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# SECOND OPINION

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HEALTH • FAITH • ETHICS

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Respecting Creation • God and Evil • Healthful Institutions • Being Neighbor to the Homeless



COVER

*Abundant Shiva Dancing.* Collage on paper by Diane Thomas Lincoln, 1992.

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S E C O N D  
O P I N I O N

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HEALTH • FAITH • ETHICS

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The Park Ridge Center exists to explore the relationships among health, faith, and ethics. In its programs of research, publishing, and education, the Center gives special attention to the bearing of religious beliefs on questions that confront people as they search for health and encounter illness. It also seeks to contribute to ethical reflection on a wide range of health-related issues. In this work the Center collaborates with representatives from diverse cultures, religious communities, health care fields, and academic disciplines and disseminates its findings to professionals and others interested in health, religion, and ethics.

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

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

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## SECOND OPINION

\*Volume 18, number 2\* • October 1992

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\* *The first 16 volumes consisted of one issue each and were published every four months beginning in March 1986.*

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# INITIAL COMMENT

## Breaking Old Molds

IN EVERY FRESH ENDEAVOR NEW CLICHÉS appear, threatening to turn the freshness to staleness. Attacks on convention can quickly turn into new conventions, ones that are no more creative than those they would replace. The endeavor of this Center and its journal to relate health, faith, and ethics to each other in fresh ways has to occur under the watchful eyes of colleagues who accept the challenge of preventing clichés from taking over where thought should rule.

“Cliché,” says Eric Partridge’s *Dictionary of Clichés*, comes from *clicher* and *cliquer*, “to click.” It is the die-sinkers’ term for “striking melted lead in order to obtain a cast.” So a cliché is a stereotyped expression, idiom, or phrase, but it can also be an approach. Our constant effort is to locate physicians, ethicists, theologians, and others who through their approaches and arguments can challenge convention without contributing to or reinforcing the manufacture of new conventions. This issue of *Second Opinion* may well serve as a case study of such efforts.

Twenty-five years ago in a now classic essay, historian Lynn White scored the Jewish and Christian traditions for using or misusing Genesis 1:28 as a text for promoting an anthropocentrism that harms the health of humans and all creation, all nature. We asked theologian John Cobb to revisit White’s charge, which has been turned

into a stereotype by many. Cobb ponders and defends what is enduring in White’s challenge, without reinforcing the stereotype or lapsing into defensiveness over Jewish and Christian claims. We see freshness in his reflection on the “integrity of creation.”

Wendy Farley knows that Panglossian theology, which finds nothing but a good God, issues in the most tired set of clichés. But the modern critiques of such an approach by now have become clichés as well. Farley gains a hearing for the notion that “resistance to suffering is not absurd; it is the footprint, so to speak, of the compassionate power of God to redeem a suffering world.”

*Narrative ethics* arose in part as a challenge to the stereotyping of ethics that often marked and marred traditions as old as Aristotle’s and as profound as Kant’s. Yet the notion that story complements principle has threatened to become the new stereotype in reflections on the good. So we turned again to Arthur W. Frank, who advocates story telling in medical ethics and in addresses to illness and healing, and asked him to expound its meaning afresh. He chooses to deal with metaphor, knowing that “the risk of any . . . metaphor is to lose real embodied suffering in literary allusion.” Frank takes the risk and exemplifies ways to keep finding such embodiment.

One of the more moving accounts we have come across in the narrative ethics approach in recent seasons is David Hilfiker's story of Clint Wooder. One phrase about Clint that catches the eye: this person was "truly available to be helped." We find Hilfiker also available to be a helper. But the reader is likely to discern that more is going on than a transaction between a helper and the helped, thanks to the way Hilfiker tells the story. Caring, helping, sharing: these have become clichés. Hilfiker does not let the reader rest content with them.

Nor would the two commentators. Kathleen Nolan takes risks with the story and explores the concept of *communion* that breaks into the "Doc" and "Clint" story. M. Therese Lysaught then breaks old molds in which the Good Samaritan story ("the Good Samaritan trap") is conventionally cast and helps ask anew: who is helper, who is helped, what is help? And, along the way, what is *community*? This concept she also does not allow to be cast as cliché.

Harold Kushner several years ago caused many people to ponder the issues that surface "when bad things happen to good people"; it is not his fault that others have made a cliché of his

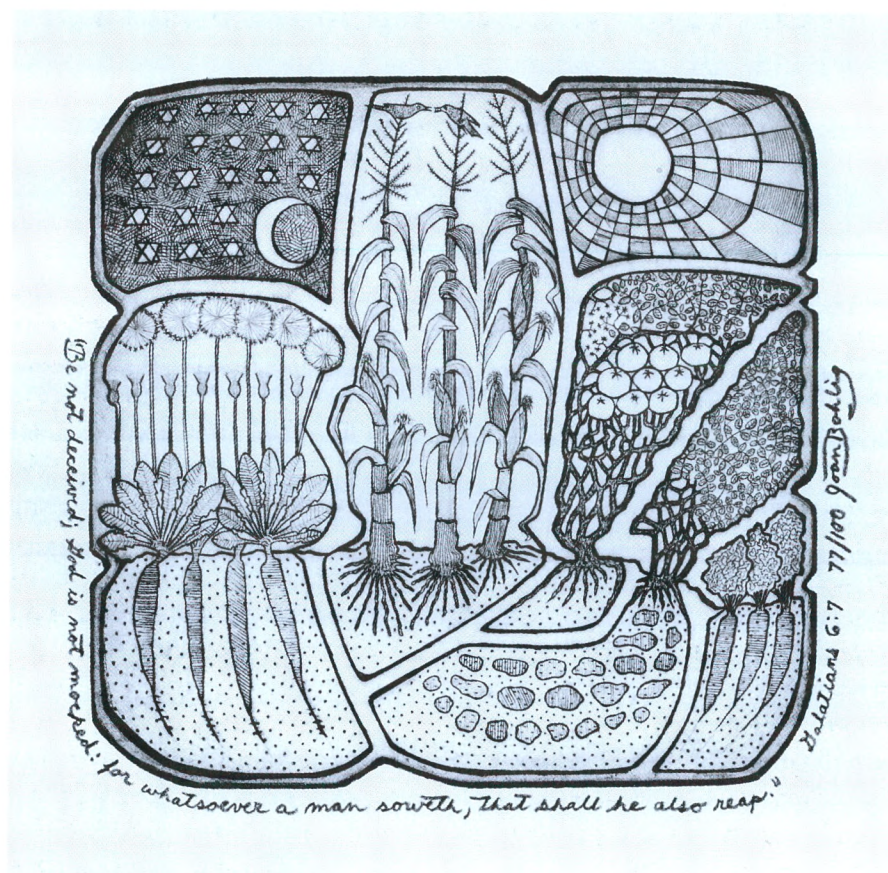
thinking. But Jerry K. Robbins assumes a counterpart task: how to reckon with the occasions "when good things happen." Because this journal, though *interreligious*, does not seek least-common-denominator religion, we asked Robbins to talk about resources in the Christian tradition for addressing the question.

One of the most tired clichés in the healing realm today is the contention that all institutions—medical, religious, governmental, legal—necessarily stand in the way of healing itself. Those who assert this conventionally accompany their accusation with the notion that non- or anti-institutionalism is the proper alternative to what we have. But Donald Shriver and Peggy Shriver do not; they know that anti-institutionalists also invent institutions and that there is no place to hide, and no need to hide, from organized life. The question for them is, How does an institution of any sort—and they give illustrations of several sorts—become a "health-maintaining organization"?



Martin E. Marty





*Whatsoever a Man Soweth.* Etching by Joan Bohlig, 1978.

# Biblical Responsibility for the Ecological Crisis

John B. Cobb, Jr.

## I

IN 1966, HISTORIAN LYNN WHITE, JR., addressed the American Association for the Advancement of Science on "The Historical Roots of Our Ecological Crisis" (1967). He shocked many in his audience by telling them that science and technology could not solve this crisis because they shared in the attitudes that caused it. He shocked them further by showing that those attitudes were derived from Christianity.

White's essay opened a new chapter in the long discussion of the relation of science and religion, and especially of science and Christianity. Much of the earlier discussion had taken the form of a polemic against Christianity for its commitment to prescientific ways of thinking, and the attack had been heightened in the late nineteenth century by Christian resistance to Darwinian evolutionary theory. Scientists saw themselves as engaged in a purely rational and empirical enterprise that would lead

society into truth. The only obstacle to this happy outcome was the interference of religious communities, especially Christian ones.

More sophisticated readings of history showed that the situation was not so simple. Until recently, the patient search for regularities in the natural world was not governed by any expectation of practical gain. Nor could it be explained as the result of a generalized curiosity or of a desire to add bits of information to the inherited store. Instead, it was motivated by the belief that through this new knowledge one was learning about the Creator. Further, the belief that there were indeed exact regularities underlying the far less regular appearances of the world derived from beliefs about the nature of the Creator. The beliefs that underlay the rise of science from the eleventh to the eighteenth century were central doctrines of the Christianity of Western Europe (Whitehead 1926). Hence, the relation of Christianity to science has been one of fundamental support, marred by occasional quarrels, rather than one of profound enmity, as many had supposed.

Until recently less attention has been paid to the history of technology, and it is in this area that White's essay broke new ground. He pointed out

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*John B. Cobb, Jr., is retired from the School of Theology at Claremont in Claremont, California. He is the author of *Is It Too Late? A Theology of Ecology*.*

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that until the middle of the nineteenth century, developments in science had had little effect on technology. Science was developed by the leisured class; technology, by artisans. Nevertheless, long before the wedding of science and technology, Western Europe had assumed global leadership in technology. By the sixteenth century a minor European country, Portugal, could become a planetary empire, because of superior technology. White traces the beginnings of this remarkable technological advance in Western Europe as far back as the seventh century.

Why did Western Europeans, during a period in which they were far outshone by other civilizations in most respects, begin a technological advance that eventually transformed the planet? White argues that this was made possible by their view of their relation to the natural environment. In this area the conversion from paganism to Christianity entailed a profound change. Instead of thinking of themselves as a part of nature, Christians saw themselves as separate from nature and above it.

People do not need to see themselves as above nature in order to modify it and adapt it to their needs. Indeed, all living organisms do this, and the actions of primal people already had had significant effects on the biosphere. Nevertheless, most cultures encouraged religious attitudes that inhibited destructive treatment of the physical world. For example, many taught that the natural environment was inhabited by spirits. They allowed some of it to remain in the form of sacred groves, and they placated the spirits of streams that they dammed and trees that they cut.

Western European Christians, on the other hand, felt no need for this. The true spirits were in

heaven and not within the natural world. That world was created for their sake and for their use. In exploiting it efficiently, they were fulfilling their religious calling, not violating a sacred nature.

White finds that the freedom to exploit the natural world without inhibition originated in and was sustained by the Bible, or at least by its dominant interpretation in the West. There the creation story has been generally read as meaning that human beings are not only the culmination of creation but its purpose and goal. They are authorized to have dominion over all the other terrestrial creatures. The story of salvation is the story of what happens to human beings, and to them alone.

White recognizes that in recent times the direct influence of the Bible has greatly declined. But he notes that in anti-Christian and antibiblical movements

such as communism, the same basic beliefs and attitudes prevail. In the now dominant post-Christian mentality of the West—a mentality shared, once again, by most scientists and engineers—the same beliefs and attitudes prevail. In these groups these beliefs and attitudes are so taken for granted that they are not even recognized as constituting a particular ideology.

Not very long ago White's paper might have been taken as an arrogant expression of Christian chauvinism. It claims that both the science and the technology of which the West is so proud are fruits of a religious faith about which it has become embarrassed. But in the new context generated by deepening concern about what human beings are doing to their environment, White's thesis was understood as yet another attack on Christianity and on the Bible.

**Even when human beings are  
realistically informed  
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the burden of proof  
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species of beetle.**



This is unfortunate. As White explicitly states within the article, he is a churchman. Furthermore, he questions the possibility of changing the attitudes of the West by rejecting Christianity and turning to Eastern traditions. Instead, he calls for a profound reform within Western Christianity, appealing to other resources within its rich and complex traditions. In particular he proposes the revolutionary Christianity of St. Francis as offering the needed direction.

White's own nuanced position is that of a Christian prophet calling the church to repentance. But the charge, derived from his essay, that the Western churches have used the Bible to justify ruthless exploitation of the environment has led many environmentalists to continue the old tradition of opposition to Christianity in general. Ironically, their reason is just the reverse of the older one. Instead of opposing Christianity for its resistance to the advance of science, they now oppose it for its support of science and technology. There is probably more justification for the current attack than for the earlier one, but White's own position is sounder than either.

## II

THE ATTACK ON CHRISTIAN AND BIBLICAL teaching has led to a great deal of serious Christian reflection. Biblical scholars have done particularly helpful work in reevaluating the meaning of the Creation story and other passages pointed to by critics as having authorized ruthless exploitation of the natural environment.<sup>1</sup> Special attention, both in the attack and in the response, has focused on Genesis 1:28. "And God blessed them, and God said to them, 'Be fruitful and multiply, and fill the earth and subdue it: and have dominion over the fish of the sea and over the birds of the air and over every living thing that moves upon the earth'" (RSV).

Jewish scholar Jeremy Cohen has written an entire book (1989) on how that text was discussed and debated in both Jewish and Christian circles

down through the late Middle Ages, with briefer reference to the Reformation. He does not find that the modern period brought out new meanings. His research makes it clear that there has been far more attention to the issue of procreation<sup>2</sup> than to that of controlling the earth. Nevertheless, he selected this verse for detailed study of its historical interpretation because critics of the Bible accused it of supporting exploitative attitudes.

Cohen's research demonstrates beyond doubt that neither among Jews nor among Christians was there widespread celebration of human domination and of the right to destroy other creatures. He lays to rest any attack on Christianity that pictures it as explicitly calling for environmental despoliation as an expression of the human dominion taught in Genesis 1:28.

## III

BUT LYNN WHITE'S THESIS DOES NOT DEPEND on any of the positions that Cohen's research has invalidated. Indeed, in his seminal essay, White says nothing about the influence of Genesis 1:28. Nor does he say that the Bible was directly interpreted as encouraging ruthless exploitation of the environment. What White *is* concerned about is the anthropocentrism of the Bible. He interprets the Creation story as follows:

Man names all the animals, thus establishing his dominance over them. God planned all of this explicitly for man's benefit and rule: no item in the physical creation had any purpose save to serve man's purposes. And, although man's body is made of clay, he is not simply part of nature: he is made in God's image. Especially in its Western form, Christianity is the most anthropocentric religion the world has ever seen. (1967:1205)

That thesis actually receives support from some of Cohen's formulations. The demonstration that



Genesis 1:28 was not used to support selfish exploitation of the environment is important. But the biblical view that comes to expression in this verse, as in the story as a whole and in many other places, may still be thoroughly anthropocentric as White avers. Cohen thinks that readers took for granted that the Bible pictures the world as made for the sake of human beings and not for its other inhabitants. This is what White calls anthropocentrism and holds responsible for the attitude that develops technology and uses it for human ends without sensitivity to its destructiveness to other creatures. Cohen points out that this attitude is so taken for granted that it did not generate much discussion among Jewish and Christian scholars. White emphasizes that this attitude began to affect actual peasant practices as far back as the seventh century and that it still determines the mentality of contemporary scientists and engineers.

In describing how Christians, freed from the pagan sense that spirits inhabited nature, actually treated their environment, White uses the language of violence. Their plows "attacked" the land; their calendars showed men "butchering" pigs. Humans became the "exploiters" of nature. And "ruthlessness" toward nature became characteristic of technology. Surely some violence is involved in all use of the environment for human purposes, especially when what is used is alive. The felling of trees is a violent act, as is the "breaking" of horses. All eating involves the killing of plants and animals. White's point is that cultures that understand human beings to be part of the natural world inhibit this violence. But when people view the natural world as existing only for human use, that inhibition disappears. There is no longer any need to minimize violence against it. The Bible certainly does not explicitly argue in favor of violence, but it provides the framework that makes this violence acceptable and even normative. As machines became larger and more powerful, the violence done to the earth increased. When scientific advance generated, first, the chemical and then the nuclear revolutions, this violence escalated unimaginably. Now it affects not

only the entire biosphere but the earth's envelope of gases as well.

White believes that as long as human beings think of the relationship between humanity and nature in anthropocentric terms there will be no basic reversal of the present destructive course of action. And he asserts that Western Christianity has been the most anthropocentric of religious traditions. Now that the relation between Western Christian teaching and the destruction of the environment has been pointed out, it is not inappropriate to declare Christians guilty for perpetuating this teaching. For this reason, Christian theologians such as myself do have a very important responsibility to reformulate Christian teaching.

#### IV

SINCE *ANTHROPOCENTRISM* HAS SEVERAL meanings, and since it is so central to White's thesis, evaluation of his thesis requires an exact definition. There are important meanings of the term that do *not* apply in his discussion. When the relation to God is in view, it must be said that, on the whole, the Bible and the Judaic and Christian traditions are theocentric rather than anthropocentric. White, of course, does not mean to deny the theocentrism of the Bible, and he does not leave us in doubt about his use of *anthropocentrism*. In the passage already quoted he says that God planned all the creation explicitly for humanity's benefit and rule. Stating this negatively, he says, "no item in the physical creation had any purpose save to serve man's purposes."

The important question today is whether anthropocentrism is in fact a major obstacle to redirecting the public practices that are destroying the human environment. Perhaps, once it becomes clear to human beings that their collective future is endangered by their continuing assault on the environment, they will, for purely anthropocentric reasons, reverse course. This has been the dominant assumption of environmentalists.





*One Must Know the Animals.*  
Lithograph by Ben Shahn, 1968.

Collection of the New Jersey State Museum, Trenton. Museum Purchase, FA1968. 192f.  
©Estate of Ben Shahn/VAGA, New York 1992.



For some, this means that ideological or religious changes are irrelevant. Others believe that the intellectual recognition of human dependence on other creatures must be accompanied by deep attitudinal changes. When people see that they cannot have a desirable future themselves except as other species also flourish, then, it is believed, human beings will redirect science and technology to different goals. The problem, from this point of view, has not been anthropocentrism but rather insensitivity to the intimate dependence that human beings have on their environment.

There is no doubt that much has been learned about this dependence and that this knowledge has had a beneficial effect. The new understanding expresses itself in the requirement of environmental impact statements and laws protecting endangered species from extinction. Current agitation to prevent the disappearance of numerous varieties of grains and other seeds also shows the growing awareness of the fragility of a too artificial environment. None of this requires a significant change in Christian teaching.

Despite the important gains that can come from the internalization of the knowledge of human dependence on the environment, White is probably right that this does not suffice. If human beings were thoroughly rational, and if their rationality were based on a view of the well-being of the human species over a long period of time, then the actions that would follow from an enlightened anthropocentrism might indeed suffice. But in fact people are not so rational, and even an ideal rationality cannot encompass *all* the possible outcomes of action.

The situation is analogous to that of individual rationality. If an individual human being aims to act

in completely self-interested ways, there is reason for concern about the results of such selfishness. The primary worry is about what the consequences of completely selfish action will be for others. But there is also reason for concern that the consequences will be negative for the actor. If the completely selfish individual intends to consider all these consequences

over a very long period of time, then, it could be argued, the resultant enlightened self-interest will produce many of the results that would follow from goodwill for others. And this is true in theory.

Still there is a difference. Even when enlightened self-interest leads to generous acts to others, such acts, consciously and intentionally motivated by self-interest, do not have quite the same character as

generosity motivated by affection and concern. And in any case, there will be times (numerous, in all probability) when the horizons of self-interest will not be broad enough to lead to the generosity needed by the other now. The burden of proof is on the justification of generosity for the sake of self-interest. And there is no assurance that even the most enlightened self-interest justifies all the actions that are important for the well-being of the human family.

As long as human beings remain collectively anthropocentric, even when they are realistically informed about their dependence on other creatures, the burden of proof remains on those who would protect a bit of wilderness or preserve an obscure species of beetle. Many of those most active in the defense of nature are in fact motivated by a love of other creatures that is not anthropocentric. Without the leadership of these nonanthropocentric persons, there would have been little progress thus far. Even today, without their continued leadership, "practical" (usually economic) concerns would quickly

**It is possible to develop from  
biblical sources a realistic view  
that attributes real value,  
meaning, and purpose to  
every creature without denying  
that a human life is worth more  
than the lives of many sparrows.**



erode what progress has been made. Unless the sensibility of many people broadens beyond anthropocentrism to a deep caring for other creatures for their own sake, it is very unlikely that sufficient change will occur in behavior and in policy to prevent ecological catastrophe.

## V

WHITE CALLS FOR A SHIFT FROM DOMINANT Christian orthodoxy to the revolutionary theology of St. Francis.

The key to an understanding of Francis is his belief in the virtue of humility—not merely for the individual but for man as a species. Francis tried to depose man from his monarchy over creation and set up a democracy of all God's creatures. With him the ant is no longer simply a homily for the lazy, flames a sign of the thrust of the soul toward union with God; now they are Brother Ant and Sister Fire, praising the Creator in their own ways as Brother Man does in his. (1967:1206)

In sum: "he tried to substitute the idea of the equality of all creatures, including man, for the idea of man's limitless rule of creation" (1967:1207).

If we do need a shift away from anthropocentrism, do we need to adopt this Franciscan ideal of the equality of all creatures? Among deep ecologists, feminists, and Buddhists there are many who agree.<sup>3</sup> Only if human beings abandon all claim to special status in the world, they believe, will human behavior change in such a way that they cease to be destructive of the biosphere.

Is this belief correct? And if so, can such a shift be a reform of Christianity, or must it be a total rejection of the biblical heritage? White seems to believe that the radical shift he proposes is possible within Christianity, but I am doubtful. I am even doubtful that St. Francis's teaching as a whole stripped human beings of their special role in crea-

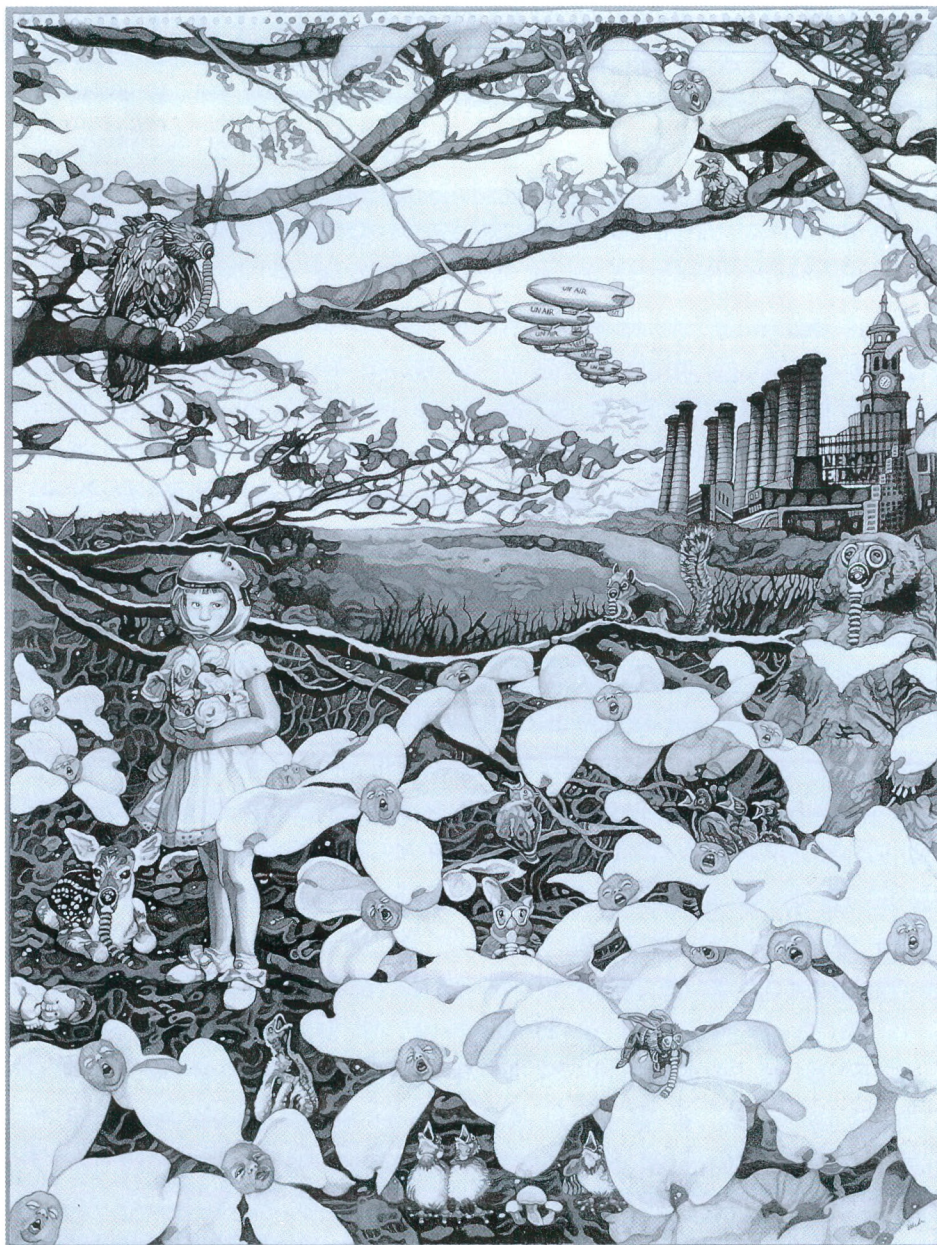
tion to this extent. I believe that White's fundamental requirement, that we overcome our anthropocentrism, can be met in a way that is both more biblical and more relevant to our present needs than the strict egalitarianism for which White seems to call.

The normal way to reform Christianity is to return to the biblical sources and discern features of our heritage that have been neglected and obscured. With respect to anthropocentrism, this process proves fruitful. Contemporary biblical scholars have shown that even Genesis 1:28 is far less anthropocentric than has been assumed. They have demonstrated that the ideal of kingship in the ancient Near East, and certainly in Israel, was not one of exploitation of subjects. On the contrary, the function of the king was to serve the welfare of the subjects. Hence, whereas Genesis 1:28 assigns human beings a position of immense responsibility for the creation, their own well-being is not the only consideration. For human beings to be given dominion over other creatures does not justify what White calls anthropocentrism.

In this connection it is significant that in the creation story animals are not given to human beings for food (Genesis 1:29). It seems that only after the Fall do human beings use animals for food, and only after the Flood does God specifically authorize this more violently exploitative relation (Genesis 9:2–3). This evidence strongly supports the point that the dominion granted in Genesis 1:28 does not imply that the animals exist only for the benefit of human beings.

Many sensitive persons today believe that a more drastic change is needed. Indeed, with a somewhat different definition of anthropocentrism, this biblical view can be called anthropocentric. According to many critics, any view that locates human beings at the top of a hierarchy of creatures is anthropocentric. They object that it is hierarchical thinking in general that has turned history into a slaughterhouse, caused oppressions of all kinds, and led to the ruthless exploitation of nature. If hierarchical thinking in general, with human beings at the top of the





*Air.* Charcoal drawing by Dierdre Luzwick, 1990.

From the collection *Endangered Species* published by Harper and Row, 1992.



hierarchy, is left intact, then the fundamental Western style of thinking will continue to do its damage.

This is a serious challenge. There can be little doubt that the biblical Creation story is hierarchical. Plants are given to animals and human beings to eat, and human beings are given rule over animals. In the second account (Genesis 2) Adam's dominance is expressed in his naming of the animals. Hierarchy does not preclude a benevolent rule, but if the attitude of rule is itself the problem, then the changes I have proposed do not address it. They leave human beings in a very special place, one of clear superiority and control. As long as human beings see themselves as properly in control, advocates of egalitarianism believe, the real need of other creatures will not be met. Their need is to be free from human interference, to be respected as they are and able to live and evolve quite independently of human beings.

The history of human control has certainly justified these anxieties. But the problem may not lie in the idea of control itself but in the neglect, through all of Western history, of the decisive point that rule should be for the sake of the ruled. For Christianity to proclaim this thesis and show it as the true meaning of the Bible would be a major shift with radical consequences that cannot be judged from the past record.

Furthermore, practically speaking, there is no way to avoid human responsibility for other creatures today. The survival of myriads of species depends today on human decisions. If equality meant that each species or each ecosystem must now bear equal responsibility for its own survival, or that human beings would disown responsibility, the results would be disastrous. But there is an important point being made by the critics. If control is exercised for the sake of other species, it will express itself first and foremost in the protection and extension of habitat and the reduction of human presence in large parts of that habitat. A proper control is best exercised by providing space for freedom from overt control.

Again, practically speaking, a strict egalitarianism leads to numerous questions that have no satisfactory answers. If it means that each individual flea should be treated with just as much respect as each individual dog, then there should be no human interference in behalf of the dog. Carrying matters one step further, there should be no interference in behalf of a human being attacked by bacteria. Few proponents of equality draw these conclusions in practice, but insisting on an ideology whose implications one does not propose to follow is not healthy. It is possible to develop from biblical sources a more realistic view that attributes real value, meaning, and purpose to every creature without denying that a human life is worth more than the lives of many sparrows.

Such a view is in fact strongly supported by the Creation story itself. White is correct that this story has been read, at least in the West, as anthropocentric. But this anthropocentrism has been read into the account as much as it has been read out of it. Probably this derives from the tendency of Christian thought to focus on human salvation, especially on that of individual persons. When the creation story is read in this light, all that it says about the remainder of creation is background for the creation of human beings in God's image.

However, when the story is read without special precommitment to the all-importance of human beings and their salvation, read in the most straightforward way, it has to be understood as attributing intrinsic value to all the other creatures independently of their use to human beings. This is the meaning of the repeated assertion that God *saw* that the creatures were good. Unless God erred in this perception, this statement entails that the creatures *were* good. This cannot mean that they were morally virtuous. But it can and must mean that they had positive value in and of themselves and not merely potential usefulness to a not-yet-created being.

That other creatures have a role in the world



independent of their relation to human beings is suggested by numerous other biblical passages. Again and again it is said that other parts of the creation glorify God. And the wonders of God's providential order are often described without reference to their human benefits. The story of Noah strongly implies that God cared for all the species of creatures, not just for those that were useful to human beings.

Tendencies to anthropocentrism may be stronger in the New Testament than in the Jewish scriptures, but there are countercurrents there as well. Jesus speaks of God's providential care for the lilies of the field and of God's knowledge of the fall of a sparrow. Paul speaks of the groaning of the whole creation as it awaits redemption.

There is no question that an anthropocentric vision can develop out of the Bible. In fact it did so, and this has had its effects. But this does not commit those who carry on the biblical tradition to follow this tack. A nonanthropocentric position has at least equal—I believe superior—support from the Bible. To reform Christianity in this direction is thoroughly justified. Indeed, this reform is actively occurring at many levels of the church's life, most visibly by the commitment of the World Council of Churches to the "integrity of creation."

Unfortunately, the political and economic life of the nations is not yet affected by the theological reform. It remains thoroughly anthropocentric. This is true also of the dominant scientific and technological thinking and practice. Even if Christianity is the parent of the anthropocentric stance, its late conversion does not insure a similar conversion of the science, technology, and economics to which it gave birth.

