987:107–27) has recently presented a superb analysis of the medical ethics of Paul Ramsey.
5. I have presented a very compressed version of some of the major themes in Beauchamp and Childress (1983:19–221), although it is important to note a couple of differences. I have distinguished beneficence and utility as separate principles, whereas in *Principles of Biomedical Ethics*, utility is considered one aspect of the principle of beneficence. I have also used the language of respect for persons rather than the principle of autonomy. In both instances these distinctions seem more representative of Childress’s own moral framework, as contrasted with that articulated in a jointly authored text. Where possible, I have directed readers to alternative sources to support my interpretation.

Childress has also given considerable attention to the role of metaphors in biomedical ethics (see, e.g., 1982a) to complement and enrich his discussion of principles and rules.
6. Childress’s account of “the moral logic of *prima facie* duties” reflects a fundamental continuity with moral reflection about the justification of lethal violence, particularly as contained within the just war tradition. He contends: “We formulate and use criteria that are analogous to those that determine whether a war is just and justified whenever we face conflicting obligations or duties, whenever it is impossible to fulfill all the claims upon us, to respect all the rights involved, or to avoid doing evil to everyone” (1982b:66–67).
7. Childress’s moral anthropology has been profoundly influenced by the thought of Reinhold Niebuhr (1964), reducing some of the optimism and idealism about human nature associated with the Quaker tradition. Niebuhr’s political “realism” and emphasis on human sinfulness were instrumental in converting Childress from a pacifist to a defender of just war theory.
8. Childress does allow exceptions “in some emergency situations” for social utility concerns to take precedence based on “specific, urgent functions” a person or group might perform for the common good (1983b:551–54, 561). For example, a leader of a country might be given priority to ensure societal survival.

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Examples

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