Reform in the church is facilitated by the fact that it has never been anthropocentric in the deepest sense. It has always been theocentric. As Christians acknowledge the biblical tradition that other beings are creatures of God, that God recognizes their value and cares for them, and that they participate in praising God, it is easy for us to recognize that our

treatment of them as if they had value only in relation to us has been wrong. Our deeper convictions provide a basis for us to repent of our anthropocentrism.

Unfortunately, the reasoning that facilitates the conversion of the church does not work well among its spiritual offspring. Even if their attitudes in fact derive from an earlier reading of the Bible, they no longer accept its authority. Whereas Christians were never anthropocentric at the deeper level, these descendants were and are. Arguments against anthropocentrism can be generated from its self-destructive character and from biological theory, but the task of conversion is more difficult.

## VI

THUS FAR, NO DEFENSES OF THE BIBLE AND THE Christian tradition have laid White's thesis to rest. White may, of course, overstate the importance of ideology to the rise of technology and science, and he may overstate the influence of the Bible on the ideology that influenced this rise in Western Europe. He may underestimate the possibilities of major change in our collective behavior without ideological or religious reform, and he may overestimate how much such reform can contribute to change in practice. Continuing debate is appropriate on all of these matters. But with relatively minor qualifications, White's thesis has stood up well in the maelstrom of debate his essay precipitated.

Furthermore, his basic prescription, a reformed Christianity, one that rejects anthropocentrism, deserves support. This means that serious theological reflection is needed. White recommends the species-egalitarianism that he attributes to St. Francis, but this is not the only option. The Bible itself offers a more realistic and more practicable position. It is past time for a serious theological debate on these and related issues. The evidence provided by Jewish and Christian biblical scholars will inform that debate. ☸

## NOTES

1. A list of scholars who have contributed to this discussion includes Bernard W. Anderson, James Barr, Phyllis Bird, Walter Brueggemann, George W. Coats, Walter Eichrodt, Loren Fisher, Rolf Knierim, Odil Hannes Steck, Claus Westermann, and Walther Zimmerli.
2. The command to be fruitful and multiply in the first part of Genesis 1:28 is also relevant to the ecological crisis. It is important to question whether there are limits to the multiplication of human beings for which God's blessing calls. Whereas through much of history the increase of numbers of a people did seem to be a blessing, today the increase of global population has become a curse. It makes all other problems more difficult to solve. Increased consumption on the part of the affluent places a greater strain on the world's ability to support the human species than do additional births among the poor, but if our goal is to provide a decent livelihood for all, additional births even among the poor make the task more difficult. It is reassuring to find that on this point the classical interpretations, both Jewish and Christian, recognize that the blessing does not entail unlimited population growth (Cohen 1989).
3. Among them, for example, are deep ecologists Bill Devall, Arnold Naess, and George Sessions, ecofeminists Elizabeth Dodson Gray and Charlene Spretnak, and Buddhists Joanna Macy and Masao Abe.

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*Tears.* Engraving and aquatint by Ruth Leaf, 1945.

Collection of the Library of Congress, Washington, D.C.

# Natural Suffering, Tragedy, and the Compassion of God

Wendy Farley

HUMAN SUFFERING IN ITS VARIOUS FORMS has always appeared as testimony against the existence, the power, or the goodness of God. Though *moral evil* causes suffering that can be traced to human wickedness (child abuse, torture, murder, corporate greed), a powerful God could still be accused of allowing these injustices to be perpetuated. Yet the anguish and conflict produced by *natural evil* (like sickness and accidents, which can be traced to natural causes) offers a particularly strong indictment of God, because this suffering stems from human vulnerability in the natural world that God created.

Theodicy is the intellectual discipline that attempts to relate the power and goodness of God to a world whose beauty entices us to love it, only to have our love betrayed by destruction and death. Within the Christian tradition, suffering is understood in five different ways: as punishment for sin, as an element of a larger harmony, as purgation, as pedagogy, or as a sign of a future transhistorical

vindication and blessedness. Whatever coherence these explanations may have, they tend to obscure the tragic dimension of existence. In their attempt to preserve divine goodness, they tend to overshadow the destructive power and the raw injustice of suffering.

An alternative way of addressing the problem of suffering is to begin with the reality of suffering as an unjust, violent assault upon human beings which calls forth compassion rather than justifications. Dr. Rieux, the protagonist in Camus's novel *The Plague*, is revolted by the endless agony of death and disease endured by humanity. After watching the lengthy death-agony of a young child, Dr. Rieux refuses the priest's advice to "love what he does not understand." "No, Father, I've a very different idea of love. And until my dying day I shall refuse to love a scheme of things in which children are put to torture" (Camus 1948:196–97). Camus juxtaposes Christian justifications of suffering with Dr. Rieux's atheistic, compassionate resistance. What follows here is a Christian appropriation of tragedy as a way to interpret suffering. But in contrast to Camus, I argue that resistance to suffering is not absurd; it is the footprint, so to speak, of the compassionate power of God to redeem a suffering world.

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TRAGEDY CONTAINS AT LEAST TWO ELEMENTS: the acknowledgment that human beings are vulnerable to suffering regardless of merit, and a compassionate response to suffering (Aristotle 1954; Greene 1944:6). One adhering to a tragic vision refuses to endorse a moral design that interprets suffering as deserved or even as necessarily tending toward some larger good.

This rejection of moralistic interpretations of suffering gives rise to a distinctive ethical vision characterized by a thirst for justice and compassion. The horror of Greek tragedy is that an admirable and upright man or woman is destroyed by some power beyond his or her control—a malevolent god, a curse, the Fates, a marauding army. According to Aristotle, it is because the suffering of the hero is undeserved that tragedy produces feelings of horror and pity in the audience. Greek metaphors for a malignancy that haunts human freedom are paralleled

in contemporary philosophy by accounts of suffering as embedded in the human condition itself (Jaspers [1952] 1969; Ricoeur 1967; Scheler 1954; Cobb and Griffin 1976). In different ways these thinkers describe human existence as being structured by the coincidence of possibilities for pain and pleasure, good and evil. The very conditions that make human life possible and even pleasant make suffering inevitable. Life becomes meaningful through experiences of physical challenges and pleasures; through the enjoyment of the beauty and fierceness of nature; through care for children, friends, lovers, and family. But each of these goods cloaks a corresponding vulnerability to suffering. Every creature is subject to destruction according to the sort of thing that it is. A star's cycle of growth and

diminishment is beautiful. But human beings, unlike stars, have both consciousness and nerve endings, which transforms the natural cycles of birth, change, and death into occasions of pain and anxiety. The relational structure of human life adds yet another dimension of suffering. When a loved one is hurt or dies, suffering radiates from the suffering

person to include all those who care for her. We are doomed to live in bodies that must eventually fail us and to love what we must inevitably lose.

A tragic reading of the human condition therefore requires one to acknowledge that suffering is anonymous, indifferent to the personal worth or capacities of those it assaults; simply living in this kind of world makes one vulnerable to suffering. "The remote subject of the tragic is always the world itself, the world taken as a whole which makes such things possible" (Scheler 1954:182). A tragic sense of

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life is further heightened when suffering is recognized to be not only unlimited in scope but unlimited in intensity as well. There are forms of suffering so intense that they sear away the human personality, leaving the person maimed in spirit as much as in body. Philosopher Simone Weil describes the destructive power of suffering in her essay "The Love of God and Affliction":

The great enigma of human life is not suffering but affliction. . . . It is not surprising that disease is the cause of long sufferings, which paralyse life and make it into an image of death, since nature is at the mercy of the blind play of mechanical necessities. But it *is* surprising that God should have given affliction the power to seize the very souls of the innocent and to



possess them as sovereign master. At the very best, he who is branded by affliction will only keep half his soul. (Weil 1977:441)

The price of all of life is the anguish of final parting: from happiness, from loved ones, from existence itself. And yet this price is paid out in the unique suffering of individuals, whose anguish cannot be absorbed into a larger scheme of things. A theoretical interpretation may make suffering intelligible, but it does little to make it more bearable. However much one might understand how suffering in general illustrates essential structures of existence, particular suffering is experienced as unnecessary and as foreign. Our theoretical vulnerability is realized in its awful concreteness in the suffering of each individual human being. Essayist Annie Dillard provides a powerful example in *Holy the Firm*:

The plane snagged its wing on a tree, fluttered in a tiny arc, and struggled down. . . . It fell easily; one wing snagged on a fir top; the metal fell down the air and smashed in the thin woods where cattle browse; the fuel exploded; and Julie Norwich seven years old burnt off her face.

Little Julie mute in some room at St. Joe's now, drugs dissolving into the sheets. Little Julie with her eyes naked and spherical, baffled. Can you scream without lips? Yes. But do children in long pain scream? (Dillard 1977:36)

Affliction draws out of the victim and her or his loved ones a cry from the soul: "Why me?" or "Why her?" Simone Weil asserts that "the part of the soul which cries 'Why am I being hurt?' is on the deepest level and even in the most corrupt of men it remains from earliest infancy perfectly intact and totally innocent" (Weil 1977:335). This cry is testimony against the "naturalness" of suffering; the cry registers the experience of suffering as unjust. Julie Norwich's mother is unlikely to remind herself calmly that, as the prophet Isaiah says, "all flesh is grass." To the contrary, she is more likely to cry out from the depths of her soul against a world order that

could subject her child to such meaningless and intolerable suffering. Vulnerability to suffering and affliction is, paradoxically, both inevitable and alien. This combination of ubiquity and injustice renders suffering absurd; it is an alien assault of meaningless suffering destroying human persons for no reason, for no greater good, and yet it is embedded in the situation of human existence itself.

Tragic vision does not rest with a simple acknowledgment of the destructive suffering that threatens all human life; such an analysis by itself could lead to cynicism or despair. Attentiveness to the horror of suffering disabuses us of the incipient belief that people who suffer in some sense deserve their suffering. An association of suffering and wrongdoing finds expression in some classical and contemporary religious writing (the cornerstone of much Reformation theodicy is this association of divine justice and human suffering); but it is also evident in ordinary responses to suffering. "Mr. Johnson down the street just had a massive heart attack." "Well, he was terribly overweight." The spark of compassion that might spontaneously flicker in one's heart at the news of another's pain or grief is preempted by this tacit moralizing. Only through attentiveness to the random and intense power of suffering can the temptation to moralize be replaced by compassion.

Tragedy's preoccupation with suffering arises from an ethical center. Compassion is that ethical center; compassion gives one eyes to recognize the sorrow of the human condition bound to death and suffering. In seeing this sorrow with the eyes of compassion one is empowered to respond to the other person with concrete comfort and aid. Recognizing the ubiquity of suffering need not degenerate into fatalism or cynicism but rather can culminate in resistance to suffering.

The Hebrew prophets, the resistance workers during World War II, and civil rights workers of the 1960s are examples of people laboring to overcome injustices that destroy human life. But in what sense can resistance occur when the cause of suffering is as intractable as nature itself? Resistance to



“natural” suffering will, of course, first mean providing whatever healing is possible: nurture of the sick, alleviation of pain, mending of broken bones. But in addition to defending the human body against random assaults of pain, compassion must also mediate comfort and courage. Philosopher Gabriel Marcel contrasts hope with despair in a situation where freedom from suffering cannot be expected. When real change is impossible, resistance is the refusal to accept “the inner determinism . . . threatening when the trial is upon me to change me into one of those degraded, abnormal and . . . hypnotized expressions of human personality produced by despair” (Marcel [1951] 1962:41). Not only is suffering the experience of sheer pain, it is an assault on the dignity or personhood of the human being. Courage to endure suffering and to comfort sufferers marks redemptive possibilities, as meaning and love are sought in the midst of the anguish of grief, pain, and disease. The compassionate presence of another person can help empower sufferers to resist the effects of suffering, even when the suffering itself cannot be completely overcome. The presence of one person to another can help steal from suffering its final victory of despair.

This tragic reading of the human condition in which irrational, random suffering unevenly afflicts human beings makes it all the more difficult to understand the attribution of creative power to God. For people who are religious, God names the ineffable source of life, justice, and beauty. This power is symbolized in the biblical myth of creation when God calls the cosmos into existence with a word and then affirms its goodness: “And God saw everything that he had made, and behold, it was very good” (Genesis 1:31). Likewise, in the Neoplatonic philosophical tradition the beauty of the world testifies to its creation by God. Augustine, equally influenced by Neoplatonism and Genesis, writes:

I asked the sky, the sun, the moon, and the stars, but they told me, “Neither are we the God whom you seek.” I spoke to all the things that are about me, all that can be admitted by

the door of the senses, and I said, “Since you are not my God, tell me about him. Tell me something of my God.” Clear and loud they answered, “God is he who made us.” I asked these questions simply by gazing at these things, and their beauty was all the answer they gave. (Augustine 1961: bk. 10, chap. 6)

But if one acknowledges the tragic structure of finitude, how is it that the world can testify to a benevolent creator as its source? The chaotic injustice of suffering would seem to witness to Camus’s starkly empty cosmos rather than to the loving and just deity of Jewish and Christian faith. “Since the order of the world is shaped by death, mightn’t it be better for God if we refuse to believe in Him and struggle with all our might against death, without raising our eyes toward the heaven where He sits in silence?” (Camus 1948:117–18).

The great medieval scholastics had an answer to Camus, one that is similar to a theistic tragic vision. Thomas Aquinas admits that the presence of evil is apparent testimony against the omnipotence of God. He argues, though, that what may be a “defect” with regard to a particular creature enhances the good of the cosmos:

Since God provides universally for all being, it belongs to His providence to permit certain defects in particular effects, that the perfect good of the universe may not be hindered, for if all evil were prevented, much good would be absent from the universe. A lion would cease to live, if there were no slaying of animals; and there would be no patience of martyrs if there were no tyrannical persecution. (Thomas Aquinas 1911, vol. 1: Q. 22, art. 2, reply 2)

Although he does not put it this way, the implication is that it is logically impossible to create a world free from suffering; such a world would be bereft of most of what would give value to creation. A tragic vision shares with this classical theodicy a sense of the inevitability of suffering. It is this inevitability which, in a sense, “justifies” God as creator. God can do all that can be done, as Thomas argues. But to create a capacity for pleasure that will always be free





*Weeping Man.* Graphite drawing  
by Adolf Friedrich Erdmann von Menzel, c. 1859.

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from pain, or a social being free from loss, or a creature that participates in the natural world but is free from conflict or danger—these things are not possible. They belie the very meaning of created being. Just as killing is intrinsic to the meaning of being a lion, so it is intrinsic to the meaning of finitude that it is mortal. One need not attribute malevolence or impotence to deity because humanity suffers grief and pain. Rather, divine power is itself tragically structured. The divine *eros* for creation is structured by the other which is called into being. The other of God is, by definition, not-God; it is finite and contingent. God draws creation out of nonbeing, as the ancient doctrine of creation from nothing argues. But God cannot heal creation of the wound of nonbeing that cir-

cumscribes its existence. To exist as other than God is to exist out of nothingness and to be vulnerable to destruction.

Just as proposals regarding the tragic structure of human existence may make suffering intelligible, if not bearable, the tragic structure of divine love functions in a similar way. But it is redemption more than understanding for which sufferers thirst. Compassion emerges again to describe resistance to suffering, this time as a metaphor for divine power. Compassion is a way of interpreting God's relationship to the world which acknowledges the fact of suffering but which also recognizes suffering as evil and therefore requiring redemption.

Compassion describes the power of love as it is present to suffering. It means literally to "suffer



with.” That is, through compassion one is immediately present to a suffering person mediating comfort, courage, endurance, or love. The description of divine power as compassionate suggests an intimacy that can occur between God and sufferers which weaves the fecundity of divine presence into a situation of violation and destruction. “Men struck down by affliction are at the foot of the Cross, almost at the greatest possible distance from God” (Weil 1977:444). But

God created through love and for love. God did not create anything except love itself, and the means to love. . . . Because no other could do it, he himself went to the greatest possible distance, the infinite distance. This infinite distance between God and God, this supreme tearing apart, this incomparable agony, this marvel of love, is the crucifixion. (Weil 1977:444)

For Simone Weil, the crucifixion of Christ expresses the presence of God at the furthest distance from God’s self, in affliction, in the depth of suffering itself. The soul ravaged by suffering can be healed only by the real presence of compassionate power, just as bodily thirst can be quenched only by the taste of water. Compassion is the presence of God in the recesses of the human soul wracked by affliction. But healing occurs within the perimeters of creation and not as alien to it; some hurts cannot be healed. Redemption does not mean that the forces of nature will no longer have power over human beings, that fire will cease to burn children’s faces or sickness will no longer exist to tether them to death. “Even the grace of God himself cannot cure irremediably wounded nature in this world. The glorified body of

Christ bore the marks of nail and spear” (Weil 1977:444). Pain is dehumanizing; it pins human beings to their bodies and mocks pretensions to freedom. It is a vise clamped on the soul to prevent any exodus from the sovereignty of its terror. But redemption contests this sovereignty. In the extremities of natural evil where no hope is possible, compassionate power is there to bear the pain even if it cannot be eliminated.

As I write these words, I feel their coldness and compare their poverty to the wealth of anguish I would feel if, for example, my daughter, Emma, should be hurt. Like all human beings, I yearn for a time when God will “wipe every tear from their eyes, and death shall be no more, neither shall there be mourning nor crying nor pain any more, for the former things have passed away” (Revelation 21:4). But in this world, in an order “shaped by death,” the penultimate victories in which the degradation of suffering is even temporarily defeated are signs of the nonfinality of evil. Compassionate power enables the terminally ill person to defy the despair which her condition would seem to demand. It empowers parents to survive the suffering or death of their children. Nothing can take away the cruelty or pain of such suffering, but compassionate power makes it possible for meaning, healing, or love to transcend tragedy. Through it the hollow absurdity of Camus’s cosmos may be superseded by a beauty that survives even the ravages of radical suffering. And when we participate in the work of alleviating human anguish, we can taste something of the empowering presence and beauty of the divine life as it is perennially incarnate in the redemption of this world. ☸

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*The Mirror.* Color lithograph by George Tooker, 1975.

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# What Kind of Phoenix? Illness and Self-Knowledge

Arthur W. Frank

In order to keep me available to myself, and able to concentrate my energies upon the challenges of those worlds through which I move, I must consider what my body means to me.

Audre Lorde, *The Cancer Journals*

HUMANS ARE STORY-TELLING CREATURES, and the stories ill people tell have a particular urgency. My epigraph is taken from Audre Lorde's account of her experience of breast cancer (1980:65). Her story is not only of fear and physical pain but of her crisis of self-knowledge: cancer and its treatment undermine her sense of who she is. As Lorde writes of her need "to keep me available to myself," her writing itself is one way she meets this need. In making her experience known to others, she creates new terms of availability to herself. Her story is the method of her self, and her self is both the possibility and product of her story.

Serious illness, whether critical, chronic, or traumatic, deserves to be called serious when it

changes the story an ill person tells of him- or herself.<sup>1</sup> The teller's past is revised to culminate in the illness, and the future now anticipates illness's effects. Telling the new story means responding to the question, "Who will I become as a result of what has happened?" The response to this question is less an answer than a figure or metaphor. The self-to-be can rarely be delimited or defined, but it can be evoked. Telling stories about ourselves is one means of evoking our (revised) possibilities.

The ethicist William F. May provides a powerful metaphor for the changes of self that illness instigates. May is writing of the most catastrophic illnesses, those changing the body so radically that the self must completely rebuild the terms of its own availability:

If the patient revives after such [life-threatening] events, he must reconstruct afresh, tap new power, and appropriate patterns that help

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define a new existence. One cannot talk simply of a new accessory [prosthesis] here, a change of venue there, but . . . of a new Phoenix that must emerge from the ashes. (1991:22)

May's Phoenix metaphor describes the case of "Dax," who suffered burns over two-thirds of his skin, including his entire face, eyes, and ears, and was kept alive despite his protests. The Phoenix metaphor of arising from one's own ashes is so literal in Dax's case that it is cruel. The risk of any such metaphor is to lose real embodied suffering in literary allusion. The metaphor's possibility is to honor Dax by presenting him as achieving what earlier generations took as possible only for supernatural beings. The more high-tech the medicine, the more we may need a mythic imagination if we are to grasp the reality of what is being experienced.

Few illnesses bring Dax's level of total bodily annihilation, but illness narratives repeatedly echo what Cornelius Ryan wrote the morning after he had been told he had cancer of the prostate: "The diagnosis changes everything" (Ryan and Ryan 1979:19). Emmanuel Dreuilhe expresses his own change in terms closer to May's Phoenix: "Our new date of birth is the day when we discovered that we carried AIDS inside us" (1988:151).

Such statements provide compelling witness that there is an experience of change, but they do not specify what this change is. That specification is not easy, and May himself recognizes the inadequacy of his Phoenix metaphor. "The Phoenix remembers nothing of its former life. The burn victim, however, remembers his past. The persistence of memory both establishes continuity with his past but also reinforces his sense of distance from it" (1991:24). What kind of a Phoenix *is* the ill person? Given the persistence of memory, how much can a self change?

Of course more persists than just memory; the physical body persists, and other people persist. Dax's surgical reconstruction is so radical that his physical body may persist only as memory, but his case is extraordinary. Most ill bodies retain a strong continuity with their former appearance and

functioning, despite the distortion and even mutilation that illness forces on these bodies.

There is also continuity in the circle of those around the ill person: family, friends, co-workers, and others. This circle changes; new people—nurses, physical therapists, doctors—are added while others defect, but there is continuity. This continuity can be both a blessing and a curse. Friends from before illness can assure the ill person that he is still valued, but they equally remind him of what he no longer is. Gilda Radner writes: "No one recognized me at all. I began to introduce myself as 'I used to be Gilda Radner.' That was how I felt. I used to be her, but now I was someone else" (1989:135). Few of us expect, as Radner did, to be recognized by strangers, but Radner's "I used to be her" is shared by all those whose faces are made puffy by drugs, whose hair has thinned or fallen out, whose step has become uncertain, and who now live with fatigue and pain.

The self that has been so changed can be restored, but this is not a return to what was before. No matter how completely "cured" the body is, the memory of trauma haunts the recovered body just as the memory of health haunted the ill body. To deal with this loss, the ill person must try to change. If she can no longer be what she was, she must become . . . what? The illness narrative is both a means for working out what she must become and a display of what has been worked out. Like any narrative, its writing is an act of creating a new self and presenting this self to others. Thus the narrative is a self-discovery that becomes a demand on others for the recognition of that newly discovered self.<sup>2</sup>

Again, the Phoenix metaphor is extreme; most ill people balance continuity with re-creation. The tilt of this balance can be in either direction. In some stories of illness, the writer discovers a self "who I always have been." In others, a self "who I might become" emerges from the story. The importance of this subtle distinction is for those who want to be able to hear illness stories more closely. As we chase the difference between these two types of narrative selves, we can begin to understand just how the Phoenix can emerge from the story of illness.



## “Who I Always Have Been”

TO WRITE ABOUT ONESELF, especially for publication, is to deal explicitly with what most people leave implicit: that the self is a *persona*, a character both spontaneous and self-conscious, a face prepared not only to meet other faces but also to reflect the self to itself. Serious illness throws that *persona* into doubt. The self wonders if it can sustain the old face, while others wonder what face they will be presented with.

This *persona* presents particular foreground attributes of a self that also has its background. Any presentation of self always accentuates some attributes of the self and downplays (to the extreme of concealment) others. This is not sociopathy but simply editing; in life as in story telling, we can only take up so much of people's time, and we have to choose what to show them. Moreover, we have only so much time ourselves, so we have to decide what to be.

The relation of the *persona* to the self is summarized in the following quotations, in which authors reflect on putting their lives and illnesses into narratives:

It was all written by me, but it was written by different mes.

Stewart Alsop (1973:x)

I have learned that the boundary between fiction and nonfiction is not as discrete as I once believed. We continually shape and reshape the raw material of our personal experience.

Sue Nathanson (1989: Author's Note, n.p.)

I didn't exactly lose contact with objective reality. There was just so much more going on.

Mark Vonnegut (1975:107)

These writers make explicit what every ill person experiences: many mes, continually shaping and reshaping much more material than can be expressed in a story that necessarily effaces the boundary between fiction and nonfiction.

In his work on narrative and the self, sociologist Norman Denzin emphasizes the importance of epiphanies, defined as “interactional moments and experiences which leave marks on people's lives. In them, personal character is manifested. They are often moments of crisis. They alter the fundamental meaning structures in a person's life” (1989:70). Illness can be such an epiphany, and the question is how the crisis of illness alters the “fundamental meaning structures” of the ill person's life.

The epiphany of illness does not, however, go without saying; changes in the self must be consolidated through story telling. In these stories the old foreground and background shift: the sickness that was only a background possibility now takes over the foreground. Whatever his or her former *persona*, the teller demands to be known, at least for a while, as an ill person.<sup>3</sup>

In the “who I always have been” narratives, the old foreground reemerges in a form that is redefined but clearly continuous between the old self and the new. This “who I always have been” narrative describes the person's discovery that the self already has the resources necessary to deal with the crisis, though the old self may not have understood how variously useful some of its resources were. Thus the new circumstances can be adequately handled with the old foreground remaining foreground, albeit with a changed emphasis in the meaning of some of the foreground elements.

Two very different narratives can illustrate this style of self-knowing: Audre Lorde's *Cancer Journals* and Robert F. Murphy's *The Body Silent*. Their differences illustrate how difficult it is to specify what background factors determine how an ill person comes to know him- or herself. Besides the authors' differences of race and gender, Lorde is writing about her critical illness, breast cancer, while Murphy writes about a chronic illness, the growth of a benign tumor in his spine that renders him progressively more paralyzed. Lorde finds her body and her life changed within the space of weeks, while Murphy's physical deterioration takes place over decades.

Despite these differences, for each, illness rein-



forces the existing sense of the self. This hardly means that illness does not bring immense changes to each's life. Murphy is finally a quadriplegic, writing on a word processor while strapped in a wheelchair. Lorde finds she has a new sense of time. "Living a self-conscious life, under the pressure of time, I work with the consciousness of death at my shoulder, not constantly, but enough to leave a mark upon all of my life's decisions and actions" (1980:16). She must also live with a consciousness of loss: "Any amputation is a physical and psychic reality that must be integrated into a new sense of self" (1980:16). Thus Lorde and Murphy must each become some kind of Phoenix.

But *what* seems to be new about Lorde's self, and Murphy's, is the discovery of what was fundamental to the self that always was. Audre Lorde finds her postmastectomy identity where she has always identified herself, in her embodied expression of difference. Her *persona* has been that of a black, lesbian poet, writing to instantiate her position of difference in a society that refuses to give positive identity to her race, her gender, her sexual orientation, and even her work as an artist.

The *persona* she has created for herself is carried into her illness in the rhetorical question she asks herself after her mastectomy, "How did the Amazons of Dahomey feel?" (1980:35; see also p. 45). This mythic metaphor of self—the one-breasted warrior woman—is powerful for her as she begins to construct a politics of cancer. She understands the breast prosthesis that medical professionals try to get her to wear as the same demand for sexual homogeneity that she has always resisted. In her new venue of resistance, she refines the self she has been and begins to live again. Her earlier Amazon identity takes a further step in its embodiment: the body's amputation becomes the self's progression.

Except that he also lives in New York, Robert Murphy shares few demographic characteristics with Audre Lorde. Murphy was an academic mandarin, chair of the anthropology department at Columbia, before he became incapacitated by his tumor. He is forced to retire from teaching but

continues to write, understanding this as a natural progression of what he has always done:

This book was conceived in the realization that my long illness with a disease of the spinal cord has been a kind of extended anthropological trip, for through it I have sojourned in a social world no less strange to me at first than those of the Amazon forests. (1987:ix)

Like Lorde, Murphy eventually finds the perfect metaphor for his new self in his previous work: "And my narration bears an eerie resemblance to the myth-telling of the shamans of the . . . Peruvian Amazon, who . . . relate their myths while holding their bodies absolutely motionless" (1987:222). Murphy's *persona* certainly has changed, from powerful department head to wheelchair-bound dependent. But in that change he refines what he always was, the teller of myths. Unable to do "outside" research, the anthropologist who wrote about shamans becomes a shaman himself, journeying within. Murphy, like Lorde, discovers the self he always has been, and that knowledge is the claim of his narrative.

In both Lorde's and Murphy's narratives, the Phoenix is not a new bird but rather the old one reformed. Illness for each is a fire, but the fire burns off the superficial accoutrements of an old self to reveal a core within. The narrative serves to rebuild the life around this core.

## "Who I Might Become"

IN THIS SECOND GROUP OF NARRATIVES, the ill person finds his or her pre-illness self to be inadequate in the face of the knowledge that illness has brought. Oliver Sacks, writing of his recovery from a traumatic injury to his leg and reconstructive surgery, asserts the discontinuity of his self: "But I knew that something momentous had happened, which would leave its mark, and alter me, decisively" (1984:197). Through the accident, Sacks learns the primacy of *experience* in illness; the physician as physiologist becomes the physician as



phenomenologist. He can no longer view disease from without but now will have to ask himself what the patient is living through, and construct a treatment from within that perspective.

The difference between Sacks's transformation and Murphy's is subtle but real. Murphy already had the metaphor for what he became; his post-illness self could be understood in continuity with his pre-illness self. Sacks searches his collection of great neurological texts, but for all the insight he finds there, he ends by differentiating any self-image he could take from those texts from what he must become. "If Sherringtonian neurology was the study of 'trigger puppets,' and Lurian neurology the study of self-activating robots, I had to go beyond these to a *neurology of the soul*. . . . I had indeed found 'a new

field . . . a new and true way of thinking'" (1984:219, 222). Murphy reconceives his old self, but Sacks imagines himself as distinctly new.

Most of the authors of illness narratives are previously published, though for many the illness narrative was their first first-person book. For those who took up professional writing only after their illness, writing itself is an act of becoming a new self. Writing of himself in the third person, Christopher Nolan describes this change: "Access to the normal world came through Joseph's breakthrough to written creative musing" (1987:3). Joanna Baumer Permut suggests how writing, as a vocation compatible with her chronic lupus, became a link between her capacity to reengage with others and her own acceptance of her illness. Through writing she grew "less ashamed of having lupus." Lupus had forced her to give up her earlier employment and the identity that went with it; "Now I could say I was both a poet and an editor. . . . I had the courage to talk" (1989:123). Writing was a part of the self that was deep background, closed off after a high school poetry class; as

it became foreground, a new *persona* formed. The self-knowledge that interests Permut is not who she was but who she can continue to become.

Perhaps the most radical shift in the self's foreground and background occurs in Sue Nathanson's narrative of her trauma caused by an abortion and tubal ligation. These were elective procedures, carried out with Nathanson's full consent, and no distinctive medical horrors took place.<sup>4</sup>

But Nathanson did not anticipate how much anguish the renunciation of her future baby, coinciding with the end of her fertility, would cause her. Although she was a professional psychologist with a career and several children, her energies remained invested in child bearing and raising. She required a new self in order to become the person

who not only had lived beyond child bearing but had cut off that possibility before its time.

Nathanson finds this self through women's groups and specifically through the feminist literature on goddesses. Her self-understanding is complex: she does not regret her decisions, but she also believes that her abortion was murder. Her interpretations of ancient myths allow her to reframe her maternal identity to include the necessity of killing. Counseling a younger woman who has had an abortion, Nathanson articulates her own emerging sense of self.

I'm coming to believe that the terrible and dark feelings of guilt over renouncing that life—murdering it—need not be experienced in a self-destructive way. These dark feelings can provide a valuable access, a trap-door, into what I'll call: the realm of the feminine, a realm that now remains outside of our patriarchal culture. In fact, without these painful feelings, there's often no access to this realm, because

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women have had to adapt to our existing society and disregard their own experience, often with great unconscious cost to themselves. (1989:206)

Rather than remaining suspended in the contradiction between her self-image as a mother and her certainty that her abortion was murder, Nathanson discovers a self in which murder can be part of the maternal role: "Women have to . . . accept the consciousness of having the power and capacity to choose to end a life that is also part of their very being" (1989:209).

Nathanson's abortion and tubal ligation were amputations as real to her as Audre Lorde's mastectomy was to her. Suffering cannot be compared; Nathanson loses no skin, but no less than Dax, the burn victim, she must reconstruct a new self in order to go on living with what she had become. Her position on abortion and the maternal is the achievement of that self.

Nathanson reaches into what was the most repressed part of the background of her precrisis self and draws into the foreground the most disturbing image—the mother as murderer—in order to reclaim herself as she now is. Whatever continuities with her former self remain, Nathanson as a woman, a psychologist, and a spiritual being claims the primacy of the discontinuities. The penultimate chapter of *Soul Crisis* ends with the women among whom she has developed her new spirituality taking her to a ritual they devise, "to complete and heal the experiences" (1989:278). The chapter's last words are those of her friend, who says, "The ritual begins now" (1989:282).

## Alternative Self-Knowings

THE DISTINCTION BETWEEN THESE TWO TYPES of selves is a heuristic device to draw readers further into the epiphany of illness. Some narratives blur my distinction, and a few seem outside of it entirely. The latter include those authors who remain ambivalent

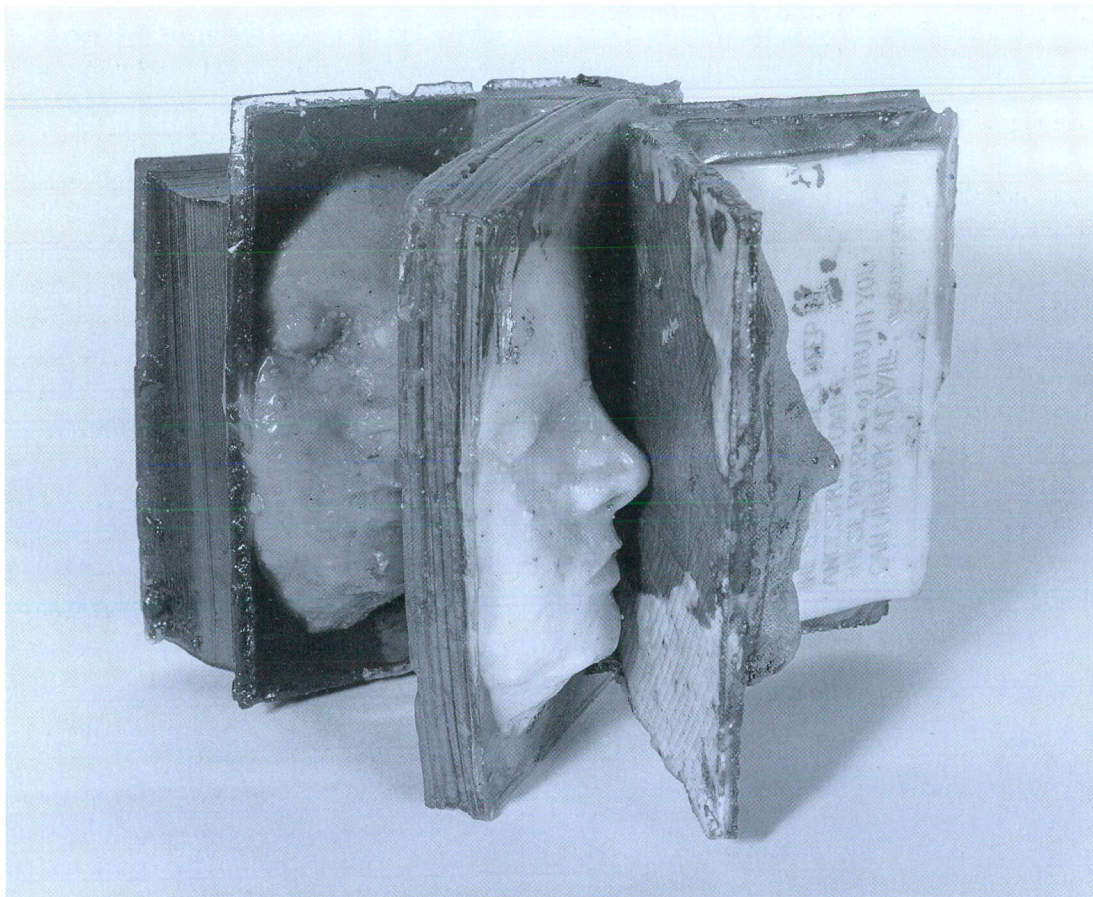
either about whether they have changed at all (for example, Heller and Vogel 1987) or about how they have changed, other than in instrumental ways (for example, Mullan 1975:195). In this ambivalence, they may be closer to the experience of most people who have recovered from serious illness. Their crises have simply not been, for them, the imperatives to change that the same medical events might be for others.

For people like Lorde, Murphy, Sacks, and Nathanson, the crisis of illness brings too awful a knowledge to allow them to go on living as they had been. The new self may be a reforging of what was previously the core of what they always were, or it may be the discovery of something they understand as completely new. But for them not to change would be impossible; the old self simply could not contain what the new self has experienced.

In a final group of narratives the self has changed, but over a very long time. These narratives represent what Denzin calls "cumulative epiphanies" (1989:71). Such narratives necessarily tell of chronic conditions, beginning in childhood or early adulthood with the narrative written years later. Both John Updike's (1989) essay on his lifelong psoriasis and Arnold Beisser's (1988) narrative of his life as one of the last of those disabled by polio present whatever each has become as having been achieved in and through illness. Illness, at least by the time of writing, is not a change for the self, it is the medium of the self.

But—again to suggest there are no rules in self-discovery—not all chronic illness narratives written over a perspective of many years tell this sort of story. Irving Zola, like Beisser, was one of the last disabled by polio. But his 1982 narrative suggests another variation of the two groupings above. Zola, a sociologist, describes a professional visit he makes to a community for the disabled in the Netherlands. Surrounded by other disabled persons, he recognizes for the first time the full implications that his own disability has had for his self. Where Lorde and Murphy use their discoveries of the selves they always have been as a way to live through and beyond





*Metamorphosis.* Polyester resin by Stella Waitzkin, 1974.

Collection of the National Museum of American Art, Washington, D.C.



their illnesses, Zola discovers the self he always has been in order to reclaim illness as part of his self. Reclaiming the disabled person he always has been, he gains renewed vision of the self he might become.

It hardly matters to Zola what “type” his changed sense of self falls into. The “who I always have been” and “who I might become” are a ladder that can and should be kicked away, once climbed. What does matter to Zola, and to all those who tell stories of their illnesses, is that these stories *create* the selves that illness has both allowed and forced them to become. For the self of the ill person to remain available to him- or herself, it must be told, and others must hear.

## Why Does Self-Knowledge Matter?

AS I HAVE RETOLD THE STORIES ABOVE, I have picked them up *in media res*, at what is often the end of the narrative but the beginning of the life, in the sense that Dreuilhe dated his new life from the moment of his diagnosis. By moving directly to the point when a new self is understood, I have left out the process of arrival at that self-understanding. This process is what the narrative *is*.

The attention to illness as a *process* of self-understanding is one of the essential shifts of emphasis in a “narrative medical ethics” (Miles and Hunter 1990). Why we need a narrative ethics is clearly stated in May’s (1991) criticism of the decisionist bias of present medical ethics:

Moralists accordingly have produced impressive work on confidentiality, truth-telling, conflict of interest, pulling the plug, and the like. But this approach does not offer much insight into the ordeals confronting patients that do not wholly admit of solution. Such problems must be faced rather than solved. (1991:3)

*Ad hoc* situations will continue to require an ethics of problem solving, but May reminds us how these problems are only the beginning of the life with illness that can only be “faced rather than solved.” Lorde’s and Murphy’s metaphors for their ill selves, Sacks’s sense of calling to a new neurology, Permut’s writing, and Nathanson’s goddess worship are all attempts to *face* the lives that illness has left them with. These stories by ill people about their suffering are, I want to argue, the core texts of any narrative ethics. From these texts, professionals can begin their own learning.

Medical ethics too often begins from the perspective of health care providers. In its stories, ill people are more often told about than they are tellers. Again May best elucidates this difference in what is relevant to lay people versus professionals, patients versus physicians.

Once they [experts] solve a problem, they move on to other, perhaps different, certainly new quandaries. As they handle cases, they enhance their expertise and sharpen their skills, but, traditionally conceived, they themselves do not usually change. In a sense, *qua* expert, they have little history; self-transformation is not usually at issue. (1991:6)

The key phrase here may be “traditionally conceived.” Fortunately, the conception is changing, and physicians are acknowledging that they too have histories, of which their present patients become parts. But May’s point remains, leaving us with a gap. The effect of illness is to require the ill person to change, while providers, *qua* experts standing outside those effects, do not define self-transformation as part of their activity. The implications of this gap extend across treatment, counseling, ethics, and politics. Leaving treatment issues for another occasion, I will suggest some questions of counseling, ethics, and politics.

Counseling ill persons should not be “therapy” in the conventional sense of intervening in order to address and resolve problems; it ought to be a process of witnessing and inviting change. This statement



should be too obvious to mention, but in the current medicalized milieu, it requires emphasis. Those who counsel the ill often take their lead from physicians. But as May suggests, physicians *qua* experts do not define their activity to include personal change. Not concerned with change in themselves, they too frequently fail to recognize change in the selves of their patients.<sup>5</sup>

The medical ideal is too often the *status quo ante*, not the Phoenix. To assist at the birth of a Phoenix is to initiate a process that cannot be controlled; it is, as it should be, more than a little frightening, or to use another phrase of May's, "a mystery more than a puzzle" (1991:4). Far safer to turn the case into a puzzle, even if this is not the reality for the ill person. The counselor needs the willingness to encounter mystery and to allow herself to be changed in the process of this encounter.

Of course many ill persons will resist change in themselves. Does too much talk of Phoenix possibilities simply place another demand on them? I would reply first, and with regret, that these people are not going to read this article or the books it discusses anyway. A more important response is the primary need to provide resources for those who *are* struggling to put their illness experiences in narrative form and need models for doing so. This struggle takes us directly to the politics of illness, and I want to argue that politics is a much neglected aspect of medical ethics.

The epigraph from Audre Lorde that began this article continues as follows: "A mastectomy is not a guilty act that must be hidden in order for me to regain acceptance or protect the sensibilities of others. Pretense has never brought about lasting change or progress" (1980:65). The problem with

any one person's pretense is that it cannot be theirs alone. Any person's pretense recreates the milieu in which others have to define themselves, and thus it is a political act. Pretense, as Lorde says, will never bring about lasting change or progress for those who will become ill after them.

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Lorde's reference to pretense is specific. She is offended at being coerced into wearing a breast prosthesis—even to the point of having doctors threaten to deny medical follow-up if she does not accede to their demands. She argues that "prostheses are often chosen, not from desire, but in default" (1980:65). The ill person defaults to the medical-social demand when she senses a confrontation she lacks the energy for.

Following Lorde, and generalizing her argument, we can speak of society's "prosthetic demand" that the seriously ill return to the closest approximation of their previous lives and selves. Nathanson faces this demand when she tries to mourn her aborted child and lost fertility. The psychoanalyst she has seen for years cannot acknowledge her mourning for just what it is: the cry of immediate, sensuous loss. Although one would presume that psychoanalysis is the medical practice most oriented to self-change, Nathanson finds that some changes are not admissible. The prosthetic demand is that she "get over it" and return to normal analysis issues. In both her psychoanalysis, which she ends, and the rest of her life she experiences the same demand: It's over, no "complications," move on.

Many of the ill persons who write narratives are among those who are most offended by society's prosthetic demand. They make a public issue of their illnesses because they each have learned, with Lorde, that nothing is gained by pretense. Some write of



specific pretenses that have been imposed on them; others leave this imposition implicit in their narratives. Robert Murphy is one of the most explicit: “A key rule for being a successful sick person is: Don’t complain! The person who smiles and jokes while in obvious physical misery is honored by all” (1987:20). Murphy later makes the same point with specific regard to the politics of disability:

Quadruplegics cannot stalk off. . . . To make matters worse, as a price of normal relations, they must comfort others about their condition. They cannot show fear, sorrow, depression, sexuality, or anger, for this disturbs the able-bodied. The unsound of limb are permitted only to laugh. (1987:107)

The cheerful outlook, sustained out of fear, is another kind of prosthesis the ill person is forced to put on so that other people, whom Murphy calls the able-bodied, can evade recognizing themselves in the situation of the ill.

As proclamations of self-change, illness narratives not only shake the boundaries that institutions and expert knowledge place on illness, they shake the many prosthetic demands that society makes to insulate “the able-bodied” from the threat of illness. But the idea of change in the lives and selves of the ill is the only viable starting point for a medical

ethics concerned with facing problems rather than with perpetuating the ideal of solutions.

I have argued that first-person illness narratives are the core texts of a narrative ethics. Let me suggest two goals of such an ethics, goals that can be achieved far more easily together than separately. The first goal is to make available to those who are seriously ill a recognition that as their selves change, as they try to become their own kind of Phoenix, the resources of others’ stories can ease their passage. Others have already told their epiphanies, and these narratives can help guide the self-transformations of those who follow.

A second goal is to render obsolete May’s provocative charge that for experts at present, “self-transformation is not usually at issue.” Medical ethics cannot be just for experts to apply to ill persons; this split of subject and object only alienates both. But for ill persons and health care providers to share an experience of self-transformation, they must be willing to share vulnerabilities, fears, weaknesses, and pain. We must recognize pretenses and see that they serve no one.

The bird Phoenix just gives birth to itself. The human Phoenix must tell itself into rebirth and requires listeners. In the telling, these listeners can find their own epiphanies. Narrative ethics understands this collaboration as the beginning of care. ☺

## NOTES

1. In these terms an illness defined by medicine as “routine” can be “serious” for the ill person if for contingent reasons it provokes a crisis, and we might be surprised how many routine medical occurrences have this effect. The complementary question is whether some people experience life-threatening or impairing illnesses with little crisis of self. The issue, beyond the scope of this essay, is whether there was no crisis of self, or whether the person lacked the resources and support to express the crisis. My concern is with the needs of the latter.
2. Particularly for the chronically ill, changes may not be obvious. Barbara Webster (1989:40) cites a publication of the National Multiple Sclerosis Society with the indicative title “But You Look So Good.” Persons with critical disease may have the same comment addressed to them, their “normal” looks providing for the other’s denial that illness can be “that serious.”
3. As packaged with the author’s photo filling the back cover, William Styron’s *Darkness Visible* (1990) trades on Styron’s established *persona*. But then this *persona* changes in the opening pages as the prize-winning author tells of barely being able to collect his prize because of his mounting depression.
4. Nathanson’s description of standard hospital surgery under the “best of circumstances” is chilling. Part of what unnerves her after both her operations is the discrepancy between the horror she experiences and the medical definition of the same experiences as routine and successful.
5. On psycho-oncology counseling specifically, see Frank (1992).



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*Mr. Broe Waits His Turn.* Oil on canvas by Katherine Schmidt, 1937.

Collection of the University of Arizona Museum of Art, Tucson.



*Eighth in a series edited by Steven H. Miles  
and Kathryn Montgomery Hunter*

## *The Case* **Clint Wooder**

David Hilfiker

IT IS CLINT WOODER WHO SERVES ME COMMUNION Sunday morning at Christ House. I look up at him, and he breaks into a smile, a little embarrassed, but it is a broad, beaming smile, almost a laugh. As I take the cup and drink, he looks straight into my eyes. "This is the blood of Jesus," he says, and I feel something crack deep within. I give the cup back and try to look again in his eyes, but I can't keep back the tears.

I can't recall Clint's actual arrival at Christ House. He was one of the many middle-aged, severely alcoholic street people admitted from area hospitals to our shelter in Washington, D.C. Records remind me he was probably the worst alcoholic I'd seen in my years of work in the city, his liver devastated by years of alcoholism, his abdomen distended with the fluid of ascites. He'd been hospitalized after vomiting blood and been treated for bleeding veins around the base of his esophagus. Not

much could be done for his liver cirrhosis, though, except to wait to see if the fluid in his abdomen would resolve with rest, abstinence from alcohol, and a decent diet. He was lucky to be alive, although at the time it may not have struck him as lucky.

I don't remember him early on, but he was probably like the others—lying low during his first days at Christ House, trying to figure out just what our angle was. He would lie around in his bed, leaving only for the dining room downstairs, heaping up huge plates of food (not quite trusting there would be a next meal), trying to remain inconspicuous among the 33 other homeless men recovering from their own afflictions. The first I do remember of him was an examination some weeks later.

Clint was a white man in his mid-forties, about my own age, born in the hills of Kentucky. He was tall and big and—except for the soft bulge of the abdomen—an angular man, his face scarred from previous battles, his eyes penetrating, a muted twang in his voice. When he undressed, the contrast between the dark skin on his face and hands, roughened by years on the streets, and the sickly white everywhere else was startling; the skin over the abdomen was stretched thin, shining, almost translucent, a reminder of the inexorable illness below.

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Clint was different from many of the others: he didn't avert his eyes. I felt he was incapable of lying.

"Doc, I have no control over alcohol. I can only hope I won't drink today 'cause it's too much to think about tomorrow, too. They said in the hospital my liver was shot, an' I guess it is, an' I know what it's from. Said I almost died. I got another chance, I guess, and I'm sober . . . at least right now. I just pray to My Higher Power I can stay sober until tonight."

And then he would smile, and it was a hearty smile in spite of the stained and missing teeth, and he'd look down at the floor and back at me, and he'd laugh, and then he would try to cover over the laugh as if it wasn't quite right. I was drawn in, trusted.

All patients at Christ House are required to attend the Alcoholics Anonymous meetings in the downstairs living room Monday, Wednesday, Friday, and Saturday afternoons. Clint not only went to our four, but he also sought out as many other AA meetings as he could. "How many meetings do you go to?" I once asked him.

He looked at me with that grin, looked at the floor, and laughed. "Yesterday I went to four, an' I took the bus down to the Metropolis Club this mornin'. I can just catch the bus back to the church for the noon meetin' there. And then the one here this afternoon." He looked at me, and I suppose he saw the puzzlement on my face.

"Doc, I have no control over alcohol. I'm just a drunk an' I gotta go to meetin's all day long. I can't promise you I won't drink, 'cause I prob'ly will. I just live from day to day, hopin' I won't drink today. I can't even guarantee you that! Some day I'll just be walkin' down the street, and someone will hand me a bottle, and I'll start drinkin' for no reason at all; an' I won't stop until they carry me into the hospital. Twict now the doctors told me the next time it was gonna be the morgue, an' I suppose it is."

I tried to imagine what it would be like to live so close to the edge, to see clearly that life hangs on the thread of one's own behavior, behavior one has little power to control. I knew, of course, that we are all like Clint, all powerless before our own urges,

that our illusion of control can crack in an instant. But Clint leaned over that abyss with no safety net. I was the guide to someone from another culture: we both now lived within the same world, but our internal realities were not comparable. I could watch and nod reassuringly. I could offer advice. But I would never understand. I felt a strange privilege.

Clint stayed dry. I thought he had it made. After a few months' physical recovery in Christ House, he moved into one of the Samaritan Inns—small, transitional group homes where homeless men can stabilize themselves, find employment and, according to the game plan, move back into society. The inns, however, are closed to the men during the day, so Clint continued to eat at Christ House and volunteered there as a handyman for whatever jobs were needed. He became something of a fixture downstairs, always willing to help out, sometimes finding or creating new jobs for himself. He had to keep himself busy.

Clint was concerned about his physical health and, unlike most of the men, kept his weekly medical appointments with me. He told me a little of his past, and we would talk occasionally about his dreams: to keep a job, to support himself, to have a place of his own. I found myself fascinated by him, attracted to him, rooting for his recovery.

After six months of sobriety, Clint grew gradually more restless and agitated in our sessions. "They don't give me enough to do," he said. "I can't just sit around or I get the angry. Sister Marcella, she's watchin' me, just waitin' for me to do somethin' wrong so she can throw me out. She says she don't like Samaritan Inns in here all the time, but she's lookin' at me. An' Tony better watch his step, how he talks to me.

"I know what it is," he said as we sat in the little exam room off the downstairs hall. "It happens every time: I get the angry. Every time I get sober for a while, the angry comes, an' I have to start drinkin' agin. If I drink, it goes 'way an' I ain't got the angry no more. It's only when I'm sober. An' there's no way I can control it. You gotta do somethin', Doc, give me somethin', or I'm gonna hurt somebody. Or



else I'm gonna start drinkin' agin." And he would stand and pace the room like the panther at the National Zoo.

I began to be afraid. I did not believe Clint would become violent with me, but I could see his agitation, and I began to take seriously his earlier protestations that he was "just a drunk."

He knew more about himself than I thought. He understood that his rage went back to those early days, after his father died when Clint was two and he was reared by an older, alcoholic brother who beat him regularly. Clint could not strike back in self-defense, and no one else seemed to care. I found it hard to believe his story that he started drinking at age five, but he insisted he learned early to cover all his feelings with alcohol. Sober, he tried to contain the cauldron of feelings inside, roiling, about to boil over. Punishing himself with intoxication, he could, paradoxically, relieve his rage.

His abused childhood left Clint with unfathomed psychological chaos. At one of our sessions I finally suggested he get some help. "Clint, you're right. The angry is going to take you under. We can both see it coming, and I can't seem to do much to help you. Would you be willing to go see a counselor or therapist and spend some time talking with him? Maybe he could find some way to help."

"You mean a shrink?" His face clouded. "Hell, I'll talk with anybody. I gotta do somethin'. Maybe he can give me somethin' for this."

But I could find no trained therapist willing to work months with a homeless alcoholic who could pay nothing. In desperation I turned to the public mental health clinics.

I called a psychiatrist I knew in the city's mental health system and lobbied for Clint. My friend

assured me that he knew the best psychiatric resident in Washington (most of the public psychiatric care here is provided by resident doctors-in-training) and that he would arrange an appointment for Clint. A week later a young resident did call me to schedule

Clint's initial interview. I was relieved. I was off the hook for a while.

"It was OK," Clint said in response to my question at our next visit. "That doctor seemed OK, the psychiatrist. I kinda liked talkin' to him." He paused and looked at me; he got up from his chair and started pacing back and forth. "We didn't do nothin' about the angry, though, an' I don't know if I can last until the next one. He said he could see me for

20 minutes every two weeks."

Twenty minutes! There had to be some mistake. My own therapy had been going on now for an hour twice a week for four years. Twenty minutes of psychotherapy every two weeks would accomplish nothing for a person as psychologically damaged as Clint.

Several days later I finally managed to reach the resident by phone—not an easy trick within the city's bureaucracy. But there was no mistake. Twenty minutes was the most he could see an outpatient who was not actively psychotic. "I know it's not enough," he said with some sympathy in his voice. "But it's all I'm allowed with the mental health patients. I see most of my patients once a month. I think Clint needs lots of help, so I managed to get him on the schedule every two weeks. But if you could find somebody who could see him more often, he really needs something like that. Maybe you could try a little Haldol; that sometimes gives people a little relief."

We tried the Haldol—a major tranquilizer which succeeded only in sedating Clint—but Clint

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had gotten the message: there was no one to help him. A week or two later, while I was at the clinic, I received a phone call from Christ House. At lunch Clint had gotten into an argument and—in response to another resident's abusive language—had grabbed him by the neck, choking him. A staff person had tried to intervene, and Clint had gone after him with a crutch. Clint knew we would not tolerate violence. He had done what he needed to do to get discharged back to the streets.

The next morning, a Saturday, I didn't know what to expect as I walked over to the Samaritan Inn to confront him. I had never seen Clint angry, only traces of it beneath the surface. "Whadda you want?" he said as he opened the door. "You gonna kick me outta here?" There was no grin this time, no laugh; he only opened the door for me, then looked at the floor.

I sank down in a chair. "I'm not going to," I said. "I don't work over here. But somebody's probably going to."

"I know," he said.

"Clint, what happened over there? You know you couldn't do that. Why'd you blow it?"

"We had some words," he said, almost meekly, "and I grabbed him, that's all."

We looked at each other. This was the same person I'd met with every week for four months. I couldn't imagine him strangling anyone. "Marcella said you did more than grab him. She said you choked him; she was afraid you'd kill him."

"I told you I just grabbed him!" I watched a fire light in his eyes, something new, something which frightened me. Clint stood up. "I'm going to kill that son of a bitch. He can hide over there at Christ House, but he'll have to come out on the streets sometime, walk by an alley. An' I'll kill him." He looked at me with defiance. This was "the angry," a rageful stranger. He sat down again. Within a minute or so I could recognize him again. But the angry was close upon him; for the next 24 hours, the two selves would do battle.

I was scared for Clint, and I was scared for others. If Clint could try to strangle someone in the security

of the dining room at Christ House, there was no telling what would happen on the streets. The only alternative I could imagine to Clint's quick return to the streets and premature death was psychiatric hospitalization.

Clint's divided selves fought my suggestion of inpatient treatment. But when I mentioned St. Elizabeth's, Washington's public psychiatric hospital, his uncertainty vanished. His body stiffened, and his hands clenched. He looked me dead in the eye with an expression somewhere between rage and helplessness. "I been there onct before," he said and then pronounced every word with emphasis: "An' I ain't never goin' back there, agin. You understand? Never!" With the threat of possible commitment to St. E's hanging unspoken, I backpedaled, telling him over and over how much better a private hospital would be until finally he consented to come with me. I called to make sure there were beds available in the psych unit and drove Clint to one of the best hospitals in the city.

The check-in at the emergency room desk was brief, and Clint was interviewed promptly, in stark contrast to the six- to eight-hour waits at the public hospitals. Dr. Lilliwen, a first-year psychiatric resident, saw Clint and interviewed me briefly; she agreed that Clint needed hospitalization to protect himself and others from the rage which sparked forth from just under the surface. She left to make arrangements, only to return in ten minutes. There were no beds, she informed me.

"No," I said, and I could hear my voice breaking. "I called over here less than two hours ago, and I was told there would be no problems with bed space. What do you mean there are no beds?"

Dr. Lilliwen, a young, pleasant woman, looked flustered, obviously caught. "I'm not sure what you were told this morning," she said evasively, "but there's no room for Mr. Wooder in the unit now. Besides, the attending psychiatrist is worried about his violence. We're not a locked unit."

"Is this because he's a Medicaid patient?" I asked.

"Well, the hospital doesn't accept Medicaid



patients into the psychiatric unit. They said there were no beds for him on the floor. Let me see if I can't find someplace else that will take him." And for the next three hours Clint waited in a tiny cubicle while I shuttled back and forth between Dr. Lilliwen, who was searching in vain for admission to another hospital, and Clint, who was becoming increasingly agitated. Finally, it was clear: there was not a single private hospital in Washington willing to admit Clint Wooder even though he was one of the lucky ones on the streets to have full-coverage Medicaid. The only remaining option was St. Elizabeth's. I went back to the little room to break the news.

He interrupted me in midsentence, stood up, turned his back on me and deliberately put on his jacket. "No way! I told you I'd go anyplace else you want me to but not to that place. That's just for crazy people, an' I ain't crazy. You don't know what they do to you in there." He would not look at me.

"But, Clint, you know you need help or you're going to hurt somebody. You told me that yourself. And you know what will happen if you really hurt somebody. Prison or the morgue will be a lot worse than St. E's. C'mon, you won't have to stay in there long. We've got to get you some help."

"No way!" The answer was always the same. The longer we talked, the more agitated Clint became. Finally, he stalked out of the hospital. I followed him, trailing like a pleading child. He strode away as I struggled to keep up and reason with him. It was no use. I finally gave up at a bus stop and watched him walk away. Emotionally exhausted, I walked back to the hospital.

Lurking in the background ever since Clint's assault the day before had been the issue of involuntary commitment. It was the poorest option, but I believed Clint needed to be in the hospital in any

way we could get him there, even if commitment were necessary, and I had mentioned the possibility to Dr. Lilliwen when we first came to the hospital. Now that Clint had walked out, she raised the issue again, the attending psychiatrist was called, and they made the decision to notify the police to find Clint for forcible commitment to St. Elizabeth's Hospital. I didn't see any alternative to commitment, but I did not believe it would ultimately help Clint, either. I knew the angry well enough to know that Clint would never respond to forced help.

Clint, not surprisingly, knew what was coming and was nowhere to be found.

Clint did return to the Samaritan Inn that night, and the innkeeper called Dr. Lilliwen who—much to my

amazement—was able to convince Clint over the phone to come back to the emergency room where he was then forcibly restrained and involuntarily committed to St. Elizabeth's Hospital. I received the word with ambivalent feelings. I was relieved that Clint was finally safe in a hospital, but I also knew that the involuntary commitment would damage the trust between us, even though I hadn't been directly responsible. Knowing he was safe, however, I prepared to relax for the rest of my weekend off.

By Sunday morning, however, Clint was no longer at St. E's. The admitting psychiatrist had—without consulting with me, the psychiatric staff at the private hospital, or any of the eyewitnesses who were readily available—determined in a short interview late at night that Clint was a danger neither to himself nor to others. At 3:00 A.M. Sunday morning, less than six hours after transfer, Clint was released to the streets, and none of us who had been working intensively with him was even notified.

I was angry—angry about having wasted a Saturday off, depressed about Clint's utter lack of options, enraged that the "system" would simply

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**I was the only one surprised  
and chastened.**

**I was running out of options  
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spew Clint back into the streets without the help he so desperately needed and wanted, in despair that the trust we had nurtured in Clint had been severely damaged. A bed would have been available in the private psychiatric unit if Clint had not been alcoholic, homeless, and poor. How quickly would a middle-class person complaining of uncontrollable rage after an assault be hospitalized or provided with at least some intensive care? Once again the system had abandoned a poor person—one, in this case, truly open to being helped.

But something was happening to me, too. Something akin to Clint's childhood rage was beginning to boil now inside of me. Clint's despair over ever conquering his alcoholism infected me, too. The abuse Clint was suffering at the hands of an unjust system seemed in some way abuse directed at me. I was beginning to see and feel the world from a position at least approaching Clint's place in the universe.

Amazingly, Clint did not return immediately to the bottle. Although we barred him from Christ House because of the assault, he continued to stay at Samaritan Inn for several weeks and to meet with me. But something had indeed been lost. Clint retreated further and further into himself. He started to miss his appointments; there was less and less communication between us. When we did talk, he was sullen and resentful. One day, Clint simply disappeared. Then came word he was on the streets and drinking again.

Two weeks later Barbara Ryan, an aide at Christ House, noticed Clint on Connecticut Avenue, drunk and disheveled. She called me at the office and then persuaded Clint to travel across the city with her to the clinic, where she sat with him until I could see him.

I was rushing from one exam room to another when I first glimpsed Clint in the waiting room; I

didn't recognize him. Later, wanting to see if he had arrived, I looked back. I saw Barbara, and there was, indeed, an older white man sitting next to her in the corner; his tall body was slumped in a chair, hidden in a large, dirty coat. His face and hands were olive green, a skin color I had never seen before. His features were distorted beyond recognition.

I led Clint into the exam room. He was drunk and sullen, the energy and fire behind those eyes gone, replaced by a vacant stare.

I could think of only one thing to offer. "Clint, would you be willing to go down to detox?"

He shook his head dully, his eyes never leaving the floor. "It won't do no good. No one can help me. I'll

drink 'til I die. Besides, they won't let me in down there."

"They've got to let you in," I said. "That's what they're there for. It's public detox. They're not allowed to turn anyone away."

"They won't let me in."

"I'll take you down. Will you let me take you to detox, Clint?"

He was silent a minute, not meeting my gaze. "Yeah, but you'll see, they won't let me in."

Office hours were essentially over. I biked back to Christ House to pick up the van and returned for Clint. I half expected he would have disappeared, but he was still there, sagging into the chair in the now-empty waiting room of the clinic. He moved slowly into the van, and we drove silently. Halfway across the city, while we were stopped at a light, I noticed his hand moving toward the door handle. But he hesitated and then relaxed back in the seat. Some small part wanted to stay alive.

I walked behind Clint as he led me up the steps to the brick building on the sprawling grounds of D.C. General Hospital. It was fortunate he knew his way, for there were no signs indicating what the

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building might be or how to proceed. We rang at the door and waited what seemed like a long time for a guard to open the door and lead us silently through large, high-ceilinged, barren rooms and up to the second-floor receiving station. Clint slumped onto the bench opposite the desk while other men in pajamas straggled back and forth. I stopped a man in street clothes passing in front of us. "I've brought a man for admission," I said. "Who do I see?"

"What's his name?" he asked.

"Clint Wooder."

"Name sounds familiar," he said and looked down at Clint's slumping body. "Oh, yeah. Wooder." He turned back to me. "He'll walk out of here as soon as you leave. Ain't no reason to have him here. He signed out before, he'll sign out again."

He turned and addressed himself to Clint, raising his voice, anger dripping around the edges. "You signed out last time, Wooder. You gonna sign out again? What you come down here for? You know you ain't gonna give up drinkin'. What you botherin' us for?" Clint made no response.

I decided to ignore the attendant's outrageous hostility and asked for the person in charge of admissions. He nodded toward another man walking by. I began to explain my mission. He cut me short and led me into a cramped office.

"I'm Dr. Hilfiker," I said, hoping that the title might count for something. He seemed not to hear. "I've been working with Mr. Wooder for over six months now, but he started drinking two weeks ago. I'd like to leave him here for detox. We'll take him back at Christ House when the three days is up."

"If he wants to stay, we'll take him. We can't force nobody to stay, you know. If he wants to stay, we'll take him."

I went out and asked Clint again, afraid that the verbal abuse from the first attendant had already done its work. "Yeah, I'll stay," Clint said angrily. "I told you I'd stay, and I'll stay."

Relieved, I was on my way out of the building when a third attendant came walking out with Clint's old chart. "You'd better come back and talk with Mr. Moore," he said to me. "Wooder signed

out AMA [against medical advice] a year ago last January. He can't stay here."

I was led back again to the second attendant, Mr. Moore, who began flipping through Clint's old chart. "Yeah, I remember him now. You might as well take him. Wooder's not gonna stay here." "He said he'd stay," I said.

"He won't stay." As if to prove his point, Mr. Moore walked out to the bench across from the door. "Sit up, Wooder," he demanded in a loud voice. "You want to stay here? You left before. You gonna stay here this time?" The tone was belligerent, aggressive. I could hardly restrain myself. He continued. "You know how long you got to stay here? You sure you want to stay here?"

Clint looked up, and some of the fire was back in his eyes. "Yeah, I know how long I got to stay here. Seventy-two hours." He virtually barked the words. His voice was angry but beaten. He knew what was coming.

"You sure you want to stay here?"

Clint stood up, his hands stuffed in the oversized coat. I was afraid he was going to start swinging. "Well, if you don't want me, I'll go." He turned and walked down the hall.

The attendant returned to me. "See, I told you he wouldn't stay. He'll never change. He left AMA and he'll leave again."

I realized suddenly that this attendant and everyone else aside from Clint and me were black. The hostility spilling from just beneath the surface of our encounters was abetted by something far deeper than Clint Wooder. Clint was white, and I was white, and the men in charge were black. The anger of generations was spilling over vindictively. I tasted, for the first time, the bitterness of minority status, the powerlessness of the one excluded. I realized there was nothing I could say or do that would make any difference. Things had already been decided.

The rest of the evening mirrored those first few minutes. I went out to the end of the barren hallway to mollify Clint, who was standing by the elevator smoking. I convinced him to return and turned back



to the attendant. I asked to see the attending physician, an older white man who was just inside an open office door trying to interview a young black man obviously spaced out on something. The physician hovered about the stuporous man, asking questions to which he received no answer, touching him timorously with his stethoscope now and then, avoiding a world he neither understood nor had any desire to enter. Receiving no answers, he left quickly for his own cubicle to write papers referring the young addict to the emergency room. I supposed—with not a little rancor—that the physician was retired, trying to earn a little extra by spending a few hours a week blessing with his title the process Clint and I had been experiencing. It was one more strike against the poor: with an occasional exception, only the least competent professionals stay in the front lines. Normally the work is left to those who burned out long ago.

I was allowed in to talk with the physician. “I’m Dr. Hedley,” he said from behind his desk. He stood up and extended a thin white hand. “Mr. Moore said you wanted to see me.”

I introduced myself as a physician and mentioned my years of working with alcoholics and addicts. I told a bit about my personal connection with Clint, his history of six months’ sobriety at Christ House, his falling off the wagon in the past two weeks, the frailty of his health in general, and his willingness to enter detox. “I’ve brought Mr. Wooder here for three days of detox; we’d be happy to take him back to Christ House after that.”

Dr. Hedley smiled politely and studied the chart in front of him. “I see that Mr. Wooder left against medical advice the last time he was here. Mr. Moore informs me that there is a rule against admitting anyone who previously left AMA.”

“The last time he was here was a year ago January!” I said. “Are you saying that an alcoholic who once leaves detox is forever banned from returning?”

Dr. Hedley looked down at the chart again. “Hmm, a year ago January, yes.” He frowned. He paged idly through the chart again, put it on the

corner of his desk, and leaned back in his chair. “I’m sure you’d agree, Dr. Hilfiker, that it’s very important to be firm with the addicted person. If one begins bending the rules, one loses his authority. I’m sure you know that from your experience. There are people here who come in every weekend; I think they’re probably after the meals. If one doesn’t set limits, the system won’t work. Don’t you think so?” He smiled and leaned forward in his chair.

“Dr. Hedley, Mr. Wooder hasn’t been here in over 20 months; surely there’s no rule against his admission.”

He leaned back again. He began a long, rambling philosophical discourse about taxes and “firmness” and abuse of the system. But it was only smoke: the only public detoxification center in the city was refusing to accept an alcoholic relapsing after six months of sobriety ostensibly because he walked away from the detox unit 20 months ago.

When some months later I finally spoke to a physician in a position of authority within the public health commissioner’s office, he categorically denied that the city limited the availability of detox in any such way; detox was available to anyone, he said. I later confirmed this with the head of the alcohol and drug rehabilitation program. As often happens in the city (especially among the poor who cannot fight back), the de facto policy is considerably different from the de jure.

Clint and I left a few minutes later. Clint was silent. I was the only one surprised and chastened. I was running out of options that Clint knew he had run out of long ago. I drove Clint back and—against all rules, rules I had vociferously supported and strictly enforced but rules I had broken for at least two others—admitted him to Christ House. To make matters worse, I knew Clint was returning to a staff divided in their feelings about him. Some of them, frightened by his sudden mood swings and the violence that had flared up several weeks ago, would argue—as I had so vigorously—for strictness: “These are the rules; if you break them you’re out.” I knew Clint would rebel. Others, particularly the aides, had told me before, almost bitterly, that it was





*Alone in this life of snares and malice.*

Etching, aquatint, drypoint, and roulette over heliogravure by Georges Rouault, 1922.

Collection of St. Louis University. © ARS, New York, N.Y./ADAGP, Paris, 1992.



our rigidity that had caused Clint's trouble in the first place. Admitting Clint would not be an easy solution.

My premonition was accurate. As Clint detoxed, he became more and more irritable, sullen, and uncooperative. He kept asking me for higher doses of the tranquilizer I was using to detoxify him. I was already using more than I had ever used on anyone else. Aside from being irritable, he was showing few outward signs of withdrawal, and I was afraid that he was manipulating me into giving drugs. Finally I refused his request point-blank. A few hours later he slammed out of the building, telling the nurses that if we were not going to help him, he knew alcohol would quiet his nerves.

Though I despaired, part of me, I had to tell myself honestly, was relieved that I didn't have to deal with him for the moment. Still, I, too, felt agitated and angry as if Clint's mood had rubbed off on me; angry at the hours of personal time that Clint had sabotaged in the end, angry at a private hospital that would refuse patients in need, angry at the city alcohol treatment system and its staff full of people with chips on their shoulders, angry that there were—for the Clints of my world—no long-term treatment programs such as Clint needed, angry even at the Christ House staff for wanting to enforce the rules that I had approved. Slowly my anger turned inward and became a sort of hopelessness: Doesn't anyone get well? Is Clint so broken that I'm wasting my time? Clint was back on the street, and I was here. He would drink and drink and drink until the morgue, and I would go on to my next patient. What was the point of all this?

But there were deeper feelings, too, ones I hardly recognized at the time. I was beginning to grieve with Clint his hopelessness. I was mourning a person who was becoming, after all, a friend. I remembered my glib self-assurance several months earlier, when I was sure that Clint had made it after only a few months' sobriety. He hadn't accepted my reassurance, and I remembered his respect for the abyss into which he'd now disappeared. I remembered his honesty with me, and I felt privileged that Clint had

taken me on his journey with him. He had shown me his fragility and his great courage before the abyss.

Paradoxically, my identification with Clint—which should have depressed and enervated me—was having this time quite a different effect. Here in Clint's battle were the real issues, the real battles of justice and mercy being waged at their most basic level. And while I was not Clint, I did not feel on the sidelines, either. This felt to me—even as I feared for Clint—the beginning of a new approach to life in relation to the poor.

As a doctor, I had little more to do with Clint, and I don't really know how the miracle occurred, only that it was a miracle. He survived his drunk and made it to the hospital once more. Eventually he returned to the Samaritan Inn to begin again. Six months later I met him on the street. I felt that instant intimacy followed by hesitance, as when one meets an old high school chum. He was still going to AA several times a day and didn't know how long his sobriety would last, but he was finding new people in our community to support him in his life away from alcohol. Another day I talked with Clint's social worker at Samaritan Inn. The angry had come back more than once, but he had weathered it. The next time I saw him in front of Christ House he told me about his new job as a part-time delivery person for a print shop downtown. A year later his employer—delighted with his work—hired him full-time. Clint moved into a small apartment of his own in the neighborhood. And he started returning to Christ House for our worship services.

Allen chose Clint to serve communion at this Sunday morning worship in the recreation room of Christ House. As always, I am aware of the slightly acrid odor in the room; a thin film of cigarette tar covered the pale plaster walls. I take my place in the communion line, vaguely noticing the scraping chairs as people move to and from the line, listening to the hymn in the background. I try to reflect on the meaning of the Eucharist, but my attention focuses on Clint and the stone chalice in those hands. As I step up to him, I look up, and he suddenly grins,



laughing silently; he catches himself and solemnly offers me the cup of communion; the laughter only in his eyes. "This is the blood of Jesus," he says, and all my awareness of the room and the other people and the hymn disappears. My vision blurs with tears, and I can feel my throat tightening. I give the chalice back and try to return his gaze, but I can't keep back the tears spilling on my cheeks.

The light covered by childhood abuse and

drowned for so many years by alcohol has flickered and is now burning. I have been his companion on part of that journey, and I do not understand why he is even alive.

Three years have passed. I ran into him recently near the house, and we talked. He was still working at the print shop, a menial job, I suppose, with no future. But Clint remains sober, a reminder of events beyond our understanding. ☸



*Self-Portrait with Dr. Arrieta.* Oil on canvas by Francisco de Goya, 1920.

Collection of the Minneapolis Museum of Art, the Ethel Morrison Van Derlip Fund.



## Commentary

# Communion with Patients

Kathleen Nolan

COMMUNION HAS NO ENTRY in the *Encyclopedia of Bioethics*. It has currency in religious contexts, of course, but it is not a term that doctors or nurses use to describe their activities, and bioethicists have not “read it into the text” of the clinical encounter. Nor is *communion* synonymous with *caring*, although it may well be what those who espouse an ethics of care actually have in mind. Indeed, if we seek a spiritual base for healing activities, then we must attend to the dynamics of communion.

Communion. Not beneficence or altruism or even empathy, but communion. Union with. “Take this and eat. This is my body which is given for you. Take this and drink. This is my blood which is shed for you.”

Communion is a special form of connection, of knowing another—literally a “being one with.” In such knowing, the boundaries that lead to a sense of separation and reflexive self-protection are absent. In communion we offer ourselves to others and are open (we usually say vulnerable) to them in an extraordinary way, relinquishing our preconcep-

tions of them and our own fixed ideas of self-identity. Relating with such intimacy can generate a powerful sense of wholeness and engender astonishing transformations. Thus in communion we can heal and be healed.

*In this story a communion cup is offered, and someone cracks open inside. We meet a patient “incapable of lying” and a physician capable of noticing. And they embark on a journey together.*

Communion begins with a paradox. To unite with another requires a prior separation. To know another as other requires individuation, requires distinctions and characterizations. We name our realities and create a world of forms and functions, roles and relationships. “I am a physician. She is tall and thin. He is an addict.”

The possibility of communion belies the irremediableness of such separation. To recognize another also requires that the other not be totally alien, entirely distant. Before the labels crowd in, we can allow ourselves to see a shared humanity and to experience another’s individuality at closer range. Then our naming becomes gentler . . . and more insightful.

*Clint Wooder, feeling powerless to control his drinking behavior, attends four or five Alcoholics Anonymous meetings a day and volunteers for whatever work will keep him busy enough not to drink. He sees his physician weekly and*

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*shares his fears and his dreams. Fascinated and charmed by him, his physician allows himself an immense luxury: he begins to root for Clint's recovery.*

Healing, like communion, involves a special type of giving. A giving of oneself. A willingness to be hurt, a willingness to hope for the seemingly impossible. A willingness to reach out to another, even at great cost to oneself. "Take this and eat. This is my body."

How many health professionals believe that the activities of healing by their nature involve self-sacrifice? That providing good medical or nursing care and repairing various bodily ills most often fall far short of true healing? Can we dare to admit this to ourselves without fear that we will find ourselves being consumed?

Communion with others does carry risks. Patients may grasp too tightly, dig too deeply into our stores of energy and compassion, and stubbornly refuse to be healed. At worst there is risk of physical injury or of rejection and other emotional trauma. At best we find ourselves exposed to another human being in the utter nakedness of honest knowing, flush against what they, and we, so routinely seek to hide as shameful or unworthy.

*When Clint starts to grow restless and feels "the angry" coming on, his physician is afraid for him. Uncertain about how to intervene, he finds help for Clint—20 minutes every two weeks with a resident in a public health clinic. It's not enough, not nearly enough. Major tranquilizers don't work either. Clint's anger erupts, and his physician sees in his eyes a rageful stranger.*

Unfortunately, many health professionals find their patients' sordid humanity at least vaguely discomfiting and wistfully yearn for a safer and more dignified relationship, an unblemished intimacy. In this we mirror modern society, desiring, even ex-

pecting, an intimacy that comes easily, without any mess or fuss. A bloodless communion, if you will. We are willing to care about our patients, but from a certain distance: not too much risk (I'll think twice about caring for you if you have AIDS, for example)

and often with a tightly circumscribed investment of time and emotions (I have my life outside of work, too, you know). The temptation to quit, to give up on a patient, to leave it to the next shift, or simply to remain subtly distant can be very powerful.

*When a promised room at a private hospital vanishes after three hours of waiting and an involuntary commitment to the city's public psychiatric hospital also evaporates within hours*

*after a cursory evaluation by one of the hospital's staff psychiatrists, Clint's physician begins to feel firsthand Clint's helplessness and rage.*

Imagine a class in which the instructor announces that beyond all the standard values and principles of modern bioethics lies a simple truth that forms the essential ethical foundation of all the healing professions: we must be ready to die for our patients.

Sounds insane, doesn't it? We are much too sensible for such talk, even when it is intended merely as metaphor. Yet we know from observing patients' responses to a tragic injury or a devastating diagnosis that the loss of a previously clear sense of self is often experienced as a form of personal or spiritual death. A similar danger lurks beyond the rare but real risk of physical death that health professionals accept in caring for patients. Is it not a kind of death to try with all one's heart and then fail, to have to admit that we are unable (and thus, we fear, inadequate) to "fix it"? What happens when we take on The System on behalf of our patients and discover that it can roll over us as readily as it does those

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without money, degrees, and prestige? If we care at all, and certainly if we come to know our patients with some intimacy, we expose ourselves to risks at all levels of human experience.

In a sense, all communion involves a kind of death: we are no longer who we thought we were. This can be joyous, but in healing activities it is frequently wrenching. We usually feel frightened and lost, for example, when our patients' anger and hopelessness infect us. If health professionals are deeply in touch with their patients, they share the emotional and spiritual burdens of weakness, disappointment, and failure. Our heroism beaten out of us, we begin to wonder, "Doesn't anyone get well? What is the point of all this?" The death of our own naiveté and invulnerability can be extremely painful, sometimes bitterly so.

*Clint, drunken and vacant, agrees to be admitted to detox, but he insists that they won't take him. His physician knows better: detox has to take him; that's why they are there. But, incredibly, detox wants no part of Wooder, and the attendants badger him into defeat before he even gets started. "See," the attendant in charge says to Clint's physician, "I told you he wouldn't stay. He'll never change."*

"Take this and eat. This is my body." The point isn't the resurrection, or at least not only the resurrection. There is the communion itself. All consideration of outcomes and consequences aside, there is the journeying with, the being with, the dying with. I know your pain. You know my knowing it, and you know my helplessness to do other than stand and watch. Yet stripped of my cloak of invincibility, I nonetheless stand here beside you. I have not run away. And despite all the odds, neither have you. You have let me touch you, and you have trusted me not to flinch and turn away. We are in this together. If you fail, it is my failure, too. You may die, but you will not die alone.

Communion is thus a supremely deontological activity: it has everything to do with moral obligation. While healing of many forms may follow from it, communion with patients may yield no obvious benefits. In many cases, knowing patients from the

inside, as it were, turns out to be extremely painful. Painful and yet strangely gratifying, for communion is essentially its own reward, a gift of oneself and a gift to oneself.

*Clint goes back to the street, and his physician grieves: "I remembered his honesty with me, and I felt privileged that Clint had taken me on his journey with him. He had shown me his fragility and his great courage before the abyss. . . . Paradoxically, my identification with Clint—which should have depressed and enervated me—was having this time quite a different effect."*

We fear communion because we do not appreciate its special healing character. In giving we also receive. And though the risk may be great, even the smallest acts of true intimacy have the capacity to nourish. A few minutes' extra time on rounds, an unsolicited invitation to talk, a ride to the grocery store or the welfare office at the end of the day—these can be gifts with healing power, not only for the patients involved but also for their tired, harried, and perhaps unappreciated caregivers.

How often do we fail to allow ourselves even this much communion with our patients? No wonder we come to feel so dissatisfied with our work. We protect ourselves from being exploited, but our security comes at an enormous cost. In our fear of intimacy, we not only hobble ourselves as healers but also deprive ourselves of the richness that both small and large acts of intimacy can offer.

*Clint survives and begins to rebuild his life. Chosen to serve communion at the rehabilitation house, he sees his physician, grins, and then solemnly offers him the cup, laughter and intimacy in his eyes. "The blood of Jesus," he says.*

At some level, we all recognize, cherish, and yearn for deeper communion with ourselves and with others. If we are honest, we cannot help admitting our thirst for the life-giving quality of shared intimacy, of real caring. For many health professionals this was a major motivation behind their choice of profession. *Communion*, being one with. As patients, we hold out our hands. As healers, we offer ourselves up. That is the simple miracle of "I am with you and I will do what I can." ☸





*One Who Showed Mercy.* Linocut by Robert Hodgell, ca. 1980.



## Commentary

# Who Is My Neighbor?

M. Therese Lysaught

BEING A GOOD SAMARITAN CAN BE A THANKLESS job. David Hilfiker's story makes that abundantly clear. The problems he recounts—from dealing with noncompliant, belligerent, drug-addicted patients to confronting a “system” that ignores, rejects, or even attacks those it purports to serve—illustrate that those who follow the example of the Good Samaritan often meet frustration, resistance, and ultimately their own powerlessness.

David Hilfiker is rare among Christians and physicians. He has taken risks that few would take, and he has followed the call to discipleship, reaching out to broken and marginalized people in an attempt to offer healing. In 1983 Hilfiker left an established family practice in rural Minnesota and moved with his family to Washington, D.C., where he became medical director of Community of Hope Health Services and a staff physician at Christ House, a center that provides medical care for homeless men (see Hilfiker 1989).

In his account of the story of Clint Wooder, Hilfiker brings out difficulties that can attend a

vocation of service. He shares what his relationship with Clint Wooder has taught him of the public health system's aggressive indifference to the poor and of his limits as a physician. He does not elaborate on religious meanings embedded in the experience that he narrates, but the particular Christian context of his vocation and the moment he uses to frame his account intimate theological insights.

These insights, for me, were clarified when I considered the story of Clint Wooder next to the biblical parable of the Good Samaritan (Luke 10:29–37); in many ways the two stories illuminate each other. Hilfiker nowhere explicitly draws on the parable, and he might even reject the suggestion that he understands his work in terms of this paradigm. But there are clearly points of contact. Sociologist Robert Wuthnow, in his book *Acts of Compassion: Caring for Others and Helping Ourselves* (1991), gives considerable attention to contemporary understandings of the parable, identifying commonly held attributes of the Good Samaritan.<sup>1</sup> These understandings may conveniently map the story of Clint Wooder. Two strangers encounter each other on the road (in Clint's case, “the road to recovery”). Clint is the classic “neighbor,” the one in need. Doc is the classic Samaritan—an individual, a nonconformist, and to some extent a social outcast (Hilfiker might use the term *broken*), whose inner

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strength and virtue encourage him to “go the extra mile,” to perform what many would perceive as a supererogatory act for the sake of another. Their recognition of their common humanity bridges the barriers created by social inequalities.

The story of the Good Samaritan has always been a powerful ideal for those whose religious convictions call them to ministry, especially ministry to the sick. Many undoubtedly find their personal stories taken up and reshaped by the Lucan parable, motivated by Jesus’ exhortation to “Go and do likewise.” For others, however, the parable condemns rather than motivates; it stands as an ideal impossible to attain, unworkable in a real world full of bureaucracy, fear, and indifference. The story of Clint Wooder reveals the limits of the paradigm of the Good Samaritan by confronting it with hard questions that the parable does not take up; the parable, in turn, traces the particular shape of grace in this healing encounter between two broken men.

## I

THE STORY OF CLINT WOODER DEMONSTRATES the inherent limits of using the Good Samaritan as a paradigm for service in contemporary settings. On the one hand, the paradigm does not address concrete problems surrounding the provision of health care to marginalized people, and on the other, it seems to advocate certain attitudes that only exacerbate strained situations.

To begin with, the parable of the Good Samaritan, though indirectly depicting “the system,” is not complicated by practical problems of access to health care faced by the poor and marginalized. The Samaritan has no problem finding someone to care for the man—he has money. He pays for his keep up front, and when he leaves he tells the innkeeper, “Take care of him; and whatever more you spend, I will repay you when I come back.” Had the Samaritan lacked the means to pay, the two would more likely have been turned away. How would he then have proceeded?

This is Doc’s experience. (In an earlier draft of this commentary, I found myself referring to David Hilfiker as “Hilfiker” but to Clint Wooder as “Clint,” which seemed to accord greater respect to David Hilfiker. After further reflection, I decided to refer to the two men as they refer to each other: Clint and Doc. The names that they use, interestingly, reveal that the two men do not see each other as equals. In fact, this nomenclature may reinforce the inequalities that often serve as barriers to friendship.) Doc does not have the Samaritan’s option of unlimited means. Like most people, he begins with what he knows—he tries to help Clint by referring him to a professional therapist and one of the best private hospitals in the city. But in both of these attempts, lack of money diverts Clint to the city’s public mental health system. Even Medicaid coverage does not suffice, for unlike the Samaritan, the government does not promise to repay the private health care system for “whatever more” it spends.

But Clint’s story illustrates that means and money are not the whole problem. Even social agencies ostensibly designed to serve the poor and socially outcast are rendered inaccessible by overburdened personnel and uncompassionate attitudes. Clint first encounters well-intentioned inability when the “best psychiatric resident in Washington” proves to be himself a scarce resource, unable to devote adequate attention to Clint. But this lack of attention seems benign in comparison to the attitudes Clint and Doc meet as they move through the public health care system. The system coerces Clint when he will not consent and finally attacks him with outright hostility when he is at his very weakest. (Several parts of this account raised questions for me. First, I wondered why Doc did not follow up on the psychiatric resident’s recommendation to look for another psychiatrist less in demand with more time. Second, his query—“How quickly would a middle-class person complaining of uncontrollable rage after an assault be hospitalized or provided with at least some intensive care?”—seemed disputable; it is not obvious that for someone with greater means,



hospitalization or involuntary commitment would be the first option. Finally, Doc's interpretation of the attack at the detox as premised on racism could be challenged, insofar as the white physician on staff participated equally in refusing Clint admission. Clearly, Doc is witnessing a power game that goes beyond race.)

With each door that closes, the crescendo of despairing frustration builds. Luke does not suggest how Doc is to follow his call when he meets hostility or finds every avenue he pursues closed off. Clint's experience teaches Doc that the system resists those who people the margins, even when they have an ally, an advocate. It treats them as a constant, ever-present burden; their demands are perceived as draining those who serve, rendering the efforts of caregivers futile.

These systemic obstacles are well recognized and are often the focus of advocacy efforts by well-intentioned would-be agents of change. But the magnitude of these obstacles can obscure attention to another difficulty that arises in providing health care to the marginalized: relationships between strangers often begin in situations of inequality. The parable does not offer details about the Samaritan's relationship with the man who fell among robbers. We know that the Samaritan is compassionate, and we might describe his behavior as rather excessive and self-sacrificing: he promises to repay the innkeeper *whatever* he spends; he detours from his own activities and tends the man through the night, oblivious to his own needs. He is not one among society who has power and privilege but rather is himself marginalized, a foreigner, an outcast, not important enough to be burdened with responsibilities like the priest and the Levite. As a Samaritan, he is offensive to and persecuted by Jews,

so one would not expect him to respond compassionately to the plight of the Jewish man he finds beside the road. But we know very little about the man who receives the Samaritan's care. The parable does not say whether he was grateful or whether he

resented the obligation such gratuitous assistance can create. It does not say whether he waited at the inn until the Samaritan's return or left "AMA." It does not say whether he ever thanked the Samaritan for his assistance. The parable does make clear, however, that the Samaritan leaves; their relationship—at least for a time—ends.

But the story of Clint Wooder displays an ongoing relationship, one that moves beyond the realm of a medi-

cal encounter and toward the bonds of friendship. Clint is looking not only for someone to treat his symptoms but for someone to trust, someone who will not abandon him even when his attempts at recovery and healing fail. Doc remarks that early in their relationship, Clint let him in, trusted him. And Doc, for his part, begins to trust Clint. Clint impresses him as being different from the other alcoholic homeless men he has treated: Clint regularly keeps his appointments; he is "incapable of lying." Clint's hearty, bashful laughter draws the doctor in, and he finds himself "fascinated by him, attracted to him, rooting for his recovery." Relatively quickly, Doc trusts that Clint had made it.

The particularities of this relationship take it beyond the stereotype of feel-good healer and grateful beneficiary. Clint and Doc meet out of different positions of socioeconomic privilege, radically different life experiences, and different levels of need (in other stories, we might encounter differences in gender and race). To some degree, Doc recognizes the disparities between himself and Clint. He feels that their "internal realities" are not the same and

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that he will never truly understand. He senses that in this inequality, he has power—he is the “guide to someone from another culture.”

As long as these inequalities exist, true friendship (contrary to Doc’s assessment) will be difficult to attain; at no point, for example, do they breach the fiduciary barrier and *reciprocally* use first names. These inequalities make it difficult for Doc to see Clint as a person, a subject equal to himself, and not reduce him to an object of his actions. Doc’s actions are aimed at effecting an objective (healing), keeping Clint straight, controlling him, saving him, moving him “back into society”; thus he feels—as do many who attempt to fix an alcoholic—that he has “wasted” his time, that Clint has “sabotaged” his efforts, that there was no point.

Doc is clearly disappointed in Clint’s failure; his trust in Clint has been betrayed. Doc, too, betrays the trust Clint had placed in him by not resisting the efforts of those who orchestrate Clint’s involuntary commitment (although he is reluctant to take responsibility for his part: his observation that “the trust we had nurtured in Clint had been severely damaged” eliminates agency). Like many who have been oppressed and rejected, Clint pushes and pushes Doc to see how far that trust, that commitment, that compassion goes. Doc recognizes that Clint, in his violent outburst, “had done what he needed to do to get discharged back to the streets”—a characteristic alcoholic action. He does not seem to recognize in this same action Clint’s challenge: an outcry for attentive discipline, in the context of forgiveness that signals a gracious love not conditioned by merit. The parable might have shed some light on these complicating difficulties had the Samaritan remained with the man.

**The parable seems to assume that the needs of the man lying on the road are relatively straightforward, an attitude that can collude with a medicine still inclined toward paternalism.**

The urgency of Doc’s desire to guide Clint from one place to another reveals another potential pitfall of the Samaritan paradigm: the parable seems to assume that the needs of the man lying on the road are relatively straightforward, an attitude that can collude with a medicine still inclined toward paternalism.

Informed by at least the medical tradition, Doc proceeds with a clear vision of what is best for Clint, of what Clint “needs.” Thus he becomes exasperated by Clint’s “noncompliance” and eventually cooperates with the system to coerce Clint into accepted patterns of action under the guise of healing and helping. It is not plain that Doc recognizes his paternalism; narrating this story several

years later, he still seems angry at the psychiatrist who released Clint from St. Elizabeth’s, though hindsight proves the psychiatrist to have been correct in believing that Clint posed no threat of violence to himself or anyone else.

It seems from this narrative that at least as much as Clint needs psychiatric treatment or Haldol, he needs simply to be listened to, to be heard. When Doc does listen, he is surprised at Clint’s insight into himself. Yet time and time again Doc fails to hear what Clint is saying. Clint admits to Doc, “I have no control over alcohol”; yet even after years of working with alcoholic homeless men, Doc glibly thinks that after only a few months Clint has recovered and expects him to behave accordingly. Clint tells Doc that to stave off “the angry” he needs more to keep him busy; Doc, in response, suggests therapy. Clint explicitly and emphatically informs Doc that he does not want to go to St. Elizabeth’s, yet Doc eventually assists in having Clint involuntarily committed. (It is important to note that Clint *was* willing to accept inpatient psychiatric treatment, just not at St. Elizabeth’s.) Finally, Clint



warns Doc that the public detox won't take him; yet Doc plows ahead, dragging him to a place where he suffers further attack and abuse.

If Clint had been listened to, we might have learned more about what he thought he needed: more work to keep him busy perhaps; more respect and acceptance from Sister Marcella who waits expectantly for him to fail; more support in his dealings with Tony, whose abuse mirrors the abuse from Clint's childhood and triggers his rage. We are left wondering, at the end of the story, what exactly Clint needed and found in the months and years following his journey with Doc that helped him weather "the angry," that made the "miracle" more explicable. Doc does not ask. Insofar as the parable of the Good Samaritan does not suggest that those in need might be listened to, it can underwrite the attitude that the most important concern is to meet their needs, to "fix" their problems and render them no longer needy, rather than to see them as persons and at times simply walk with them through their trials, quietly listening to their stories.

Lastly, the parable of the Good Samaritan can be interpreted in highly individualistic terms that both protect the insularity of the physician-patient relationship and fail to take account of the limits and needs of those who serve. This individualistic reading can burden those who are genuinely compassionate with expectations they cannot possibly meet, a program for failure, betrayal, and burnout. In the parable, the Samaritan and the man meet as strangers and individuals, not circumscribed by a common context, a community. Stories like Clint Wooder's, however, suggest that communities are crucial for sustaining both the broken person and the healer. One wonders what happened to the communities that support Clint and Doc; they bracket the narrative but do not constructively enter into the dynamic. At the beginning, Clint regularly—almost obsessively—attends AA meetings. But as we move to the story of "the angry" and through the episode at Christ House, no mention is made of the role of the AA communities, communities whose members share Clint's "internal realities" and whose

experience might help Clint through this crisis (and probably eventually does).

At the same time, the narrative does not idealize or romanticize communities; Clint's story displays the limits of the other community, Christ House. The narrative suggests that the situation at Christ House may in part have precipitated Clint's behavior: Clint perceived that he was rejected by Sister Marcella, that he did not have enough to do to keep him busy, that the rules were too rigid. Nor does Doc turn to Christ House for support. Even though Christ House is the context of his service, he seems to feel that he must negotiate Clint's situation on his own, a task well beyond the capabilities of one person.

Moreover, given that Christ House is the context of this episode, it is peculiarly striking that a central Christian practice plays no part in the account of this community, namely, the practice of forgiveness. In the practical world of illness, healing, addiction, and recovery, communities and individuals fail. Yet no mechanism is described that might mediate the acceptance or forgiveness of failure. In an incident not unlike what happened at the public detox, Clint breaks the rule and, for his single offense, is expelled. No steps are taken to mediate the dispute and cultivate forgiveness between Clint and Tony, yet Tony's actions are clearly implicated in Clint's rage.

Although not present in the parable of the Good Samaritan, communities, despite their frailties and failings, are necessary to support and sustain both recoverer and healer. Community is crucial for creating out of chaos a disciplined life; AA recognizes this. But forgiveness is crucial for sustaining a disciplined (root: *disciple*) community. In a Christian context like Christ House, this practice of forgiveness ought to be grounded in the central moral practice of eucharistic worship, worship that could truly provide the foundation for friendship between these men of unequal backgrounds. Unfortunately, this dimension does not play a role in their relationship. Until the end.



## II

SO THE STORY OF CLINT WOODER ILLUSTRATES some of the limits of the paradigm of the Good Samaritan. In spite of all Doc's efforts, the Good-Samaritan formula breaks down: Doc is relieved to be rid of Clint; Clint returns to the streets and alcohol; they don't see each other again for six months. But at the end, the two men meet over the chalice, and we begin to see how the parable of the Good Samaritan might illuminate theological aspects of the story of Clint Wooder. For this, however, we need to return to the parable and draw upon a slightly different interpretation, one offered by Arthur C. McGill (1982) in his *Suffering: A Test of Theological Method*.<sup>2</sup>

In the parable, the righteous and earnest lawyer asks Jesus what he must do "to inherit eternal life." Jesus affirms the lawyer's response: "You shall love the Lord your God with all your heart, and with all your soul, and with all your strength, and with all your mind; and your neighbor as yourself." Being a lawyer, he is not satisfied with this and presses Jesus further: "And who is my neighbor?" This question prompts the telling of the parable, at the end of which Jesus asks the lawyer, "Which of these three proved neighbor *to the man who fell among the robbers?*" to which he must respond, "The one who showed mercy on him." Thus Jesus asks the lawyer to identify not with the Samaritan but with the man on the road. The *neighbor*, thus, is not the one who needs our help, our service, our charity, but rather that one who, though we may despise him and may have persecuted him, reaches out to us excessively, expecting nothing in return, tending our wounds, loving us compassionately. Hearers of the parable are exhorted to love not those

they find in need but rather those who tend to their needs.

If the original ideal of the Samaritan was unworkable, this is not much better. McGill questions whether we would ever find one like the Samaritan to love as ourselves; real-life Samaritans are generally too limited. And more to the point, McGill suggests, if we did happen to be found by one, it is not clear that love would be our immediate response; such unmerited selfless, sacrificial love can create a sense of obligation which, challenging our deeply valued sense of autonomy and self-reliance, can foster feelings of resentment. Neither image compels our joyful emulation.

But this, McGill suggests, is precisely the parable's point. For as he notes, Jesus does not offer the parable as a model of human activity. This

parable is not first anthropological but rather theological: "Like all Jesus' other parables, it does not tell us about our human love and about how we can go about displaying it to needy people. . . . It requires us to identify ourselves, not with the heroic Samaritan, but with the poor wounded man on the side of the road. . . . It tells us about God's love for us in Jesus Christ" (1982:110). The Good Samaritan, the neighbor the parable exhorts us to love, is God in Jesus Christ.

This interpretation of the parable casts the story of Clint Wooder in a different light. Doc is no longer the Samaritan figure, the healer; he is, with Clint, one lying "at the side of the road." Although Doc comes close to this insight, he misinterprets their points of commonality and difference. It is not, for example, that we share with Clint powerlessness "before our own *urges*." Rather, the parable would suggest that our commonalities lie where Doc posits difference: our "internal realities" in many ways are

**Those who are in need reveal  
in their day-to-day survival the  
condition the parable reveals  
about humanity:  
that we are all broken, needy,  
spiritually and existentially in  
the same condition.**



comparable; we *all* live close to the edge, leaning over an abyss, with our sense of power and control largely illusory, our lives radically contingent. Those who are marginalized and in need have perhaps less ability or reason to hide behind the ideology of control, revealing in their day-to-day survival the condition the parable reveals about humanity: that we are all broken, needy, spiritually and existentially in the same condition.

So, in fact, the story of Clint Wooder is the parable of the Good Samaritan. At the end of his narrative, Doc looks into the grinning face of his acquaintance, receives communion, and cries. And, of course, he should. In this moment at the altar, the true and only Good Samaritan, Jesus Christ, ministers to Doc through the broken but healed person of Clint. Tears are a natural response to being touched and healed by God in Jesus, who touches and heals most powerfully through those who, like himself, are most broken.

### III

THE STORY OF CLINT WOODER hence illustrates both the limits and the possibilities of the parable of the Good Samaritan for shaping self-understandings of those who seek to redress the needs of others. But three points remain, points that can be treated here only briefly. To claim that the parable of the Good Samaritan is first theological rather than anthropological tells only half the story, for theology implies anthropology. The parable exhorts its hearers to “Go and do likewise,” magnificently embodying the “is/is not” tension characteristic of parables, the illuminating juxtaposition of the real and familiar with the theological. McGill’s theological interpretation reads this phrase as an exhortation to “Go and likewise accept the gracious ministrations of God who meets you in the form of one who is marginal. Love this God as your neighbor.”

But a significant aspect of the parable, an aspect that has formed charitable actions across history and cultures, is that the Samaritan *does* stop; he does try

to help. The exhortation to “Go and do likewise” is concrete, practical; it suggests that those whose lives have been touched by the healing grace of God are called to do the same, to be ministers of God’s healing grace, to be disciples after the fashion of the one followed—broken, humble, gracious. Doc lives this exhortation. This would imply that the theological and anthropological require each other, that each alone is incomplete. But if this is the case, we are confronted with a dilemma. It is not clear that the paradigm of the Good Samaritan so construed can be viable in a contemporary culture uncomfortable with theological language. At the same time, as Wuthnow’s analysis and Clint’s story suggest, it is not clear that contemporary understandings of the story—exhorting an anthropology derived from the individualistic “theology” of secular humanism—can sustain compassionate service and not fall prey to the pitfalls Hilfiker encountered. Wuthnow found that for many volunteers who were familiar with the story of the Good Samaritan, the “moral” of the story was that the Good Samaritan and the man, in recognizing their common humanity, overcame significant social barriers. For Clint and Doc, however, neither common experience nor common humanity proved sufficient to overcome completely the barriers between them. Wuthnow’s survey also revealed that many volunteers were reluctant for their relationships with those in need to move beyond the carefully circumscribed boundaries of the volunteer realm. Acting as isolated individuals, they—like Clint and Doc—do not have enough in common to sustain their relationship.

Wuthnow concludes that an important factor in motivating and sustaining caring activities is community. Wuthnow’s analysis implies that this is true for those who seek to serve the needs of others in a variety of contexts, whether secular, medical, or congregational. But it is not clear how these kinds of communities will emerge in the contemporary context, or whether they will be equipped with skills to survive. The presence of religious congregations, pervasive but latent in our culture, is one possible answer to both of these concerns. Not only have

congregations historically served as communal loci of identity and caring activity, they have at their disposal at least two powerful practices for sustaining both communities and their members in the difficulties they encounter—the practices of forgiveness and common worship.

This claim holds two final implications. First, for people who serve those in need, either vocationally or occasionally, some sort of communal context will be necessary (though not sufficient) for sustain-

ing their efforts. Second, the stories of the Good Samaritan and Clint Wooder speak to Christian congregations. In the vignette that brackets the story, Clint acts as minister of the eucharist, and this is extremely fitting. For the meaning of the Good Samaritan suggests that those like Clint are most truly the core of the church. The broken and healed especially body forth the broken Christ's healing, living examples of the way that God's power can be made perfect in weakness. ☸

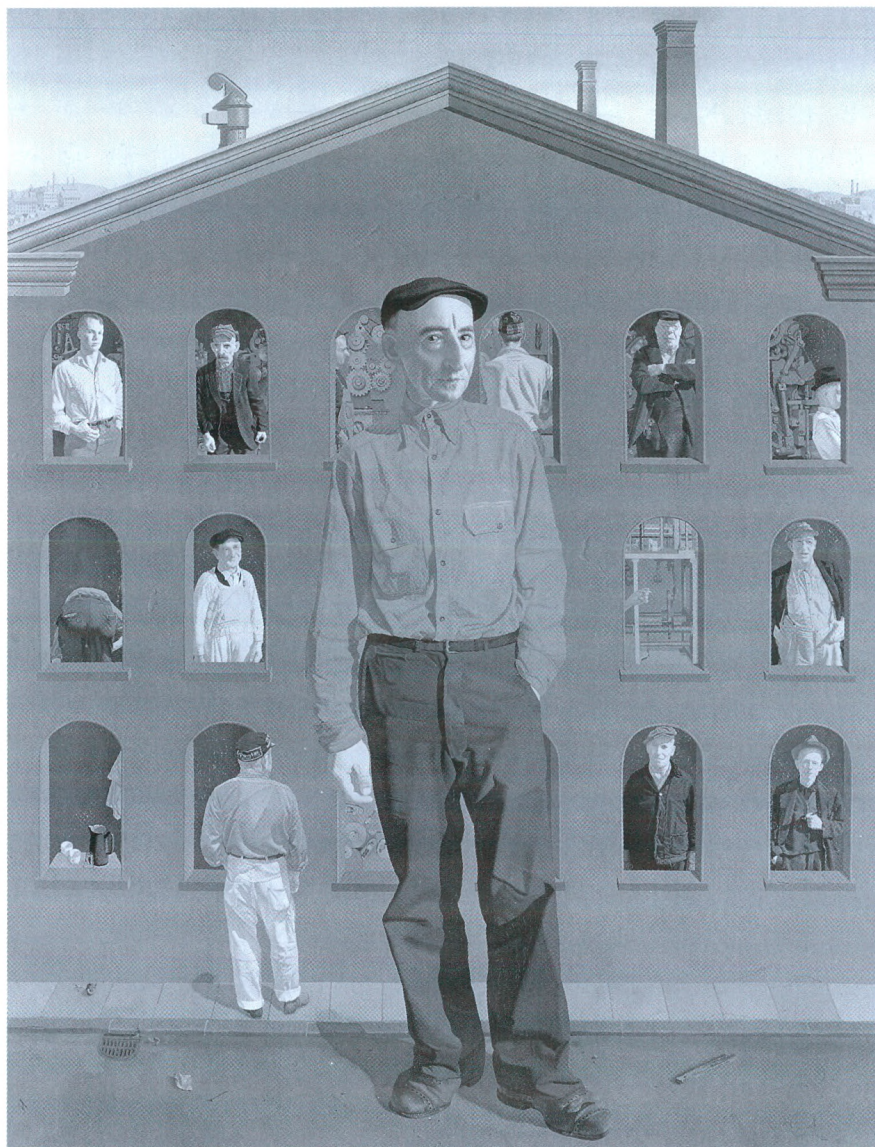


### NOTES

1. In April and May 1989, Wuthnow conducted personal interviews with 2,110 adults in the U.S. to document the extent of “caring” activities in the U.S. and analyze the contributing and sometimes conflicting values that motivate individuals to engage in volunteer work. He found, for example, that 45 percent of all Americans over 18 engage in volunteer activity in one form or another and that the languages used to explain this behavior combine values as diverse as individualism, religious beliefs, justice, compassion, fulfillment, and hope. Wuthnow devotes an entire chapter to discussing the consistent correlation between caring activity and the story of the Good Samaritan. In his survey, 49 percent of those interviewed thought they could recount the parable, a number that increased to 66 percent for those involved in caring activities. He concludes that the story seems to provide “an underlying pattern, a deep structure, for telling stories about caring” (1991:163).
2. Wuthnow gives an account of a medieval allegorical interpretation of the parable of the Good Samaritan that overlaps significantly with McGill’s theological interpretation. The allegorical account, interestingly, casts the inn as the Church, suggesting a communal dimension to which McGill does not attend but which is worthy of further exploration.

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*Tribute to the American Working People* (detail). Oil on composition board by Honoré Sharrer, 1951.

Collection of the National Museum of American Art, Smithsonian Institution, Washington, D.C.,  
gift of the Sara Roby Foundation, New York City.



# Every Institution an HMO?

Donald W. Shriver, Jr., and Peggy L. Shriver

EACH MORNING SALLY EVERS, secretary to a religious leader, comes to her office at church headquarters as eager to pick up stray rumors as to do her work. Around the coffee urn she and her co-workers whisper about the possibility that her own boss may be the next to be let go in a series of sharp and painful institutional cutbacks. "What will happen to me?" she asks, but her friends can only shrug, for they are asking themselves similar questions. Is there a health crisis in Sally's life? Does the institution bear some responsibility for the "health enhancement" of its employees?

The answer we attempt below assumes from its beginning that for most Americans, the contributions of a workplace to good or bad health are at most partial, often indirect, and sometimes hard to prove. Outside of medical institutions, health is not the major purpose of most workplaces, nor should it be, for health is not the all-consuming purpose of

human life. Furthermore, even those institutions that do perceive health as their purpose find the task risky, and people are often wisely wary of institutions bent on doing things "for your own good." That, like the physician, they should try to "do no harm" is, we believe, a worthy goal. That they might also prove "health enhancing" is worth exploring.

We take two liberties with the term *health* here. Life has taught us that health is a matter of body, mind, and spirit. We consciously adopt a broad definition of health and concede that we cross the boundary between physical and mental health frequently in this exploration. Some of our illustrations suggest that this boundary is very porous. Second, in speaking of *health enhancement* we mean to avoid speaking of *healthy institutions*. Health is a prize enjoyed by individual human beings, and we resist the attempt to make this term a synonym for all sorts of human good. An economy may be "healthy" or "sick" in various ways, perhaps, but we think the terms are overstretched in such usage. To *health* here we attribute a rather modest, commonsensical meaning that includes individual feelings of well-being and freedom from physical malfunction. The definition is not sophisticated, but we believe that institutions of all sorts, within due limits, should

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enhance health or at least not harm it. There are many tests of an "effective institution" that we ignore below in order to focus on the effects that an institution can have on the health of its employees.

One of the dangers of this focus, we caution ourselves and readers, is that it seems to assume that an institution is a discrete organization, often housed in a building, with a purpose rather isolated from other institutions. But most institutions float, so to speak, in the social ocean composed by other, usually more powerful institutions: one thinks here of the forces of government, law, professional organizations, and the economy, which institutions of religion, education, and medicine are bound to heed. To speak of the influence on one's health of the place where one works, therefore, may be to invite blindness to all the influences of other powerful institutions on that institution.

Having just returned from South Africa, we are newly aware of those *large* institutional structures—government, law, military force, and economic systems—that impinge on the smaller structures usually brought to mind by references to "institutions." Sometimes it is the power of the larger that really shapes the pattern of help and harm to health in the affairs of the smaller. In the United States, the black medical doctor who discovered the process for blood transfusion died for lack of such a transfusion at a hospital in North Carolina that refused to admit him because of the segregation law of the times. The analogy to South Africa is clear: institutions of government have distributed the institutions of health in South Africa in such a way that black people in homelands cannot possibly get adequate protection against TB, measles, and intestinal diseases. Until recently, in the cities, they could not get into the superbly equipped white hospitals, either. It is almost nonsense in South Africa to talk about health-enhancing *hospitals* in the broad context of racism in the political and economic institutions of the country as a whole. The same must be said about the impossibility of "health-enhancing marriages" in a migrant labor system that separates men from their families for 11 months a year; however helpful

factory wages may be for keeping a homeland family from starving, and however good the working conditions in the factory, ill health abounds as a result of powerful overarching systems. All the factors that keep 30 million Americans without medical insurance illustrate much the same phenomenon.

This article proposes to explore the concept of a "health-enhancing" and "health-maintaining" *institution*, taking an analogy from the relatively new notion of a health maintenance organization. With the invention of the HMO, a subfield of public health—preventive medicine—was lifted to prominence. Surely this is a conceptual gain of great human significance for medicine and its patients, that is, all of us.

Employed Americans spend about 40 hours a week in *organized* workplaces. Two centuries ago barely 10 percent of Americans worked in and for organizations outside of their families; now 90 percent of us do so. If organizations can either enhance or harm our personal health, our workplaces should be of much concern to everyone involved with health care. There are, of course, the obvious safety issues for which the Occupational Safety and Health Administration (OSHA) serves as watchdog, but our interest here is to explore health-enhancing aspects of institutions not addressed by OSHA regulations.

We are convinced through our own work in religious and educational institutions, buttressed by social science studies, that even institutions can be health enhancing. "Even" institutions, we claim, because in recent decades institutions have been thought by many people to be barriers to human fulfillment. Like M. C. Escher's sketches of stairs that lead eternally nowhere, institutions are pictured to be convoluted and self-serving, as rigid as the concrete and brick that house them. A jaundiced view of institutions as "unhealthy to children and other living things" flourished in the sixties and seventies on university campuses and in many church groups, where we have done most of our volunteer and remunerative work. We have become rather uniformly skeptical of those who are uniformly skeptical of institutions. Even the most acerbic



critics of universities now seem glad to be counted graduates of these still-existing institutions, and many take their children to a church Sunday school.

Institutions are, in fact, with us now more than ever—for better or worse. We may want sometimes to escape them, and one's ability to escape may be a door to health. In this society, however, even escape from institutions tends to require some institutionalization, like the Hebrew sabbath or state-protected wilderness preserves. Aside from this irony there is the sober reality that our Monday morning job will confront us with human interactions shaped by institutional structures and processes in our workplaces. What makes such institutions worthy of the description "health-enhancing" or "health-threatening"?

## A Healthful Fit between Formal and Informal Relationships

THIRTY YEARS AGO RUSSELL DICKS, professor of pastoral care at Duke Divinity School and one of the founders of that discipline, told this story to a group of church pastors: A woman in the hospital was experiencing great anxiety about the operation to be performed on her the next morning. A janitor stopped by to empty the trash and made his usual comment, "I hope you are getting better," to which she replied, "I'm very worried about my operation tomorrow." "Who is your doctor?" he asked. "Dr. Smith," she replied. "Oh," said the janitor, "you don't have to worry. Dr. Smith's patients *always* get better!" The woman promptly went to sleep and went confidently into the operating room the next morning.

Of course not all Dr. Smith's patients get better, but the janitor was perhaps unwittingly functioning as a member of the health team simply by testifying spontaneously to his experience in the institution. He had reason to have confidence in Dr. Smith,

reasons that were reassuring to the patient. Only practitioners who think that reassurance is medically insignificant will doubt the value of having such janitors at work in a hospital. Contrast this story with Peggy's experience after childbirth. Returning to the office of the doctor who delivered her baby to have episiotomy stitches removed, she complained of some discomfort to the nurse. "Yeah, the doctor is a real butcher," the nurse replied with casual candor. "He's clumsy with a needle, doesn't know how to sew a decent stitch." At that, the discomfort reached a deeper level! Yet such refreshing candor was oddly reassuring and comforting.

One way of generalizing this point comes from sociology: a health-enhancing institution may be one in which the informal organization supports the purposes of the formal, and vice versa. Janitors and nurses are part of the formal organization; but no formality—rulebook, supervisor, job description—can affect their personal commitment or contributions to the organization's purpose. That is something no bureaucracy can predict or require of its members. This truth about human organization is relevant to other aspects treated below. For example, formal and informal organizational communication had better display some fit, some compatibility, or people may find themselves split between two organizational worlds. A painful negative example would be a male pastor who, in sexually harassing a female administrative assistant, destroys her image of the church that he himself has projected from the pulpit. Such workplace conflict threatens one's spiritual sustenance and thus affects one's total well-being.

Positive illustrations abound, too. A pastor who has lost a dear son in an automobile accident combines his grief with his faith in a memorable sermon that congregants and church staff repeatedly request in printed form because his personal and public self have shown impressive continuity. A doorman who has kept watch at a seminary for many years greets a middle-aged alumnus by name, thus reinforcing the personal interest and care of the institution for its graduates in the eyes of the alumnus—and build-



ing up his self-esteem before his wife and children.

We think, also, of some institutional crises at a certain theological seminary. Various witnesses testify that it was the friendship of three faculty members that formed the “glue” that kept the institution intact through the crises. One of these faculty members died during the time of the crisis, prompting some observers to the sad diagnosis: “The place killed him.” Who can be sure of that? Yet after many a hard workday, almost everyone returns home with the weary, half-serious exclamation, “That place is killing me!” In such clichés may be hiding more wisdom than institutional leaders, in particular, like to admit.

Many an institution is more health enhancing because the formal and the informal structures take due advantage of the healthy influences that emerge from both sides. We think, for example, of a person on the “support” side of a seminary who, after years of service in a department that handles record keeping, developed such a network of sympathetic relationships with faculty and students that he was promoted to a position on the academic side of the institution where he now functions as an ombudsman for the entire seminary. The belief was universally held that “if you tell *him* about it, something will get done about the matter somewhere in the institution.” No wonder that people consider him one of their most valuable associates. To the institution’s credit as well as to his own, administrators, recognizing that his informal and formal services to the mission of the place dovetailed in remarkably consistent ways, promoted him to the position he now occupies.

Such personal rewards for “service beyond the call” of formally prescribed duty do not always happen in organizations, however. Yet the informal

reward system is often the factor that keeps people coming cheerfully to work, even when formal rewards of income and prestige are only modest. At the religiously oriented institutions in which we have worked, for example, one such informal reward has been associated with worship. Regularly scheduled weekly worship services brought mem-

bers of all parts of the organization into one room. The freedom not to come to such worship is an institutional rule, of course, and work schedules frequently do not permit attendance by everyone all the time. Certain busy executives began to consider eliminating worship time, but the testimony of an administrative assistant dissuaded them: “These worship services are the only place where we in the support staff get a sense

of the mission of the whole organization. In the coffee hour afterward we sometimes even feel comfortable about talking over our work concerns with some of the executives. We just wish more executives came to worship with us—it is important to have this time together.”

Mental health, if not physical manifestations of bodily health, is being described in these incidents. Insofar as one’s mental state affects physical well-being, one can speak of institutional arrangements like weekly worship as being health enhancing. Self-esteem, for example, is necessary before people can decide to take care of their health. People who fill roles of comparatively modest reward in institutions are vulnerable to the thought, “I don’t amount to much around here.” Team building in industry not only serves productivity but may also serve the personal health of its workers, who, by feeling valuable to the team, take wise and healthy precautions. Team spirit in any organization may sustain its employees. That quiet, withdrawn secretary who

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works up on the third floor in a room by herself, who comes and leaves by a side door, and who seldom speaks to anyone in the halls is a person whom some supervisor and some peer had better visit or invite to lunch, if only to be assured that no problem exists. (We are reminded of Herman Melville's classic short story, "Bartleby, the Scrivener: A Story of Wall Street." Bartleby, when attempts were made to draw him out of his clerk's corner, always replied, "I would prefer not to." By the end of the story he had virtually committed suicide through his withdrawal.)

Lunches together, birthday parties, a few moments at the start of a week to share weekend stories—these are not "wasted time" but forums for self-esteem. They are times for building the work relationships that sustain people in times of stress. Perhaps the simple truth is that in every workplace people need at least a few friends if they are to keep the body of their work together with the soul of their personhood. Healthy people are neither captives to a work role (workaholism) or victims of a work role they hate (alienation). A challenging work role that brings one to work each day with boundless enthusiasm and a host of friends at work may not always lead to personal health, but there are ulcers and depressions aplenty being fed by the opposite in too many institutions. One remedy is likely to be the search for a closer, more careful fit between the formal and informal human relations of the place.

## Information: A Delicate Question of Balance

SOME YEARS AGO A STUDY OF A CERTAIN manufacturing firm uncovered a long history of tension between the department that set production schedules and the warehouse that inventoried the product. Elaborate efforts at increasing communication between the two were attempted, to no avail. Finally the managers concluded that there was a built-in conflict of interest between the two depart-

ments that no amount of communication would overcome. Production and inventory were subject to pressures that could not be harmonized. They could only be taken into account on each side and grudging adjustment made. Management accordingly ordered the heads of the two departments to communicate with each other only through a mailbox.

Having worked mostly in those two highly verbal sectors of religion and education, we are sobered by this illustration, for it calls our attention to the fact that—as in our society at large—we can subject each other to information overload as well as to information scarcity. The gradual decrease of lengthy, emotion-laden memos and an increase in direct face-to-face encounters was seen in one of our institutions, however, as a sign of health in human relationships within the institution. The form of the communication may be as significant as the message itself.

A great variable in communication effectiveness has also to do with not only *what* gets said but *who* in the organization says it. The formal-informal fit between people in an institution applies here as well. The janitor in Russell Dicks's illustration was the ideal person for reassuring the patient precisely because he was not a doctor and had no obvious vested professional interest in testifying to Dr. Smith's skill as a physician. Similarly, what the secretary in the local church office or in the president's office says about the pastor or the president is likely to affect seriously how others receive communications from these leaders. Is the pastor anything but pastoral in her relations with the church treasurer? (Has the secretary indirectly implied that the pastor is not around enough to deserve a raise?) When the president calls on the faculty to spend less money on *per diem* travel, have the president's own economies in travel been observed by office staff? It is difficult to keep such matters secret in any institution, and such knowledge has an effect upon the ability of leaders to communicate. (It was impossible in 1991 to conceal the fact that Detroit auto company executives were awarding themselves huge bonuses in a



year when thousands of auto workers were being fired. In Japan, however, the custom among industrial executives is to share in the pain of cutbacks, thus lessening some of that pain throughout the organization—an example of now-famous Japanese “teamwork” in corporations.)

Finances and human health in organizations have a more intimate and intricate relationship than leaders often acknowledge, but that connection is most obvious in job loss. The chronic unemployment in American society is making us painfully aware that *joblessness is bad for health*. Health studies among unemployed steelworkers in Pittsburgh in the 1980s underscored this fact for a group of people who were once at the very top of the wage scale in American industry. Their vulnerability to alcoholism, domestic violence, divorce, and depression increased discernibly, a vulnerability hugely present among the vast numbers of unemployed people in the poorest countries of the world.

All this may seem irrelevant to communications within institutions, but it is not. A general problem of communication inside institutions becomes painfully specific when institutions are forced to “downsize,” which usually means cutting out jobs.

When and how does the institution communicate to an employee that her job has been cut? There is hardly an administrator in any organization who does not lose sleep over the task of delivering such a communication. There is hardly an employee, even among administrators, who has no fear of receiving such a communication. We can testify from experience that such a fear is disturbing to psychological health, if not always to physical health. Further, when so much as one person’s job is cut, waves of anxiety can sweep through an organization, leaving

only the tenured professors, perhaps, still sleeping well. (Tenured professors, when they know the financial facts of even the most prestigious institutions in the 1990s, do not sleep securely. Ask the faculties of Yale, Stanford, and Columbia.)

At stake here is a delicate question of balance in the communications, formal and informal, that the leaders of an institution send out to their co-workers

as a whole: How much assurance, how much anxiety, is it right, proper, and health enhancing to propagate? Anxiety-riven workers do not work well. Both unfocused anxiety and focused fear can be health threatening. As the stress research mentioned above suggests, the loss of a job can be the “last straw” in an already overstressed personal life.

This latter circumstance complicates the ethics of economic cutbacks in institutions, of course. Too

often such considerations do not enter the minds of the decision makers, and labor union rules may keep them out of the picture. But quite a different question of health and communication enters in a case like the following: An incompetent person is to be eliminated from the organization. Only close associates and one responsible administrator know the facts of the case, which are detrimental to the reputation, the future employability, and the personal relationships of the person. The ethic of confidentiality is at stake here: to communicate broadly the troubles of this person is further to damage him. Rather than a duty to communicate, responsibility requires a duty *not* to communicate. The case in general institutional life is not much different from the case in medicine, where the Hippocratic duty to “do no harm” has direct relation to norms of confidentiality between doctors and patients.

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The case is worth dwelling on, we believe, because religious and educational institutions, in particular, are often filled with people who believe that it is usually a sin to keep secrets! One is reminded here of the final chapter of Dietrich Bonhoeffer's unfinished volume, *Ethics*, entitled, "On Telling the Truth." Bonhoeffer wrote this chapter while he was intimately involved in one of the great political secrets of World War II—the conspiracy against Hitler's life. He knew that some facts are too important to humanity to be revealed in inhumane circumstances. His illustration of this principle comes from an ordinary primary school classroom. A pupil has arrived late to class. The teacher asks her publicly, "Are you late again because last night your father was drunk again?" The child replies "no," though in fact her father was drunk. She is justified in so replying, says Bonhoeffer, because the obligation to protect the integrity of one's family outweighs the obligation to answer some questions truthfully when posed by persons in circumstances that neither require or deserve such truth.

Whether one reveals publicly the reasons that a person may have to be "let go" is an issue of confidentiality with the potential to cause harm in two ways: first, harm to the person concerned, and second, harm to the *culture* of the institution. No one's personhood is secure against the demand of the culture that the personal must become public. An administrator may have to absorb the assault of those within the institution who demand "all the facts" (but none of the responsibility) in order to protect the already fragile personhood of someone who is losing a job. There are instances in society, of course, in which the diminishment of privacy has merit, especially in difficult deliberations over the fit between the personal and public lives of politicians and other societal "role models." But most of us, in our ordinary work, need spaces outside of work where our selfhood gets nourished, expressed, and authenticated in ways that no workplace is likely to do. Institutions do not *own* us: that is another term for oppression. Institutions require personal commitments: that is another expression for humanity in

the workplace. But institutions do not require or deserve the whole of us or the whole truth about ourselves. Only God deserves that. This, too, is a truth that institutions will protect as a part of protecting our health and our well-being as persons.

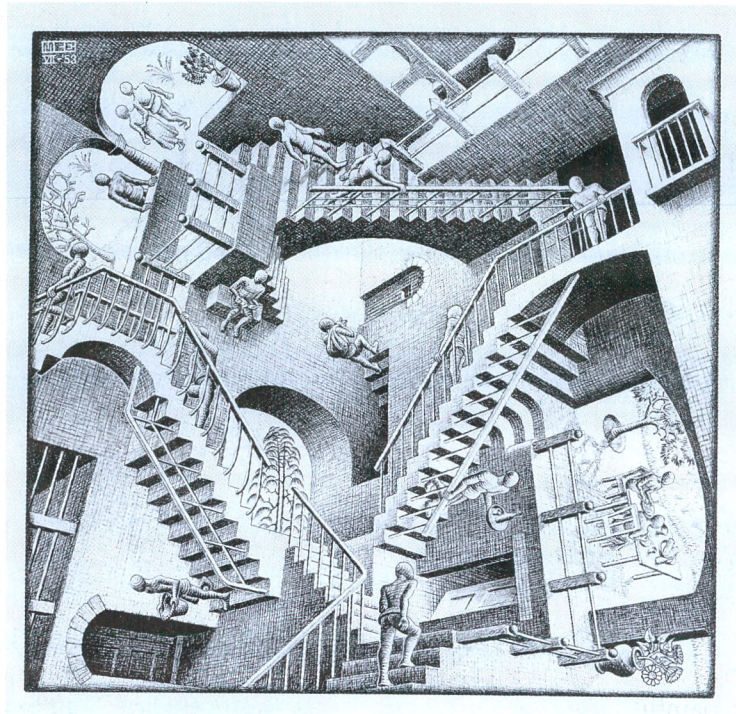
## Financial "Health"

BEFORE DON BECAME PRESIDENT OF A SEMINARY, the institution decided, as an economy measure, to eliminate its food service. The reasons for doing so were persuasive: declining student patronage, new patterns of student housing, and a mounting deficit in the operation. At the same time and for similar reasons, seminary worship was reduced to a weekly service. The "atmospheric" result of these two cut-backs was not surprising: a deepened sense of isolation among participants in the educational institution, their inability to meet each other in any time or space common to all, and a general feeling that the business of the educational institution was now exclusively centered in the classroom. People came and went with minimal informal interaction with each other. When added to other reasons for alienation among persons in the school, the shortage of times to eat and worship together intensified a sense of estrangement and loneliness in this educational workplace that some felt to be in painful contrast to the conviviality of the "old days."

No one can prove that from lack of eating and worshipping together, human beings decline inevitably into bad health. The physical requirement of food can be supplied to us in our solitariness, but it is an ordinary truth of experience that eating alone is seldom joyful, so that in this respect once again is expressed the empirical validity of Jesus' reply to Satan, "One does not live by bread alone" (Luke 4:4, NRSV).

But bread, food services, and worship services all have economic costs. This truth would be embarrassing to put into print if it were not so routinely ignored in the culture of many religious institutions that are our principal illustrations here. Religion,





*Relativity*. Lithograph by M. C. Escher, 1953.

Photo: Art Resource, New York.

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like health, concerns human beings in ways that tempt them into cost unconsciousness. What can be closer to sacrilege than the notion that money can buy the worship of God? (There is a specific New Testament indictment of the notion in Acts 8:9–24: “May your silver perish with you, because you thought you could obtain God’s gift with money!” This apostolic word comes close to being a death threat.) No wonder that many an heir to biblical religion understands the term *spiritual* as equivalent to *noneconomic*, quite in contradiction, we would argue, to the steady commerce the Bible discerns between “spirit” and “flesh” in all things divine and human. For better and for worse this “religious” avoidance of cost considerations has produced some of the great problems of modern medicine: What is a closer analogy in medicine to sacrilege in religion than putting a price tag on a human life? The

medical profession has often seemed to ask just this question, all the while prevailing upon patients, insurance companies, governments, and businesses to pay the high real costs of lifesaving technology and large hospital staffs. It costs money to save lives: on a global scale this truth is embarrassing, especially in countries like South Africa, where measles is the chief cause of infant death and tuberculosis the chief cause of death among adults. Somewhere, at some time, someone *budgeted* the protection for the poor that most Americans enjoy from these two diseases. (For lack of their claims on some such budget, among other reasons, tuberculosis is increasing at an alarming rate among the urban homeless of America.)

Though all this may seem a detour from an account of health enhancement in institutional life, it is not. In the past several years, the direct relation-



ship between budgets and health care has been witnessed in the rising cost of health insurance. Commonplace in institutions now is the reflection among innumerable workers, “I can’t afford to quit because I need the health insurance.” Furthermore, for institutions with less than 100 employees, a few expensive long-term illnesses (cancer, AIDS) can change the group insurance rates. Employees may then face the danger of a job cutback fueled by budgetary insurance pressures as well as loss of insurance coverage. Firing some people in order to care for the needs of other people is one of the ordinary pains camping in the offices of presidents and other managers in institutions across America in 1992. They can acquire ulcers from having to make such decisions in every annual budget cycle. And they acquire them in the knowledge that they are giving others reason to acquire them. We have yet to find an institutional administrator who does not agree that the most painful part of the job is firing somebody.

In an era when almost anyone in an institution, from president down to gardener, is vulnerable to losing a job because of financial pressures on the institution, it is time for the most and the least vulnerable to consult together around a question rather new for most American workers: “Is there a way to share the pains of financial crisis, so that no one avoids some financial loss but no one incurs the loss of a job?” Neither of us, we must report ruefully, has ever worked in a church or educational institution whose *culture* sustained a consistently positive answer to this question. In the U.S., labor unions, while fighting job cutbacks, have historically preferred to keep wages high even at the cost of job losses. That same assumption has largely prevailed even in those church-related agencies in which we have worked. This is doubly ironic, for in these institutions, often enough, not only have religious principles such as “bear one another’s burdens” been widely affirmed, but these have also been overlaid by frequent acclaim for a socialist ideology. It is hard, in retrospect, to detect the power of either of these sets of ideals as they affect the majority of

individuals in the institutions in question. American individualism, competition, and faith in the justice of the job market seem much more powerful, else *exceptions* to this behavioral generalization would not stand out so starkly: one senior faculty member who suggested that he and his colleagues accept a salary cut and one student who offered to give up his part-time campus job!

The spiritual power of a voluntary across-the-board reduction in salary was demonstrated in 1933, however, when the seminary faculty voted (with considerable encouragement from the president) a 5 percent reduction in their salaries in order to bring into their midst an outstanding German theologian who was an academic and political refugee—Paul Tillich. People continue to remark on this generous and appropriately Christian behavior to this day.

Because we have yet to be blessed with living in an institution whose rules and expectations really do mandate the sharing of economic pain, we can only speculate on what work in such an institution would be like experientially. But examples of such institutional culture do exist—in Japan and now increasingly in the United States. One thinks of the highly successful South Carolina steel manufacturer NUCOR, which has not fired an employee in 20 years. Not just productive efficiency but the sharing of cutbacks has been the secret of this record: managers, long-time workers, and newcomers all take cuts in income and in days worked when stringent economic times come. Interviewed workers testify that there is a great difference between worrying about less income and no income at all. And the credibility of managers is greatly increased when announcing cutbacks means announcing cuts in their pay, too. As administrative leaders who have experienced both the burden of firing and the burden of having a job cut from the organization, we can only yearn for a time when religious, educational, governmental, and medical institutions of American society can participate in a new birth of community resulting in far fewer of us having to bring home the news: “I got my raise for next year, but my deskmate lost her job.” The infrequency of



that thought might be a test of the health-enhancing quality of any workplace.

## Authority, Power, and Conflict

CONFLICT IS INEVITABLE BETWEEN HUMANS, and the health of many groups of people seems to thrive on it: athletes, lawyers, politicians, many business leaders. But for all humans conflict has its own psychological, social, and ethical provocations. It can be health enhancing when it gets solvable human needs out into the open; when it issues in new levels of truth, justice, and love between people; and when it widens a social community so that it includes among its members those who were wrongly excluded from participation.

But distinctions between “healthy” and “unhealthy” conflict are often difficult to draw, especially in institutions made up of persons with varying degrees of tolerance for conflict itself. Perhaps the variance relates psychologically to diversity of biographies with their different histories of pain and benefit from the experience of conflict. Families whose members have learned how to argue with each other without insulting or otherwise damaging each other are very different from families whose members have in their histories the traumas of physical and verbal abuse, lifelong hostilities, and irreparable alienations. Institutional, communal, and national illustrations could abound; but the point is that while even certain kinds of war can lead to new health among nations, most wars are going to damage at least some of the participants. *Power* in an institution, among other things, is the designated responsibility of some leader to determine who is to bear the benefit and who the pain of inevitable damages.

Both individuals and institutions have a stake, then, in “managing” conflict in ways that can yield healthy results for all possible participants. This is a very difficult norm to pose for religious and educa-

tional institutions, for two major reasons: the leaders of both are likely to make frequent appeals to standards of love, justice, and reason. Conflict is likely to offend some of these standards. But the second reason has more to do with the uniquely *weak* authority structures of those institutions. In contrast with most governmental, legal, business, and medical institutions, the leaders of academic and religious institutions have very little economic or coercive cultural legitimation for making and enforcing their decisions. They are officially and even legally responsible for what happens in the institution, and they have powers of appointment, budget, and judicial appeal; but they are surrounded by people habituated to challenging authority—faculty and students in educational settings, members and their elected representatives in church settings. Inherent in this situation is the built-in weakness of any claim to “final authority” by these leaders. Both religion and education like to appeal to authorities above all institutions whatsoever: pity the college president or the local minister who tries to run the institution with the same sense of authority possessed by a judge in a court of law, a general in the army, a CEO of a corporation, or a chief of medicine in a hospital!

Religious and educational institutions, in short, are places that because of their structures lie open to conflict. Indeed, in the “liberal” institutions in which we have worked, some of our colleagues and constituents have sometimes complained, “Things have been too quiet around here. It’s time someone stirred up something.” In such settings, leaders will think hard and long about the distinctions between healthy and unhealthy conflict. They are likely to experience an abundance of both.

Since we are trying to write only a few pages rather than a book on these matters, two illustrations will have to suffice to suggest what this distinction might be:

*Dignity is as health enhancing as victory.* The athletic coach who invented the slogan “winning is the only thing” was not very reflective about the ethics of most games. Mathematician Anatole Rappaport defined the difference between a *fight* and a *game* as



the difference between contests of sheer power and contests governed by rules that structure and limit the costs of conflict. Prize fighting notwithstanding, no game has to do with the murder of opponents. Such rules, often broken, apply to conflicts in institutions. Some, not all, faculty will get tenure; some, not all, will be elected to the board of deacons; some, not all, secretaries will be promoted to administrative assistant; some, not all, will keep their jobs at budget-cutting time. So there will be losers, as there are in every segment of human society. But how a society treats its losers and with what mantle of care it surrounds them is a sure index to the value of health enhancement in that society. What, after all, is *medical* care about if not the special concern for humans who, temporarily or terminally, are losers in the battle against sickness? In the institutional affairs central to our discussion here, both the ethics of compassion and its social expression can keep the processes and the end results of many a human conflict from becoming lethal for some of the participants. We think of the negative example of certain conflicts between peers on a faculty or colleagues in a church bureaucracy where the “word play” is part of the “power play,” and where the “care-full” choice of words may spell the difference between a tolerable and a traumatic outcome to the conflict. Whoever coined the folk wisdom “Sticks and stones may break my bones, but words will never hurt me” was not much experienced in the agonies of some human conflicts. Words have a way of poisoning human relations long after they are used to denigrate some opponent in a conflict. Successful administrators, like politicians, often have a reputation for public utterances whose sharp edges have been rubbed off: they specialize in “smooth talk.” In their position they are often the

**The leaders of religious institutions, like the Hebrew prophets of old, are charged by their theology as well as by their practical responsibilities to combine judgments about human sin with efforts to heal persons and relations.**

targets of conflict while being responsible for holding the conflicts of associates within some bounds. Occasionally they may have to use their administrative power to curb the behavior of those associates; but such power in our experience is best used sparingly. Sharp words are poor investments in the future of ongoing relations. They can become knives that wound every time they are remembered. Only people who have never stayed awake at night tormented by what people *said* about them in the midst of some institutional conflict will doubt this truth and its potential relation to the ill health of insomnia. And the dignity lost in such conflict can be the overture to depression.

*Institutional life can train people to experience the freedom of knowing that they can survive*

*conflict with equanimity and new strength, even when they lose.* This is an extension of the reflections above. Some years ago one of us worked on a sociological research survey designed to answer the question: Who are the people in this (North Carolina) urban area who are most likely to participate in communal affairs, and what are their characteristics? Unsurprisingly, we found only a minority of the population who were “politically” active as measured by their membership in community associations, their communications with political authorities, their willingness to initiate action on behalf of the poor, the environment, women, and the like. But what we found about the relationships of these persons was surprising: they had high ideals, they had some very strong friendships, and they had participated long enough in community conflicts to learn that one does not win all of the battles. On the contrary side, we found that people little active in community affairs, or with a short record for such activity, were often people with few friendships and with ideals



that left them feeling more frustrated than inspired. Perhaps the most dramatic (and medically significant) of our findings was that the highest incidence of insomnia and stomach ulcers was predictable for a group of people who professed very high ideals for social change, who had very few firm friendships, and who had experienced a defeat or two in community affairs and had withdrawn from the battles. We decided that this was an apt portrait of the “tired liberal”! Ideals not acted upon seem to be bad for health.

The institutional, health-related wisdom that might be derived from such findings is that groups of people bring different degrees of success in weathering conflicts from their previous histories; some are more gun-shy than others; some are more easily hurt by a given conflict than others; and some are more eager to engage in conflict precisely because they know they can survive it. The job of many a responsible *leader* in institutions, therefore, is to search for ways to encourage the shy and restrain the bold in these events. One suspects that it is by the building of a culture of expectations, rather than by direct exercises of unilateral power or resort to shrewd techniques of conflict management, that such leaders do most to effect such encouragement and restraint. “Habits of the heart” are hard to inculcate in the heat of controversy. The *postmortem* may be the time for building such a culture.

Some institutions so muffle conflict that their constituents are likely to be forever anxious over the thought “People are too repressed around here; they never speak their minds, and they fear to challenge authority.” But other institutions are so conflict prone that they nourish in their members the thought, “The atmosphere is angry, hostile, and always upsetting here. There’s never any peace, and it’s making me feel bad about coming to work in the morning.” The health-enhancing institution will nourish a very different set of feelings among its inhabitants: “You can speak your mind around here and not get put down; you can object and have someone listen; you can organize for justice and not get accused of betraying the institution; you can

quarrel and make up; you can make mistakes and be forgiven.” For us, this is a formula for health-enhancing *politics*.

## Pastoral and Prophetic Leadership

THE RELIGIOUS INSTITUTIONS of which we have been professionally a part aspire to being a prophetic foretaste of life in God’s new world order. Yet they are primarily very human institutions, with the weaknesses thereof. Their leaders must carry the prophetic banner but also minister to despair and anger over human shortfall. One pastor in Mississippi, during the civil rights pressures of the sixties, had preached a brave, forceful, prophetic sermon against racial prejudice in his state and locale. The next day an elderly woman called him on the telephone. “Don’t you love us anymore?” she asked tremulously. “Of course I do!” he replied. After a long pause she said, “Then preach what you want to preach.” The leader must find ways to combine the prophetic and the pastoral—justice and love.

Many of the themes in this article can be woven together around this theological and ethical core. After a particularly difficult season of budget cutting in the seminary, for example, the president reluctantly responded to student requests for a chaplain, an added expense. But, like other institutional costs such as worship and a refectory, this proved decidedly beneficial. She functioned as ombudsman as well as pastor to all parts of the institution, while sitting with administration and board as a person of real power—not as a placebo for student unrest. What, in a mental hospital, would be called a therapeutic-administrative split has continued to serve the institution well.

As in medicine itself, “health enhancement” in institutions presupposes definitions of health and illness that, in the moral and religious context, are analogous to definitions of the right-relatedness of justice and the wrong-relatedness of sin. The



therapeutic-administrative split in mental hospitals would never have been invented had not psychiatrists learned to see the hospital itself as a place where patients had to deal with social-institutional as well as intrapersonal standards of behavior. As it happens, the leaders of religious institutions, like the Hebrew prophets of old, are charged by their theology as well as by their practical responsibilities to combine judgments about human sin with efforts to heal persons and relations damaged by sin. The unavoidability of this task is not unique to religious institutions—doctors, patients, administrators, and auxiliary workers in health institutions are sinners too; and their sins can harm patients and each other. The challenge here is to combine prophetic protest against wrongdoing with pastoral compassion for wrongdoers. For example, there might have been less trauma among Vietnam veterans had American churches been able to do this in the sixties and seventies—reject a war without rejecting the warriors.

The ultimate model for this combination, for believers in the biblical Word, is the Supreme Judge and Healer pictured in that book. Any perusal of the writings of Hosea, Isaiah, and Jeremiah will yield many images of the striking, interwoven connections of divine judgment and divine power to heal. The “spiritual” dimension of health for these prophets was intimately related to all sorts of physical and social health. They could as little imagine a deity unconcerned with both judgment and healing as they could imagine a “salvation” that was personal without being simultaneously social. In one place Hosea has Israel confessing its sin and its hope in these words:

“Come, let us return to the Lord;  
for it is he who has torn, and he will heal us;  
he has struck down, and he will bind us up.”  
Hosea 6:1, NRSV

In the well-known passage introduced by the divine revulsion against Israel’s propensity for idolatry, God makes a self-comparison with a human mother and nurse:

I was to them like those who lift infants to  
their cheeks.  
I bent down to them and fed them.  
Hosea 11:4, NRSV

And in an equally well known passage, the prophet Jeremiah utters a lament that intertwines his own feelings of revulsion and compassion toward his erring neighbors. Seldom have judgment and grief been so locked in passionate connection or so infused with medical metaphors:

For the hurt of my poor people I am hurt,  
I mourn, and dismay has taken hold of me.  
Is there no balm in Gilead?  
Is there no physician there?  
Why then has the health of my poor people  
not been restored?  
O that my head were a spring of water,  
and my eyes a fountain of tears,  
So that I might weep day and night  
for the slain of my poor people!  
Jeremiah 8:21–9:1, NRSV

God is the ultimate enemy of human sickness in all its guises, and the ultimate Healer, too. Faith can believe no less, and the faith-full can aspire to nothing less than some imitation of both dimensions of that divine faithfulness. Are we capable of such an imitation in human institutions? The religious spirit can only answer a repentant “no” as prelude to a hopeful “yes.” ☸

# Looking for Grace in a World of Real Evil

Jerry K. Robbins

IN A RECENT ADDRESS, HELEN HARRIS PERLMAN made this observation: "Not long ago a friend called and told me about the number of illnesses in her family, and she asked, 'Why me?' It struck me how curious it was that I'd never heard that from a person who had been the possessor of some great good fortune. You never hear *them* ask 'Why me?'" (Perlman 1991:15). At first, I viewed this line of thinking as a doomed project, certain to end in empty platitudes and pious question begging. It also struck me that Perlman may have overstated her case, that possessors of good fortune *do* ask this question. Yet I was intrigued by the novelty of this approach to the age-old problem of evil. Why *don't* we pay more attention to the good data when working over the problem of evil?

Here, I will suggest some reasons for the neglect of this approach, and some arguments in its favor. I will also deal with some objections to this way of thinking, of which there are many. While sympathetic to those criticisms, I will, nevertheless, emphasize the importance of keeping the goodness

of life in view. Finally, I will address those who care for the suffering and suggest ways that they can contribute to the volume of good in the world. Of course, none of this is intended as the final comment on this subject. Rather, it is a case study of the theologian-in-action, located within the Christian tradition, wrestling with a tough problem from an unconventional standpoint. I invite you to join me in this uncharted adventure.

## I

AS PART OF HIS REGULAR REGIMEN, BILL OFTEN stops in my office to chat. Interspersed with talk about current events and the football scene, he sometimes reminisces about the past. One day he related a story about a close cousin who was killed in World War II, a war in which he also had fought, and of his grandmother who had foreseen the cousin's tragic death and Bill's survival in a dream. His voice choked with emotion, Bill unburdened his soul. "I just don't know why I was spared," he anguished. "Why did my cousin die, while I escaped without a scratch? Why was I given all these years, but he was taken? Why me, and not him?"

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While there are important exceptions among survivors of terrible destruction (e.g., the Holocaust), the sentiment of my retired friend is rarely encountered in our society today. To be sure, we are far more likely to hear the negative form of the question, *Why me?* In that form it is a cry of anguish and perplexity over seemingly unjust suffering. But the positive form of the question seldom surfaces. J. L. H. Thomas writes, "The question, 'Why did it happen to me?', when asked seriously is asked only in circumstances of misfortune, such as bereavement, accident, or permanent incapacitation, not of good fortune; someone who has received some benefit even if as great and as unexpected as many misfortunes, is unlikely to ask why it should have been accorded him" (1990:323). Even though many novelists, essayists, and poets document good fortune, or "count their blessings," and thank God for it, few ask the question, *Why*, in a world of suffering, have I been favored or spared?

What is the source of such questioning? First, it springs from a natural reflection about the ultimate nature of things. On a deeper level, though, it reveals a belief in an overall cosmic order, often equated with God's divine scheme, a transcendent purpose into which the questioner's life fits. Suddenly that order is shattered by some failure or excess. Then the question *Why me?* springs to the surface.

But why is it less common to hear the question raised in a positive context?<sup>1</sup> People who believe there is an order to reality view goodness as part of that reality. When good things happen, it is not a puzzle but a blessing of divine plenitude. Also, we seem more inclined to blame God for suffering than to praise God for happiness. As the Book of Job and the Psalms suggest, theological reflection is most urgent in tough times. Further, asking the positive *Why me?* question may seem in bad taste for some people. Søren Kierkegaard exposes the gross theology that can underlie some pious gratitude: "All this talk about thanking God for not being involved in adversity, for having a comfortable life etc., can so very easily be fraudulent. This kind of talk actually transforms God into a shopkeeper who discriminates

among his customers or does not have fixed prices, but to a few gives good, cheap deals under the counter" (1975:372).

Nevertheless, the positive question, however rare, submerged, or flawed, *is* asked as part of the human experience. Both Perlman ("You never hear *them* ask") and Thomas (the recipient of a benefit is "unlikely" to ask) overstate the case. People voice the question when they are amazed and gratified at some seemingly inexplicable, undeserved, gratuitous good fortune in their lives. The question comes up in widely different contexts. In the glitz and glitter of his television show, Arsenio Hall asks, "Why me? Why among all the talented performers was I fortunate enough to be where I am today?" In the glare of the wrecking truck, the dazed accident survivor gropes to understand why she escaped the mangled wreckage of an accident that claimed two other victims. And, in between those extremes, people wonder about their good fortune in being born in a country with a relatively high standard of living, of winning in love the very person who seemed beyond reach, and of living to an age far beyond the mortality tables.

It is a significant question also for those who daily supply care and comfort to the suffering. Those who labor on the edges of life and death are especially vulnerable to the haunting presence of ultimate questions. Here, the question might be phrased, *Why is that person sick, and not me?* In their work, they might ask, *How can I restore balance and hope to those who suffer?* Human beings are meaning-making creatures, and pain, disease, and death severely challenge meaning. In dealing with the profound mysteries of life, it is important to survey as wide a horizon of human experience as possible. That is where asking the positive form of the question can generate valuable data.

The reflections in this article, therefore, are directed primarily to health professionals and other caregivers (as well as researchers, ethicists, and religious thinkers) who ponder over the problem of suffering. Increasingly, it is care providers and help companions who are pressed to make sense of



catastrophic events. A theologian and professor of internal medicine writes, "Once a dread diagnosis is made, the response almost inevitably begins, 'Why me?' followed quickly by 'It isn't fair.' This requires actuation of a personal theodicy" (Vaux 1982:255). As well as being called into a physician-priest role in which they are expected to serve as religious counselors, doctors may find themselves in the role of patient, wondering about their own place in the scheme of things (Mullan 1975:42–43). Family caregivers may even raise the question for themselves in their personal struggles with the heavy demands placed on them (Wright, Pratt, and Schmall 1985:35). The negative Why me? question is an invitation to become part of a subjective world seldom entered by health professionals. Once entered, however, can the *positive* side of the question find a hearing in the discussion?

The thesis of this article is that the positive question is an important ingredient when wrestling with the problem of evil. Recently, television entrepreneur Ted Turner complained that he could not reconcile the concept of an all-powerful God with so much suffering (*Parade*, 5 January 1992). As well as posing a theological issue before a vast public audience, Turner expressed a common attitude: namely, that if people didn't suffer so much or if they experienced more happiness, belief in God would be easier. In this essay, I want to suggest that an important part of this calculus, sometimes overlooked, is the fact that *many people do lead healthy, happy lives*, to their amazement and thanksgiving. This fact does not prove God exists or answer the problem of suffering, but it can have salutary benefits: "There are occasions when an afflicted person needs simple reassurance that life is not absurd in spite of all appearances" (Karff 1981:75).

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## II

AT A RECENT LECTURE I ATTENDED ON happiness, the speaker, a former outstanding college football quarterback, made the point that people are often miserable because they continuously feed their subconscious negative thoughts. Similarly, I would argue, one reason we sometimes paint a sorry picture of life is that we usually look primarily at the bad things that happen. Ask the man and woman on the street which space launch they most vividly remember, and it is likely to be the *Challenger* disaster. Yet there have been dozens of spectacularly successful missions. Those safe missions may be little comfort to survivors of the tragic one, but

they should count for something. Nevertheless, theologians typically start with the dark side of the story (Sontag 1970:4–6). We need to ask why the negative is the determining category of our thinking. Instead, why not construct our thinking about meaning from a positive theological base and the astounding goodness we find in the world (Hick 1981:63–64)? The tradition of a positive approach does exist in various privation theories of evil, set forth by St. Augustine, Thomas Aquinas, William Temple, and Karl Barth, among others. According to this theory, the world is good overall, and evil has only derivative status. This point of view assumes a positive picture of the world in which evil is only a minor discord.

A shift of attention to the goodness in life is consonant with a recent emphasis in thinking about the problem of evil—namely, that the proportion of happiness to suffering matters in our judgments about meaning. Although this approach might be caricatured as the "accountant's solution," in which occasions of joy and misery are listed in two columns,



then tallied to see which side wins, a cavalier dismissal overlooks the fact that amount *does* seem to matter in our thinking about the nature of things. A recent *Time* essay expresses a popular attitude and approach. The author imagines a character called Dark Willard giving the morning “evil report,” in which all the catastrophes and humanly caused horrors are documented. The writer then speculates, “Is there more evil now, or less evil, than there was five years ago, or five centuries?” and proceeds to deal with that issue in much of the remainder of the article (Morrow 1991:48–51).

The German philosopher Leibniz elected to add and subtract his way to solving the problem of evil, arguing that, considering *all* of this life and the next, there is more good than evil (1952:379–80). Another philosopher, David Hume, joined this issue in the response of one of his literary characters to a grim view of life:

The only method of supporting Divine benevolence—and it is what I willingly embrace—is to deny absolutely the misery and wickedness of man. Your representations are exaggerated, your melancholy views mostly fictitious; your inferences contrary to fact and experience. Health is more common than sickness; pleasure than pain; happiness than misery. And for one vexation which we meet with, we attain, upon computation a hundred enjoyments. (Hume 1965:122)

It has been said, too, that, could we see the whole picture, the disproportion of evil to good might fade away (Niven 1926:325).

In more recent times, the matter of the amount of happiness versus the amount of misery has been placed at the very center of the problem of evil. It is precisely the quantity of evil in the world that fuels criticisms that God has not designed a very cost-effective system. Others argue that if one can just show a proper balance of good and evil, then evil is no longer an issue (Sontag 1981:55–56, 85, 139; Davis 1981a:70–71; Roth 1981:89). Optimistic writers believe we can improve the “odds for God”

by increasing the number of good things that happen to people (cure of illness, happy relationships, satisfaction in life’s work) over the number of bad things. If it is the case that happiness goes up as misery goes down, it is also true that more happiness tilts the scales in favor of belief in God as suffering fades into the background (Griffin 1981:53).

But is there actually more goodness than misery? Certain voices today say there is. R. W. K. Paterson is not satisfied with a one-sided concentration on evil so typical of usual discussions, and he offers the intriguing prospect that in the long run more good will accumulate than evil (1979:1–23). Clark Williamson readily acknowledges that we live in a world of discord and suffering. Yet even in the midst of massive evil, he suggests that the “gentle light of good” does flicker, creating a “perilously slight margin by which good is still dominant” (1983:55–56). Whether or not these judgments are correct, these writers make us think about the issue in a new way. To be sure, a calculus of good and evil can backfire, but the point is that we should not simply give away the case to those who see mostly the negative picture without looking more carefully.

Wherever good shines forth, however faintly, it matters in an assessment of this world and God’s place in it. If the person of faith sometimes believes more than the evidence warrants, there are others who *dis*believe more than the evidence warrants. The positive Why me? question encourages a vision that takes in the widest range of evidence possible. But is that more-inclusive perspective enough to resolve the problem of evil, or to be much real help to those who care for the sick and suffering? To that evaluation we turn next.

### III

ONE OF THE MOST SERIOUS OBJECTIONS to an inductive approach to evil is the criticism that, no matter what the tally, so long as there is *any* suffering, the ship of faith sinks. Let us suppose there is a Supreme Rainmaker, defined as one who causes rain



to fall from every cloud. But there is one cloud in the sky that produces no rain. The existence of just that one rainless cloud proves there is no Rainmaker. Similarly, suppose there is an omnibenevolent God, defined as one who causes every human being to be happy. But one human is unhappy. The existence of just that one unhappy person proves there is no omnibenevolent God.<sup>2</sup> As long as there is any gratuitous evil, so the argument goes, no amount of goodness can carry the day. Since no quantity of gratuitous evil is tolerable, the total amount of evil, or even the amount relative to the amount of goodness in the world, is unimportant.

While the rainless cloud argument poses a considerable challenge to a system that measures good against evil, one still has to ask *why* it wouldn't matter if the world had more good than evil. Perhaps a world with good but also evil is just the world God has designed for us to live in. Perhaps that is the only world we can occupy with any autonomy and meaning. In such a world it would be shortsighted to consider only the suffering we find. We would not survive long in humane work, or any purposeful vocation for that matter, if we admitted only the data on disease, destruction, and death. But, in fact, we recognize, for example, that hospitals can be places of recovery and celebration, where healthy babies are born, bones heal, some symptoms are benign, pain is stilled, and hope abounds (Holst 1985:6).

A second objection to the mathematical paradigm is that there is no way to know the sum of misery or happiness in the world. Lacking any means of measurement, it is impossible at any moment to calculate the grand total of goodness in the world. Who can see far and wide enough to make a judgment? It would seem that such a figure is available to an omniscient mind only (Reichenbach

1982:116). Moreover, even if one could determine the sum of evil at any moment, this quantity could change substantially in the future. A nuclear holocaust could bring misery to millions, while a period of peace with medical progress could significantly raise the level of happiness. The picture is further complicated by the fact that the intensity of pain for a few people might be far greater than the level of happiness for many. How could that subtlety be recognized in a sweeping survey?

Still, human beings are forever weighing events around them in their formation as optimists or pessimists. In making our evaluations, we operate with the information we have so far. This "accountant's approach" to evil invites us to join in the full measure of the human drama, to recog-

nize the good as well as the bad. We are asked only to acknowledge that, so far as we know, happiness is a part of many people's lives for much of their earthly existence. Also, we can acknowledge that it is as much favorable as unfavorable that the future is unknown to us. Now, there is at least an even chance that the amount of goodness will increase as time goes on. As for the intensity of misery, while that may be overwhelming in some cases, and must never be trivialized, the light of victory over adversity sometimes far outshines the adversity itself (Hebblethwaite 1976:80–81).

The most serious drawback to seeking sums of good and evil is that the process may not help or soothe those caught in the grip of suffering. Health professionals can only wonder what the happiness of others can mean for those who are far from happy. How does the sunny side of life relate to the nether side? How can people in the midst of suffering have faith in goodness? It would seem that recounting the positive *Why me?* question to those struggling with

**Those who suffer need to  
know that they are not alone,  
but they also need assurance  
that their suffering  
is not the last word.  
That is the central message of  
all effective caregiving.**



the negative question would only exacerbate their anguish and misery. It means telling stories of excessive good fortune and glowing good health to those who have neither. It means telling the sufferer that others experience unexplainable pain-free lives and good luck. Would anyone be so callous as to pursue such a therapy with the sick and grieving?

On the other hand, sufferers are little comforted by stories of the misfortunes of others, either. Thus there is good reason for caregivers to guard against a “gloom and doom” attitude or style. The message that suffering is a common lot, shared even by God, may only confirm the victim’s hopelessness. To point out that others are as unfortunate implies that suffering is the norm, or, at least, is gaining ground. An empathetic strategy is a two-edged sword, soothing in that it assures the sufferer that he or she is not alone, but alarming because it implies that evil is normative and extensive. The only way to correct that dark perception is to bring some good news into the picture.

Those who care for the suffering must act not only to decrease suffering and increase good, but also, through their own confidence and hopefulness, to enhance the quality of a patient’s spiritual life. Kenneth Vaux has written, “Medicine and theology go hand in glove as vehicles by which the human race comes to grips with the problem of suffering” (1982:209). Caregivers who acknowledge that the positive *Why me?* question may be both a credible and practical medicine for the wounded in spirit can cure souls as well as bodies. Such caregivers can help sufferers locate their suffering in a larger harmony. Those who suffer need to know they are not alone, but they also need assurance that their suffering is not the last word. That is the central message of all effective caregiving.

## IV

BUT HOW CAN WE CARE FOR OTHERS in this way? Those who anguish in their suffering often do not want help with their questions (Thomas 1990:324).

They are usually served least of all by abstract arguments: theoretical explanations of sickness are “about as useful for the sufferer as a lecture on cholesterol is for a starving person” (Fichter 1981:26). Words of advice from the well and happy often are empty of light or comfort for the sick and unhappy. Yet we must never forget that people *do* struggle with the problem of evil, and typically do so for theological reasons. The problem is about *God’s* place in the suffering. For that problem, theological resources that are not pat answers or mere philosophical fluff are required.

The negative *Why me?* question surfaces and is often a challenge directed to the justice and goodness of God. Suffering can cause severe spiritual turmoil, even for those without strong religious sentiments. Fitzhugh Mullan, a young physician, writes of his feelings facing cancer: “Was I a victim of the supernatural—some malevolent and vindictive force disseminated by chain letter? . . . What act of *hybris* had I been guilty of? . . . What had I done wrong?” (1975:43).<sup>3</sup> Several years ago, a family in our local congregation lost a son in an automobile accident. Soon after that, the mother was diagnosed as having breast cancer. The anguish in the hearts of these good people cast a dark cloud over their life in the church. Perhaps they were experiencing something of the spiritual pall that Robert Stromberg has voiced in these questions: “Why did this happen to me? Am I being punished? Is God trying to say something to me?” (1985:131).

Among the many stages sufferers go through in coping with their affliction, the stage of aggression is a kind of turning point. Serious illness can stir up a cauldron of hostility and protest. If the sufferer does not express these feelings, the result is resignation and depression. Unless a person is able to express anger, experience a catharsis, and move on, he or she cannot grow or become more whole. Caregivers provide a vital service to the suffering by helping them work through aggression to acceptance (Schuchardt 1989:32–33, 40–41). One way they can do this is through loving affirmation of the sufferer and compassionate care that relieves pain. I



can well remember visiting an elderly man who grumbled a great deal about his growing infirmities. Suspecting that his quarrel was spiritually grounded, I decided to be unfailing in my pastoral care of this person. Over months of listening and offering supportive prayers, I noticed a change in his attitude. He began to feel better about himself, he seldom complained, and he became more cheerful in conversation.

We know that people caught up in suffering are often consumed by their difficulties. A friend of mine who has spent all his life helping others and now suffers from a terminal disease recently confided: "It is hard not to be totally self-centered when you have a mortal illness." Another person, with a heart ailment, said of his condition, "It is all I can think about every waking moment. I can never get away from it, never forget about it." Sickness is the masked thief, the consummate robber that gradually steals all light and goodness from the vision of the afflicted. Only a more balanced outlook can liberate the suffering from their obsessive focus on illness.

By their conviction and behavior, caregivers can *act* to tilt the balance in favor of goodness. They can incarnate a spirit of goodness set loose in creation that is waiting to be made visible in human effort (Meland 1953:171–72). This effort can take many forms, including the particular shape given to it by Christianity—namely, acts of faith, love, and hope. By so doing, caregivers can increase the likelihood that the positive *Why me?* experience will occur as a counterpoint to the negative form of that question. Surrounded by faith, love, and hope, the sufferer can perceive more of the goodness in the world than he or she might otherwise see.

Caregivers with religious faith help those who suffer to maintain a more inclusive perspective (Maes

1990:11, 24, 149). They assist those overwhelmed with suffering to locate their suffering in the wider horizon of human experience. In that broader context, some good is present. In particular, the sufferer may come to see a world infused with a positive, harmonious order. The sufferer may be helped to see

that life is also hospitable, supportive, and enjoyable, sometimes beyond expectation. These experiences are often profoundly religious, centering around intimations of God and "powerful divine graces." Faith helps lift the downcast sufferer to see a glimmer of light in a world of dark shadows and frightening passages.

The support that caregivers provide can cover a wide range of services, in-

cluding medical and surgical procedures, nursing care, feeding and cleaning, education, priestly activities, and communication (Maes 1990:149). Hospitalized following a motorcycle accident, Carol Schuller writes about the practical ministry her renowned clergy father provided by rubbing her toes, bringing soap, rigging up a shower seat, and monitoring her medication (1986:19, 41, 43–44, 82). Dr. Mullan describes a foot bath that restored his stressed psyche as well as his tired body (1975:126). The caregiver can offer a supportive presence to the sufferer in countless ways.

By providing such support, caregivers defuse the awful feelings of victimization that sufferers experience. By their action, they make a statement about the balance of good and evil. They show sufferers that they are not alone, that even if impaired they are not without worth, that suffering is not a tyrant, and that misery need not be the bottom line on the script of their life. Where the caregiver extends this support from a spiritual base, he or she makes a statement about the love of God as well. The caregiver offers a "symbolic modeling" of the divine

**Those who care for people in desperate circumstances can encourage the human capacity for hope. By their patient, steadfast ministrations, they make an impressive statement about the shape of reality.**



intent and effort to be companion and helper to the sufferer (Holst 1985:114). In the love of the caregiver, the sufferer sees a force in the universe stronger than evil. Deeds of mercy alleviate suffering and affirm that the everlasting rule of reality belongs to God, who acts for the healing of creation. It is clear that people *can* contribute to the mass of goodness in the world, and where this takes place, even sufferers can feel that something positive is happening to them and ask, Why me?

Hope offers a vision of ultimate goodness. Those who suffer need to know their suffering will end. The human spirit is resilient and clings tenaciously to hope. In fact, the human spirit will nurture hope even in the bleakest circumstances. This is especially true where the hope has a religious foothold. Recently, when ministering to a patient, I observed the amazing strength of such hope. Told that the X rays had turned up a spot on his lungs, the patient consoled himself with the possibility that it was benign. When the biopsy showed cancerous growth, he was certain surgery would remove it. He met the subsequent spread of the cancer with a confident reliance on chemotherapy treatment. As metastasis continued, the patient tailored his hope to survival for a few more months, then days. At the end, his hope became a wholly spiritual anticipation of life after death. At no time in this long process did I see this person doubt the goodness of life or his place within it.

Those who care for people in desperate circumstances can encourage the human capacity for hope. By their patient, steadfast ministrations, they make an impressive statement about the shape of reality. Pain, sickness, and death may appear to have dominion. The situation may seem utterly without hope. But faithful caregiving says that one thing is stronger than these destructive forces, and that thing is love. Self-giving, empathetic care for the sick demonstrates that goodness, not evil, is the most enduring word. Especially when grounded in a spiritual context and expressed in actions overcoming suffering, love with flesh on it anchors hope in reality. Love that serves faithfully is a penultimate

statement of the ultimate victory of goodness. The suffering person has good reason to hope for an eternal goodness, inasmuch as that goodness has broken through into his or her life in the present. Where compassionate caregiving is powerful enough to displace the negative Why me? question with the positive, a miraculous pre-enactment of the ultimate order of things occurs.

## Conclusion

DOES THIS ESSAY THROW ANY NEW LIGHT on the problem of evil? I would submit that it does. Much advice about this issue counsels merely adopting the correct outlook or sentiment. Some say, for example, that while we cannot change our situation, we can change our attitude (Lewis 1948:21), that “there is an alchemy that turns all things into spiritual gold, and that alchemy is the right attitude to them” (Weatherhead 1962:89). Accordingly, the effort in rational theodicies is designed to change our attitude toward evil by changing our evaluation of its meaning. In this approach, the actual balance of good and evil may not be very important.

But looking for goodness in a world of evil is not the same as changing one’s attitude. If the amount of goodness in the world matters, all those positive experiences included, and there are ways we can contribute to that amount, then dealing with the intellectual problem of evil is not just a matter of adopting the correct outlook or sentiment. If it is only a matter of attitude, we can condition ourselves to see a half empty glass as half full. But dealing with the problem of evil can also mean scouting out the ingredients that can fill the glass. This approach goes in search of such ingredients, trying to consider all the data pertinent to the problem of evil, including the good information. It is a new viewing of the landscape that picks up the peaks as well as the valleys, a looking that searches for grace moments in a world of real evil.

An abundance of theologians and ethicists merely supply rose-colored glasses. They tell us this is the



best possible world because every tapestry must have its dark colors, and suffering is good for us. But these are merely mental tricks in the apologist's house of illusions. This new strategy offers eyeglasses that do not so much color our perception of things as open our eyes to a wider horizon. The rubric for treating suffering is neither optimism nor pessimism but realism. An inductive approach is based on the fact of goodness in a context where there is also pain and suffering.

Any credible campaign against evil will celebrate the victory of goodness. Finding people of positive Why me? temperament and lifting up their experience are challenges in this approach. Such a project is not for the faint of spirit, therefore, but for those with a vision big enough to see goodness where it exists and to give it voice and vote in the difficult work of making sense of life. ☸

## NOTES

1. It has been pointed out to me that Jews from Eastern Europe feared bringing too much attention to their blessings because of the evil eye.
2. This analogy is provided by Theodore Drange, Department of Philosophy, West Virginia University.
3. I have frequently referred to Fitzhugh Mullan because he is a living voice from the medical community. At the age of 23, while working for the U.S. Public Health Service at a community clinic in New Mexico, he was diagnosed with cancer. His story as a patient is filled with insight, humor, and poignancy. Especially noteworthy is this comment: "Throughout my months of illness and recuperation I experienced countless acts of support and encouragement by individuals connected with every aspect of my life. . . . What I remember are the people who commiserated with me, helped me, rooted for me, pinch-hit for me, and eventually cheered for me" (1975:163).

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# REFLECTION

## His Bed Is Empty

*Brian Chicoine*

MR. Z. DIED TODAY. HIS STRUGGLE IS OVER. His bed is empty. He had been in bed for six weeks, but he had not rested. He is resting now. He had been poked, stuck, and cut. He had had untold tests, X rays, and consultants. He had fought all the way to the end, but he did not lose the fight. He went beyond it.

He was a family friend. He had known me since my birth, and I had gone to first grade with his son. Nearly every one of his seven children had been in a class with one of my brothers and sisters. We had moved away many years ago, but they had remained in the old neighborhood. Although my parents had kept in contact, I had not talked with him in over 25 years.

I was out of town when his chest pain struck. One of my partners admitted him, and a cardiologist worked very hard to save his life. "A massive heart attack" was the explanation given to his family as the cause of his very unstable condition.

When I first saw him the next day, he required machines to help keep his lungs and heart going. He was also on multiple intravenous medications. His only hope for survival rested on improving the blood flow to the remaining living heart tissue by bypassing the blockages, but it was a slim hope.

In the few days that followed, we waited for him to stabilize, and he was able to get off the ventilator.

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His wife and seven children and their families all rallied around him, as did his parish priests. He was understandably frightened, but their encouragement helped him face the upcoming surgery.

I also talked with him and encouraged him in his struggle. He kept calling me "David," the name of my eldest brother. I understood his mistake in light of all the other concerns he had; I never corrected him. I held his hand. I listened. I reassured. I sensed a tremendous role reversal from our last encounter when I was a child. We had come a long way from the times of my playing in the snow in his backyard with his children and having picnics at the beach, but I could still remember the sense of respect and even fear that a six-year-old has for the father of a friend.

Mr. Z. came through the surgery well. The surgeon found more healthy tissue than had been expected, but the patient still needed the assistance of the machines. There was hope, but it was still slim.

In the days that followed, he made very slow improvement. We all hung onto each little bit of progress. His family was a constant presence. Always close by, they cared for him, prayed for him, and lived with him. If hope and love were going to be enough, Mr. Z. would survive.

The agonizingly slow progress was tough on them, though. My concern was that his slow progress was a window for a major setback to crawl through. I voiced this concern to the family but did so softly. Their hope was intact but was being tested by his condition.

Unfortunately, my concerns were realized. First Mr. Z. developed a severe infection. Despite the life-threatening setback, he successfully forged ahead, but



he was too weak even to eat, and we had to feed him through a tube. Though he disliked this procedure immensely, he remained hopeful, as did his family.

Then came kidney failure. It was slow at first—just some minor changes in the lab reports. There was no response to intervention, however, and soon there were major abnormalities and then no urine output. He began to fill up with fluid, which is not well tolerated by anyone but especially not by someone with such a damaged heart.

Dialysis was his only hope. He refused at first, then was reluctant, and then finally consented. He was extremely tired, and the repeated setbacks were pushing his very tiny energy reserve to its limit.

Dialysis went poorly, as it frequently does in people with very poor heart function. Mr. Z. became disoriented for hours during and after dialysis. This was very frightening to him and his family. The day after his fourth treatment, when he was wide awake and completely coherent again, he asked me to stop the dialysis treatments.

We had a long discussion that morning. He understood that his life depended on dialysis. He also understood that he might always be dependent on dialysis, that he might never get off the IV medications helping his heart pump, and that he would probably never have a life-style resembling his previous one. He was exhausted; even eating was too much work, but he no longer wanted the feeding tube. Breathing was a struggle, but he definitely did not want to go back on the ventilator. He had sat up in bed and dangled his feet once in five weeks. It was too exhausting; he was too weak.

I called his family in for a conference; most of them were able to come. After I explained his request, his family struggled with it for a long time. They had supported him and had agonized over each setback, and now they were having a great deal of trouble not seeing this choice as giving up. They finally agreed to

go along with his wishes. They understood that it was not necessary for me to get their permission to stop dialysis, but they knew I wanted them to understand the decision. He still needed their support.

I did not think he would live more than a couple of days. He had minimal heart function and no per-

ceivable kidney function. But Mr. Z. surprised us: he kept living. The family had prepared themselves for his death, and now they were dealing with feelings of renewed hope for his survival. It was difficult for me, too. I always find it difficult to predict when someone will die. There just seem to be too many unknown factors. My best medical opinion was that he should not be living this long off dialysis, and other consultants felt the same way.

Mr. Z. wasn't quite ready to go yet. His family wasn't quite ready either.

All he could do was lie in bed and breathe, and even

that was getting tougher. He could eat only very small amounts before he became too exhausted, and he still did not want to be fed in any other way. He understood that to survive he would need to agree to being fed by the tube, he would need dialysis, and he would have to go through a long recovery process. Even so, we were offering little hope for his survival. If he did survive, he would probably always be on IV medications to help his heart pump, and he would probably always be on dialysis.

"Let me go." He had reached his limit physically, emotionally, and spiritually, and he voiced it when I was making rounds a few days later. His initial request was that I give him something to help him die. I explained that my personal beliefs would not allow me to do that but that we could stop all his medications and allow him to die. He asked me to do so. He had a very clear understanding of what he was asking. He was ready for the next step.

I called his family in again, and we met in a conference room away from Mr. Z. I explained his

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## REFLECTION

wish. After a great deal of struggle and with a tremendous amount of courage, they again agreed to accept his decision.

His youngest son and I went into his room. It was the son with whom many years before I had attended first grade. We had gone our separate ways, but now, together, we were going into his father's room to carry out a very difficult task.

I leaned over and asked Mr. Z. if it was still his wish that I stop his medications. He said he would be thankful if I did and that it was time for him to go to heaven. I told him that he would probably not die immediately and that it might even take a few days. It was only then that he showed displeasure with the events of the day. He expressed frustration that it would take so long, but he seemed quickly to accept what would happen. I leaned over and turned off the IV pump that was delivering his medication.

There was an undeniable silence in the room. I asked him if there was anything else I could do for him. He asked me to pray for him, and I said I would. I paused for what seemed to be several minutes but was probably only a few seconds. He wasn't asking me to go home and pray for him, I realized; he was asking me to pray with him *now*. I paused again, feeling exposed and vulnerable. I was in front of colleagues and staff. Doctors just don't pray with their patients—that was the message I had been given during my years of medical training and practice.

I asked him if he wanted me to pray with him then and there, and he confirmed my suspicion. It came to me that both of us needed to pray: he was thanking me and blessing me for what I had done for him, and

I was blessing his decision. I had previously made it clear that his was a medically correct decision, but now I could share my sense of peace with his decision on another level. We were no longer merely doctor and patient but two humans who had struggled with life and death for six weeks. Now we were supporting each other in the most human of ways as we were letting go.

We prayed the Lord's Prayer. I couldn't hear if the others in the room were praying, but it really didn't matter.

I then said good-bye and left the room to console the family further and write the appropriate orders on the chart. I thanked the cardiologist and the nurse for participating in the process and headed for home.

I later learned that Mr. Z. called each family member individually during that night and talked to them. He told them that he loved them. I never learned and never asked what else he said, but it sounded as if he had been able to say good-bye.

It took 57 hours after we turned off the IV medicine for Mr. Z. to die. This demonstrated what I already knew: Mr. Z. didn't want to die; he was still fighting to survive. He had a great family to share life with, and he wanted to be able to go on doing that. But he no longer had the physical, emotional, or spiritual energy. He wanted to live, but he was ready to die.

At the wake, his family thanked me for coming and for caring for him. But it was I who needed to thank them. I had been given an opportunity to view his family pulling together and supporting Mr. Z. They had served him well. But his bed was empty now. He was finally resting . . . and so could they.



# ON THE BIOETHICS FRONT

*Action and motivation—what we do and why we do it—are often dealt with as separate matters. Sometimes we are concerned about the rightness and wrongness of actions; at other times we focus on the goodness and badness of motivations. Christine Cassel and Allen Verhey here guide us through two sets of recent articles that challenge us to question this neat categorization. We are encouraged to consider physician-assisted suicide by looking at underlying motivations and to assess compassion by looking at various actions. Warning: All those who want to keep their actions and motivations separate read further at their own risk.*

— John F. Kilner

## Physician-assisted Suicide: Are We Asking the Right Questions?

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*Christine K. Cassel*

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Richard A. McCormick. 1991. "Physician-Assisted Suicide: Flight from Compassion." *Christian Century* 108, no. 35 (4 December): 1132–34.

Leon R. Kass. 1991. "Why Doctors Must Not Kill." *Commonweal* 118, no. 1, Special Supplement (9 August): 472–76.

Dan Brock. 1992. "Voluntary Active Euthanasia." *Hastings Center Report* 22, no. 4 (March–April): 10–22.

Mark A. Duntley, Jr. 1991. "Covenantal Ethics and Care for the Dying." *Christian Century* 108, no. 35 (4 December): 1135–37.

THE TRUE COMPLEXITY OF THE VALUE CONFLICTS inherent in the public debate about whether physicians should assist patients in dying has only

begun to emerge. Until recently, most physicians, most ethicists, and most theologians would have agreed that, regardless of one's personal views on "allowing to die," the medical profession must draw "a bright line" against active assistance in dying. To point to the Hippocratic oath's proscription against giving a lethal dose to a patient and to point out the risks of abuse have been adequate to settle the issue in the minds of most professionals.

This has not, however, settled the issue in the minds of the general public. At least since 1976 the majority of people in the annual General Social Survey conducted by the National Opinion Research Center answered that they believe that "when a person has a disease that cannot be cured . . . doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it." In fact the number of people agreeing with this statement rose from 60 percent in 1978 to 72 percent in 1991. Numerous other public opinion surveys done in the last couple of years with the flurry of renewed interest in this issue confirm that a majority favors allowing physicians to help people die if the patients themselves request it.

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What has led to the growing intensity of the public voice in this matter? Recent events have certainly increased media attention. Among these events are the widely reported activities of Dr. Jack Kevorkian, who with his suicide machine, or "mercy-tron," as he now prefers to call it, has helped three women to die, none of whom had terminal illness. Kevorkian's actions, so obviously publicity-seeking and taken without any prior relationship with the patients, have been repellent to most within the medical profession. Yet the publicity seems to have stirred even more interest among those in the general public who want such an option to be available to them. Timothy Quill's account of his own involvement in physician-assisted suicide—with a patient who was dying of leukemia and whom he had known for many years in an obviously intense and caring relationship—only strengthened the public's interest. The Hemlock Society has also received increasing media attention, and its membership supports proposals to legalize physician aid in dying which this year appeared on the ballot in Washington State and will undoubtedly appear in numerous others. In the background of all this have been reports from the Netherlands, where the national medical society itself chose to make both active euthanasia and assisted suicide open practices. The society set forth standards under which such practices could be considered ethically appropriate and not subject to prosecution, even though existing statutory law forbidding the practices has not been changed.

The U.S. medical profession will have to continue responding to all these events, even as views within the profession are becoming less unified. In informal discussions with colleagues, many physicians will acknowledge that they can understand and accept the wish of a terminally ill patient to have some control over the end of his or her life; they may acknowledge their thoughts in this vein about their own deaths; or they may report that they have actually helped a patient die—always under unique circumstances of untreatable suffering and respect for the person.

Unlike some other questions in biomedical ethics, physician-assisted suicide is difficult to address with the straightforward relativism that our emphasis on self-determination and patient autonomy has framed for other issues. It is more difficult at least in part

because many of the world's great religions believe that suicide itself is an immoral act, an act against God. The tradition of medical ethics—medicine's own religion—reflects those beliefs. Most responses from the medical profession have drawn on the tradition of Hippocrates, with arguments that killing is intrinsically antithetical to the integrity of the profession, which has the value of life at its center. Psychiatric determinism gives clinical reinforcement to this basic value: any suicidal thought is considered evidence of depression and therefore evidence of the need for treatment; the possibility of rational suicide is denied.

It is odd that religious dimensions of the debate about physician aid-in-dying have not been emphasized in most discussions to date, be they ethical or sociological or both. Spirituality is a deep and thoroughgoing influence on human beliefs and behavior. It is not, or at least not entirely, the kind of rational and cognitive choice referred to by the sterile phrase "patient preferences." The religious beliefs of physicians and patients alike have a direct and meaningful relationship to their views on death, on suicide, and on the physician's role in these most personal and profound matters. In this review I comment on a few recent articles in which the spiritual dimension plays a major role, either explicitly or implicitly. Adding the dimension of religious belief to this debate does not make it simpler, as some might think, but adds further to its complexity. I believe this is good. This important topic is complex, and it deserves to be discussed as fully as that complexity demands.

IN "PHYSICIAN-ASSISTED SUICIDE: FLIGHT FROM Compassion," Catholic moral theologian and ethicist Richard McCormick argues that patient autonomy is not an adequate enough reason to step over the line into assisted suicide. When autonomy is absolutized, little thought is given to the "values that ought to inform and guide the use of autonomy," and people do not "confront the features that make choices good or bad" (p. 1132). McCormick suggests that many people want aid in dying because they abhor dependency, but this abhorrence can be changed, he advises, by a proper understanding of the obligations of *agape*, love. He quotes from an Anglican Study Group document, *On Dying Well* (1975): "Love, *agape*, is the equal



and unalterable regard for the value of other human beings independent of their particular characteristics. It extends to the helpless and hopeless, to those who have no value in their own eyes and seemingly none for society. . . . In the giver it demands unlimited caring, in the recipient absolute trust. The question must be asked whether the practice of voluntary euthanasia is consistent with the fostering of such care and trust." McCormick argues that dependency and frailty are "a call to cling to a power (God) beyond our control" and that medicine should not become so secular as to let respect for patient choice override this important theological reality. Most (but not all) of the Judeo-Christian faith traditions would agree with McCormick about where to draw the line. Indeed, as shown in the Park Ridge Center-sponsored volume on euthanasia, *Choosing Death*, very few denominations currently favor the initiative toward physician assistance in dying (see Hamel 1991).

Many physicians and ethicists who oppose physician assistance in dying draw on aspects of a faith tradition in their arguments. These arguments are exemplified in a recent special supplement of *Commonweal* entitled "Euthanasia," published in response to the then-pending Washington State Initiative 119. Physician-philosopher Leon Kass, in "Why Doctors Must Not Kill," argues: "The deepest ethical principle restraining the physician's power is not the autonomy or freedom of the patient; neither is it his own compassion or good intention. Rather, it is the dignity and mysterious power of human life itself, and, therefore, also what the oath calls the purity and holiness of the life and art to which he has sworn devotion. A person can choose to be a physician, but he cannot simply choose what physicianship means." For Kass, this may be a double imperative coming both from his own religious tradition and from a comparable faith tradition within the history of professional medicine. As is indicated clearly by the title of his article, most of the arguments against physician assistance in dying argue the moral importance of the physician's hands' remaining clean: the hands that heal should not kill.

These four authors strongly favor a merciful approach to patient suffering and respect for patient autonomy when the act at issue is the withdrawal of life support. (Indeed, McCormick argues vigorously that physicians' becoming more compassionate and more sensible in setting limits to the use of life-

sustaining technology would obviate the need for physician-assisted suicide.) These writers are not denying human mortality or the important role of the physician in making possible a dignified and meaningful death for her patients. For them the moral cusp is the action itself of giving pills or administering medication intended to cause death. The principle of double effect—which distinguishes between the direct and indirect consequences of an action—allows the physician to discontinue life support without assuming responsibility for the patient's death.

Philosopher Dan Brock, in a recent *Hastings Center Report* devoted entirely to this topic, argues that drawing the bright line between allowing to die and killing is missing the point, morally speaking. He argues in "Voluntary Active Euthanasia" that we should be evaluating the motive, not the act itself. Life-sustaining treatment might be discontinued for malicious motives, and that would be just as much "killing" the patient as administering a lethal dose would be. He argues further that in discontinuing life-sustaining treatment, the physician intends the death, that is, does it knowing that death will result, regardless of whether the action is viewed as "causal." Thus to make an ethical distinction between allowing to die and killing is meaningless if we do not examine the motives of those involved. This argument implies that a good motive could make assisted suicide as acceptable as allowing to die, that the motive, not the act itself, is where one finds good and evil.

Brock makes this argument as a philosopher and does not examine the theological implications of killing versus allowing to die. Nonetheless the issue of motives inheres in every aspect of theology; for example, an emphasis on mercy is essential in Christian thought. To discontinue life-sustaining treatment for a merciful reason rather than for a malicious one is more likely to be theologically acceptable. And there the "bright line" grows murkier, because in many acts of discontinuing treatment (for example, discontinuing ventilator support), the dose of morphine adequate to relieve the patient's suffering also in fact brings about the patient's death. Mercy is confounded if physicians are excessively scrupulous about not causing death. Tragically, many dying patients are given inadequate comfort care because the physicians are fearful of "getting their hands dirty." This has become a problem of national scope, leading to the publication



of guidelines on pain control by the Agency for Health Care Policy and Research (1992), to correct the widespread inadequacy in pain management that has been documented in our medical institutions.

This emphasis on the merciful motive also appears in Mark A. Duntley's article "Covenantal Ethics and Care for the Dying." Duntley examines the difference between the Kevorkian and Quill cases and argues that assistance with dying can be consistent with deep Christian compassion if it takes place in the context of mercy. Mercy, however, "is inextricably tied to relationships, particularly covenantal relationships" (p. 1136). Thus, for Duntley it is also in the motivation more than in the action that the theological importance inheres. Within the deep and profound connection of a covenant between doctor and patient "assisted suicide can indeed become an experience of mercy and grace" (p. 1137).

Behind this public debate, interestingly, there are increasing numbers of anecdotal reports suggesting that the practice of physician-assisted dying has been going on for as long as there have been encounters between physicians and patients. No doubt some of these acts have been morally reprehensible, and others perhaps morally acceptable, but many physicians (in conferences on the topic, in correspondence, and in private conversations) acknowledge that there have been "a few" cases in their careers in which they felt that the right thing to do was to help a patient die and did so. Others have reported regret that they refused such a request, thinking in retrospect that the decision betrayed a misplaced emphasis on the purity of the profession rather than on the mercy of a covenantal relationship. A recent survey done by the American Society for Internal Medicine sampled 1,000 mem-

bers. Four hundred returned the survey, and of those, 20 percent said that they had assisted a patient in dying (Crosby 1992). Even this relatively unscientific survey has uncovered not a small minority of physicians who acknowledge this practice. Thus dealing with the policy questions is as important as achieving philosophical and theological clarity about the meaning of the bright line and where it ought to be drawn. If there are so many "exceptional cases," should this act remain illegal and covert? Are these physicians immoral and unethical? Are we better off with a double standard? In the *Commonweal* supplement all the authors—Albert R. Jonsen, Leon Kass, Daniel Callahan, and Carlos F. Gomez—emphasize the perils of legalization because of the risk of abuse and the potential loss of public trust in the profession. And yet what does it mean when we continue our current practices, knowing that numerous physicians are engaging in an illegal act because they believe it is the moral thing to do? Would it not be better to establish standards that the profession would have to adhere to and an open process by which it could be accountable to a public already so distrusting because they feel physicians are not willing to help them in their deepest hour of need?

It is at least an open question whether allowing physician aid in dying requires rejecting the claim that it is the deepest constitutive essence of the physician to respect the dignity and power of human life. Moreover, is it not just as important for physicians to respect the dignity and power of human death—that is, to participate in covenant with their patients to explore the meanings of death which challenge all of us, not only as physicians but as human beings?

### NOTE

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## Compassion: Beyond the Standard Account

*Allen Verhey*

Bernard O. Brown. 1990. "The Problem of Compassion." *Criterion* 29 (Winter): 24–26.

Eric J. Cassell. 1991. "Recognizing Suffering." *Hastings Center Report* 21 (May–June): 24–31.

Warren Thomas Reich. 1989. "Speaking of Suffering: A Moral Account of Compassion." *Soundings* 72 (Spring): 83–108.

I HAVE LOST TRACK OF THE NUMBER OF TIMES I have been asked, "If you were sick, would you want a compassionate physician or a competent one?" It seems the standard question after any remark which suggests that being a good physician means something more than the technical mastery of a set of skills. To that question I have frequently made what is, I suppose, the standard reply: "I would prefer a physician who is both." Lately, however, I have grown a little suspicious of that reply. No one ever disagrees with it; the assent it invariably wins is too easy.

The problem with the standard reply is the problem with compassion, or rather, the problem with the standard account of compassion. Compassion tells us, in view of suffering, to do something, but it doesn't tell us what thing to do. When moral theologian Oliver O'Donovan complained about compassion (1984:10–12), he did not complain about the lack of it or about "compassion fatigue"; he complained about the emptiness of compassion, or the openness of the notion. It is, he said, "the virtue of being moved to action by the sight of suffering," but it "presupposes that an answer has already been found to the question 'What needs to be done?'" (1984:11). Compassion will move us to do something, but what thing we do will be decided on other grounds. And in the context of our culture's confidence in technology, compassion

will simply arm itself with superior technique, relying not on wisdom but on artifice against suffering (1984:12).

It is little wonder, then, that the standard reply wins such easy assent from physicians who ask the standard question. A call for such compassion sounds like nothing more than a call for technical competence in the face of suffering. Compassion, after all, has motivated the development of medicine and the technology it utilizes, and the motive of compassion is sometimes matched by outcomes that relieve suffering and restore the integrity of embodied selves. But the reduction of the standards of excellence for medicine to (properly motivated) technical competence creates problems which the standard reply and the standard account of compassion can hardly hide.

For example, technology is not ever just the power of humanity over nature but also always the power of some people over other people. Technology is power, and in the hands of a competent physician it is joined not just to good motives and to good ends but also, willy-nilly, to power over the patient. Where medicine is regarded as a technical competence, there patients are regarded as manipulable nature. It is little wonder, then, that compassion withers. The standard reply may remind competent physicians of their proper motive, but when renewed compassion arms itself again with artifice rather than with wisdom, compassion withers again and sometimes dies.

It is also little wonder that some complain against the arbitrary dominance of physicians and attempt to restrain that power by attention to the autonomy of the patient. Such a complaint is familiar in the literature on medical ethics. But while an emphasis on a patient's autonomy may restrain the powerful do-gooder (the compassionate and competent physician), it is powerless to sustain compassion or to nurture genuine attention to suffering. And such complaints (if I hear right) are familiar in the stories of the sick: that physicians don't seem to care and are inattentive to their suffering. When in Cartesian fashion the mind is set over against the body and respect demanded for autonomy while the body remains manipulable nature, then no progress is made toward attention to

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suffering, for people suffer neither as ghostly minds nor as biological organisms. They suffer as embodied selves.

The standard reply to the standard question needs to be reconsidered and reconstructed. One alternative would be to say, "I would prefer a physician who is competent and compassionate and suspicious of our culture's confidence in technology." Another alternative would be to say, "I prefer a physician who is competent and compassionate and humble and truthful and patient and fair and . . ." A third alternative, happily, may be simply to repeat the standard reply but to insist upon a fuller account of compassion, an account that arms compassion with wisdom as well as artifice. Recent essays by Eric Cassell, Warren Reich, and Bernard Brown point beyond the standard account of compassion and toward the plausibility of this third alternative.

Cassell begins (and ends) by stating that the goal of medicine is the relief of suffering and by lamenting the substitution of "a reductive knowledge of diseases and their causes for direct knowledge of suffering" (p. 24). Suffering is not hard to define; it is the distress experienced when the "intactness" or integrity of a whole person is threatened. But suffering is hard to recognize, hard to know.

One can, and Cassell does, ask what must be true of a self in order for it to experience a threat to its "intactness," in order, that is, for it to suffer. Such a self, Cassell argues, cannot be reduced to a biological organism or to its capacities for autonomous decision. For a self, any self, to suffer, there must be an identity that endures through time, constructed or reconstructed by the constant adaptation and defense of the self in response to the (interpreted) "facts of its existence," characterized by aims or purposes (one of which is "the preservation of myself as I know myself"), and formed or reformed in particular communities (p. 25). The difficulty is that these general features of a self, any self, who can suffer are also always individualizing. So although suffering may be common, suffering is also always individual and particular. The individuality and particularity of each self and of each self's suffering are what make truly knowing the suffering of another so hard. It would seem to demand "an exhaustive understanding of what makes them the individuals they are" (p. 26), an exhaustive understanding not only of their past but also of their inter-

pretation of their past, a complete knowledge not only of the facts of their present but also of their understanding of those facts, a full account not only of the communities to which they belong but also of the quality of the relationships in those communities, and an exhaustive understanding also of their purposes for the future.

It begins to sound not only hard to know another's suffering but quite impossible. Cassell rejects this conclusion, but he acknowledges that a medicine that focuses only on the self as biological organism will not learn to recognize or to relieve suffering, and an ethic that focuses only on the self as autonomous individual has denied the means for such awareness (p. 31). It is "not an easy matter," Cassell admits, but "compassion is possible" (pp. 24, 30).

We can know another's suffering only imperfectly, but we can know it. If we know the "natural facts" of a person's life and the values and purposes that constitute a person's identity, and if we are capable of aesthetic judgments concerning the "fittingness," the "harmony," of those facts and purposes, then we know enough to recognize not only that another suffers but how and why. And if we know that, then we may be able to discern how to relieve that person's suffering. Cassell says that we will have "better tools" (p. 30), but this compassion is armed not with artifice but with wisdom and discernment. Compassion's recognition of and response to suffering requires aesthetic judgment rather than scientific or technical judgment (even of the "natural facts"). Aesthetic judgments are "ineluctably subjective" but "not necessarily idiosyncratic" (p. 29). The aesthetic judgments that belong to compassion are stable rather than ephemeral, evoked by an object rather than simply experienced by a subject, and open to communal review, illustration, discussion, and education. These characteristics protect compassion from being an empty and ephemeral feeling; they enable compassion not only to move physicians to do something but also to provide physicians some direction concerning what they ought to do.

The community of physicians is therefore properly enjoined not only to have compassion but to develop the fund of wisdom necessary to recognize and respond to suffering (p. 31). Part of that wisdom, a part one might wish Cassell had developed more, is the acknowledgment that suffering, even when recognized,



cannot always be remedied. Then the course of compassion will not be "the alleviation of the distress" but simple presence to and community with sufferers, lest they slip "into unconquerable loneliness" (p. 31). Another part of that wisdom, a part Cassell ignores, is the acknowledgment that the compassionate physician armed with wisdom is ineluctably a moral teacher. Sometimes the suffering recognized in the aesthetic judgment of a lack of fit between the "natural facts" and the "central purpose" of a patient can be remedied not by the addition of a new fact, like the presence of a compassionate and competent physician, but only by a reconstruction of an identity, a reformation of purpose, a revisioning of the whole, in ways tutored by a sage physician. The 150-pound college sophomore whose central purpose is to be an offensive tackle may suffer because of his size, but what he needs is not steroids but a good talking to.

Reich, too, begins with suffering. His splendid essay's attention to the "process" of suffering, however, allows him to say more clearly and candidly how and why compassion will be present to the suffering and assist the sufferer when armed with wisdom rather than artifice.

The process of suffering is described as the struggle to discover a voice that will express one's suffering and the search for meaning in the midst of it. The first phase of that process Reich calls "mute suffering" (p. 86). Sufferers are "struck dumb" by their suffering; they may be screaming or moaning rather than silent, but in this phase they are unable to communicate about their suffering. And because they are unable to communicate about their suffering, they are also unable to articulate a self or a purpose that can contain the suffering and make it meaningful. The course of compassion in response to this first phase is simply silent and empathetic presence. The compassionate practice of presence provides a first and fundamental break with the desolating isolation of suffering, and the readiness of another to care and to hear nurtures the readiness of the sufferer to seek care and to express one's experience, to move, that is, to the next phase.

That second phase Reich calls "expressive suffering" (p. 88); in it sufferers find a language to express their suffering, whether plaintive lament or story or metaphor. When sufferers find voice, the course of "expressive compassion" (p. 94) is to listen, to be sure, but also to raise one's own voice in com-plaintive

lament, to empower the sufferers to name the threat (with a diagnosis, perhaps), to reformulate the stories they tell, and to reconsider the metaphors they use. "Expressive compassion" will utilize both "translational statements," which enable sufferers to translate their feelings into comprehensible words, and "interpretive statements," which empower sufferers to understand their own past and future and present, their own stories and metaphors, themselves, in a new way. It is not that compassion benevolently or paternalistically imposes a story. It does not ignore or deny sufferers' capacities for understanding and choice. Like a good teacher a sage compassion engages those capacities and educes from sufferers stories at once their own and transforming.

Such compassion is midwife for a "new identity," the third phase of suffering. This third phase of suffering does not necessarily involve "freedom from adverse conditions," but it does involve the "freedom to take a stand toward the conditions" (p. 91, citing Frankl 1963:205). It involves a fundamental decision that is constitutive of the self, a reconstructed wholeness.

By this account of the process of suffering Reich points beyond the standard account of compassion to a fuller account. Like Cassell, he calls for a revision of the "excessive attitude of objectivity in medicine" (p. 98) and a reformation of the tendency of medical ethics to describe a caregiver's options as either a benevolent paternalism or a respect for the rights of an autonomous patient.

His account of the process is not intended to be prescriptive, as if there were stages that must be successively experienced in order for one "to suffer or to be compassionate in the right way" (p. 104). Moreover, Reich admits that the process seldom achieves "finality," "for the wounds of this or another form of suffering open up again," and "the 'final' word is rarely spoken in the language of suffering and compassion" (p. 105). Therefore, in order to be—or at least to continue to be—compassionate, the caregiver must receive compassion. One might wish Reich had developed these observations more. A sense of limits and of grace in the midst of both suffering and compassion might point the way to a compassion armed not only with wisdom but with piety.

This notion is what makes the essay of Bernard Brown interesting. He invites us to the prayer and piety chiseled on an urban cathedral: "Christ look



upon us in this city. And keep our sympathy and pity fresh and our faces heavenward lest we grow hard" (p. 24). Brown acknowledges that "we grow hard" in the midst of suffering. Our capacities for compassion are not unlimited, and the suffering that surrounds us seems intractable and hopeless. But we can learn compassion and be present to the sufferer if we "keep our faces heavenward." "To look heavenward is not to look away"; it is rather to see suffering and compassion in a new way; it is to interpret the stories of our suffering or our compassion in a new light; it is to be "tutored to lives of compassion" (p. 26).

Brown could have done more with this intriguing idea. Looking heavenward could remind us, for example, to see in those who suffer not only a suffering that alienates but the very image of the Lord. And when we are present to the least of those who are sick and suffering, we are present to Christ (Matthew 25:31–40).

Looking heavenward could also remind us of our limits. Physicians who look heavenward and make petition for a patient may, of course, be tempted to corrupt and trivialize prayer by making it into a means, a supplementary technology, an old and desperate artifice to insure the effectiveness of their own work. On the other hand, looking heavenward, attending to God in the form of a petition for a patient, may form an altered (and an altared) sense of responsibility. In petition physicians hand the one under their care over to the hands of God, remembering and

hoping that the God to whom they look is abounding in steadfast love and able to heal the hurt no medicine can touch. Looking heavenward, they let go the anxious control they had conscientiously assumed. They can take themselves a little less seriously, for they learn again that they are not Messiah, and they are freed from the intolerable burden of inaugurating God's good future for the patient. They can freely acknowledge the limits of their artifice and their own limits. Looking heavenward, they will provide the best care they can, but they no longer anxiously substitute for an absent God. In making petition, in looking heavenward, physicians can learn again a carefree care. Compassion is evoked and sustained as no less a response to gift than are the prayers of thanksgiving that accompany petition. It is in that "altared" sense of responsibility that we might lay our best medical skills and our worst medical cases before God and, looking heavenward, find new resources and new direction for compassion.

To the standard question I think it still plausible to reply, "I would prefer a physician who is both competent and compassionate." That reply, however, should insist that we look beyond the standard account of compassion to the richer account provided by Cassell and Reich and, yes, beyond even that in the direction Brown pointed, "heavenward." In a full account of compassion care is armed not only with artifice but with wisdom, and not only with wisdom but with piety.

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# NOTEBOOK

Over the past two decades, more than 130 free medical clinics have sprung up around the country, many of them because members of local medical societies have grown tired of waiting for national leaders to make up their minds on systemwide reforms and for state governments to fashion workable public-private health insurance programs.

"It's a way for me to give back my time and to say 'thanks for making me a doctor,'" says Randy Albert, one of thousands of physicians nationwide who have opted for the hands-on approach in dealing with the health care access problem faced by an estimated 35.7 million uninsured Americans, many of them classified as the new "working poor."

Patients usually first visit primary care physicians who can then refer them to participating specialists, hospitals, pharmacists, and dentists. Most facilities receive no government money, relying instead on the altruism of local doctors, fund raising, and contributions from individuals, businesses, churches, service clubs, and charitable organizations. As an example of how hospital networks can be involved, the Kentucky Hospital Association has a program called Fair Share in which every acute care hospital in the state agrees to accept its share of indigent patients.

"We believe that with just \$15,000 of seed money and a core group of a half-dozen or so volunteers, including a couple of doctors, we can have a free clinic up and running and serving a couple thousand people in a matter of months," says one clinic director. "No clinic we've ever helped start up has failed."

(*American Medical News*, 6–13 July 1992)



German theologian Jürgen Moltmann, viewing the crises caused by threats to the environment, takes seriously the critiques of Jewish, Christian, and Enlightenment understandings of how humans should "have dominion" over nature. The result, say critics, has been exploitation and ruination. Moltmann, after agreeing with much of the criticism, turns to a basic text of the biblical tradition (Genesis 9:9–10) and



finds in it a formula for a different mode of understanding and action. "God says in the story of Noah: 'I am establishing my covenant with *you and your descendants* after you, and with *every living creature* that is with you.'" From this he comes up with a short and memorable formula:

*Fundamental human rights* come from the "with you."  
The *rights of future generations* come from the "and your descendants."

The *rights of nature* come from the "and with every living creature."

Such an understanding could provide the basis for a healthier people and environment.

(*Word and World*, Spring 1991)



Three-quarters of people over 75 who now live alone would be impoverished within a year if they moved into a nursing home.

(*New England Journal of Medicine*, 13 July 1992)



Because of high blood pressure and other health problems, African-Americans are twice as likely as whites to contract end-stage renal disease, a condition that requires dialysis or, preferably, a kidney transplant. Yet African-Americans and other minorities do not receive transplants as often as whites because most donors are white, and tissue compatibility is most likely between persons of the same race.

At the end of February 1992, there were 19,851 people on the national transplant list waiting for kidneys; 52.9 percent of them were white, 31.8 percent of them black, 9.6 percent Hispanic, and 4.8 percent Asian, according to the United Network for Organ Sharing, the national center for organ donation, in Richmond, Virginia. But in 1990, the latest year for which statistics are available, 82.8 percent of all kidney donors in the country were white, while 9.2 percent were black, 6.1 percent Hispanic, and 0.9 percent Asian.

People familiar with the issues of organ donating find no single reason that so few African-Americans



donate organs. Religious belief, however, is one factor. Many fundamentalist churches emphasize a belief in the resurrection of the body. Some people interpret the concept literally and do not want body parts removed after death. But according to the Regional Organ Bank of Illinois, no major religious group officially opposes organ donation. Even the Jehovah's Witnesses, who have strict guidelines on blood transfusions, approve of organ transplants if the organ is thoroughly cleansed of blood.

Another factor is distrust. Doctors and counselors have said that some blacks believe that organ centers discriminate and that their organs will most likely be donated to whites while blacks are left waiting. The process for determining the best match between an available organ and a recipient is not subjective, however: a computer makes the decision. Family counseling by specialists can alleviate distrust and misunderstanding, thus encouraging organ donations among blacks.

(*Chicago Tribune*, 22 March 1992)



Research into the field of psychoneuroimmunology has suggested links between emotional well-being and physical health, especially in the case of cancer. The discovery of this link has enabled some patients to gain a sense of control over their illness, but at the same time it has led to an increasing tendency for people to blame cancer patients for their disease. Author and psychologist Harriet Goldhor Lerner commented recently on that tendency:

Theories about "cancer-prone personalities" obscure the fact that increasing numbers of young people are victims of environmentally induced cancers. The men in power who are more concerned with profits than people would prefer us to maintain a narrow focus on psychological and genetic determinants of cancer. Such a focus deters us from protesting against the poisoning of our communities by toxins and carcinogens. Profit madness, not personality deficit, is causing an epidemic of early cancers. . . . Living right is undoubtedly a good and healthful idea, but it is no guarantee against getting cancer or preventing its return.

Conversely, the diagnosis of cancer does not indicate that one has not lived well enough, or that one could have prevented cancer by having done (or been) more (or less) of this or that. The fact that we can gather our emotional strength to help heal ourselves does not mean that we are in any way at fault for getting a cancer diagnosis. This blame-the-victim syndrome is a terrible distortion of recognizing the healing powers of loving oneself and one's life. Glib prescriptions for cancer patients to "look on the bright side" and "keep a positive outlook" instruct us to clean up our attitude; instead, we more desperately need to insist on clean air, water, and food and a safe, livable Earth.

(*New Woman*, January 1992)



■

A Japanese trading company has been ordered to pay compensation to the widow of a victim of *karoshi*, death resulting from overwork. The executive, found dead in his hotel room on July 15, 1990, had during the preceding year spent a total of 115 days abroad on business trips. Approximately 30 deaths annually are officially attributed to *karoshi*, but most such cases involve blue-collar workers. The National Defense Council for Victims of Karoshi blames overwork for up to 10,000 deaths annually.

(*New York Times*, 16 July 1992)

■

In a review of British physician Troyan A. Brennan's new book *Just Doctoring*, reviewer A. M. Daniels comments on Brennan's strong stance against physicians' paternalistic behavior toward their patients:

We can all agree that surgeons ought not to amputate their patients' legs against their will, even if such operations are life-saving. The right of adult Jehovah's Witnesses not to be treated with blood transfusions has by now been established, but in most medical situations the issue of patient autonomy is less clear-cut. When I have been very ill . . . I have willingly surrendered decision-making to my physician, first because I believed



that by trusting him I was making his task easier, second because I wanted to believe in his complete control of the situation, and third because I had a terrible headache. I am glad to report that my trust was entirely justified and not in the slightest abused.

The practice of medicine calls for judgment, including the judgment about how far to be paternalistic. To suppose that all patients are alike in their ability to face a fatal diagnosis, for example, is crudely simplistic. There is no rule which will

cover all cases. Insofar as the doctor matches the explanations he gives his patients to their ability to understand them, he is being paternalistic, and necessarily so. Errors of judgment are possible, of course, even likely, but error itself cannot be eliminated by the application of rules. A society in which a thousand rights are enshrined in statutes or codes of practice, but in which no one trusts anybody, is not the kind of society in which I should like to live.

(*Times Literary Supplement*, 3 January 1992)

■

It is well known that divorced women often suffer the triple burden of a drastic reduction in income, increased responsibility as a sole parent, and disapproval from the community. But how does divorce hurt men? While the loss of the role of husband and father may carry little economic penalty for men, divorce often exacts a high price in terms of emotional stability. When a man loses his family status he loses his social status as "breadwinner" and "head of the house." He must adapt to traditionally feminine tasks like doing household chores and maintaining ties with friends and relatives. The emotional isolation that often occurs helps explain why divorced men have a higher



percentage of mental health problems (suicidal thoughts, low self-esteem, lack of purpose and structure) than do married men and even divorced women. In this situation, many men tend to escape their "intense loneliness" by resorting to various social and sexual encounters and rapid remarriages that are often unstable.

This raises several questions for church communities: What would informed postdivorce counseling for men look like? How can the church offer something positive to men in the different stages of divorce? What resources can denominations share in order to develop a postdivorce counseling curriculum?



What steps can be taken to ensure that the former spouse and children are not abandoned? What can you do in your church to help male members hook their self-esteem on things other than traditional male images? What family arrangements do we tend to institutionalize, and how do these perpetuate social stereotypes?

(World Vision Canada's *Context* newsletter, December 1991)



A study prepared at Harvard University by 40 experts predicts a far worse scenario for the spread of HIV infection than any previous report. In contrast to the World Health Organization's (WHO) estimate that 1.5 million individuals currently have AIDS, the Harvard study estimates 2 million. Its estimate of the number infected by the virus is several million above WHO's estimate of 9 to 11 million. WHO predicts that by the year 2000, 30–40 million people will be infected. The Harvard study predicts 120 million, with 42 percent of those in Asia, surpassing the 31 percent in sub-Saharan Africa. The incidence of HIV infection in women is rising dramatically, from 25 percent of all infected individuals in 1990 to 40 percent in 1992. The report also predicts that no place in the world will escape the epidemic. In 1991, spending to prevent AIDS in sub-Saharan Africa amounted to seven cents per person, whereas in North America it was \$2.70.

(*AMA News*, 22 June 1992)



The Center for Addiction and Pregnancy at Francis Scott Key Medical Center is one of a few programs in the country that combine drug treatment with prenatal care and the teaching of parenting skills. The center



was created by Johns Hopkins University physicians and is funded largely by Medicaid.

Women who come to live at the center learn how to eat properly while pregnant, how to be a better parent, how to handle money, how to use birth control, and, most important, how to resist drugs. They and their babies receive regular checkups.

"This is a window of opportunity," says Pat Paluzzi, the center's head nurse-midwife. "In a moment, they get a flash of: 'I'm pregnant. I want to stop using drugs for my baby.'"

In its year of existence, the center has shown promise as a solution to the staggering problem of drug-affected infants. On average, the 71 babies born there have been one pound heavier and closer to term than the U.S. average for infants born to addicts. Just 13 percent have required intensive care, compared with 40 percent nationally.

(*American Medical News*, 6–13 July 1992)



"Should the Church Help Shape Public Policy?" was the title of an address to Catholic hospital administrators given by Archbishop Daniel Pilarczyk of Cincinnati on May 17, 1992. "One of the most important features of a democratic form of government," said Pilarczyk, "is discourse, discussion, dialogue, conversation, the exchange of views in the widest possible contexts." A church, like any other group, is free to participate in this process. "The only restriction is that it can assert no legal claim for compliance to its wishes that are based on its own religious beliefs."

What is the goal of church participation in the political process? It is not to induce others to accept particular religious beliefs but rather to persuade them that the implications of these beliefs are "beneficial to society on society's own terms." The common ground between the church's principles and those of society is the dignity of the human person. In this regard, the church's role in shaping public policy is to try to keep public policy consistent with the principles on which society is founded, to point out opportunities and dangers in the process of forming public policy through democratic conversation, and to highlight the harmony or disharmony between society's premises and its behavior.

(*Origins*, 11 June 1992)



■

A community-based computer network for people with AIDS has proved helpful in reducing patients' feelings of social isolation, according to the project's director. Patricia Brennan, director of the three-year-old network ComputerLink, developed at Cleveland's Case Western Reserve University, refers to it as a "support group without walls."

Here's how it works: Patients at home are linked via computer with other patients and with medical professionals. The networking helps them to learn more about their disease, assists them in decision making, and lets them share problems and ask questions.

Brennan has recently established a second ComputerLink network supporting caregivers of Alzheimer's patients.

(AHA News, 1 June 1992)

■

In a meeting sponsored by the Office of Research on Women's Health, National Institutes of Health, several hundred scientists and physicians, mostly women, discussed ways to encourage women's full participation in the biomedical sciences and to break through the "glass ceiling" that keeps women from achieving their potential. Proposals included

- establishing a pilot program to retrain women scientists for reentry into research after time off to raise a family
- reforming rigid tenure requirements for academic medicine
- increasing and improving mentoring of women scientists
- establishing a national clearinghouse for information on jobs, training, grants, and awards
- making federal funding for research contingent on the institution's track record for sexual harassment and the promotion of women

(*Journal of the American Medical Association*,  
8 July 1992)

■

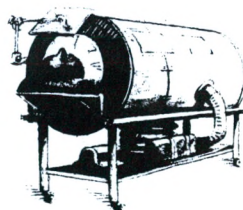
New data suggest that within the next 10 years, an ozone hole will form over populated regions of the northern hemisphere. The NASA-run experiment conducted over a six-month period also revealed that experts have overestimated the atmosphere's ability to defend itself against ozone-destroying chlorine pollution. As levels of chlorine climb each year, the chances of severe Arctic ozone depletions rise. "The immune system of the atmosphere—its ability to suppress chlorine—is weaker than we expected. . . . I think this is an early warning," says project scientist James Anderson of Harvard University.

(*Chicago Life*, June 1992)

■

Ninety percent of the medicine being practiced today did not exist in 1950. Just two centuries ago medicine was an art, not a science. Even 60 years ago there was usually little the medical profession could do once disease set in except alleviate some of the symptoms and let nature take its course. Around 1930 the power of the doctor to cure and ameliorate disease started to increase substantially, and that power has continued to grow exponentially ever since. This new power to extend life, interacting with the deepest instinctual impulse of all living things—to stay alive—has had consequences that society is only beginning to comprehend and deal with.

Financing this extension of life is one of the greatest problems embedded in modern medicine. In



1930 Americans spent \$2.8 billion (3.5 percent of the GNP) on health care. That amounted to only \$23 per person. The average physician that year earned less than \$10,000. In 1990 the country spent 235 times as much on medical care, \$666.2 billion (12.2 percent



of the GNP). That amounted to \$2,566 per person. The average physician that year earned \$132,550.

When inflation is accounted for, the country's per capita medical costs have risen 10 times in 60 years while the average physician's earnings have risen less than 3 times. According to the Health Care Financing Administration, health expenditures will almost triple in the next 10 years if current trends continue.

(*American Heritage*, May/June 1992)



In 1990, more than 60 percent of group health insurance plans had provisions excluding coverage for preexisting conditions. Since as many as 81 million Americans under 65 have medical problems that insurance companies may consider "preexisting conditions," many employees may feel locked into their current jobs.

(*New England Journal of Medicine*, 13 July 1992)



*Sleeping Beauty: Memorial Photography in America*, recently published by Twelvetreets Press, is a collection of photographs of the dead and dying from 1842 to 1925, an era when postmortem photography was a common practice. Says the book's editor, Stanley B. Burns: "These photographs were often the only ones taken of their subjects and much pride and artistry went into them. It is astounding that although postmortem photographs make up the largest group of nineteenth-century American genre photographs, they are largely unseen, and unknown."

Novelist and essayist John Updike, in his review of the book, has this to say about modern attitudes toward death:

In the course of this lethal century, death has been rendered increasingly abstract—a choreographed plunge on the television screen, the punch of a red



button in a bomber or a computer game, a statistic in a column of print. . . . As a domestic reality, at least in the Western world, dying has been eased out the door—sent off to the hospital or the nursing home, and the corpse dispatched straight to the mortician, who is handsomely paid for performing his magic out of sight. . . . Men and women not involved in mortuary, medical, or police work can now lead full, long lives without ever having to see, let alone touch, a corpse.

. . . Our own time, which celebrates the living body—in exercise, diet, gladiatorial games, and pornography—with more frankness and zeal than any culture since the pagan Roman, is very squeamish about the body once dead. . . . No longer susceptible to the commercials of sex appeal and consumerism, the body becomes trash. The piety of the previous century clung to the Christian tenet, unemphasized in today's churches, that the body *is* the person, with a holy value even when animation ceases.

(*American Heritage*, May/June 1992)



The United States does not make the list of the 20 countries with the lowest infant mortality rate. The countries with the lowest rate—including Japan, Sweden, Finland, Singapore, and the Netherlands—all have rates below 9 infant deaths per 1,000 births. The rate for the United States is 9.80.

(*American Medical News*, 13 April 1992)



# READERS' RESPONSES

## On Medical Noncompliance

*The Second Opinion staff invited a number of its readers who are physicians to respond to our recent Case Stories section on medical noncompliance, which included a case story by Kevin Coleman and commentary and overview by Arthur W. Frank (Second Opinion 17, no. 3 {January 1992}). These letters continue the Readers' Responses section that appeared in Second Opinion 18, no. 1 (July 1992).*

### To the Editor:

A long time ago, when I started in the medicine business, I was stationed at a U.S. naval base near a large military hospital. During my tour I got to know a couple, well into their 70s, who had been to the hospital and then returned to our care. The wife had chronic congestive heart failure and was on medication and a low- (no-) salt diet.

During the time they were in my care, the wife asked, since she knew there was no cure for her heart problem, if she might have a piece or two of bacon (which was off the list of acceptable foods) on Sunday mornings. Apparently she and her husband had always enjoyed this kind of breakfast in the past.

As a neophyte physician, not long out of what was then called a "rotating internship," this caused me a great deal of concern because I was not the "heart specialist." After some discussion, we decided together that she could have the piece of bacon if it had no untoward effect on her heart. There was no adverse effect or worsening of her condition, and the

couple was able once again to enjoy their Sunday breakfast.

I mention this situation not because we accomplished anything magic but because it seems to me there was a communication process that was not present in Kevin Coleman's case. Granting that the piece of bacon on Sunday morning is not medically on the same level as chemo- or radiation therapy, the same principle applies.

Indeed, while it is true, as stated in the commentary by Arthur W. Frank, that there is a gap between the professional and the layperson, there should be no gap in their ability to respect and communicate with each other and work together against their common enemy—in the case of Mr. Coleman, the lymphoma. Such collaboration, like the rest of life, is likely to involve discussions where there might not always be complete agreement. This is particularly likely when there is an enemy whose cure may be prolonged, uncomfortable, and possibly in the end, futile.

The woman who wanted the bacon, and her husband, it seems to me, were at least willing to share with the physician in the decision-making process. The physician can do no less than to listen.

The most desirable outcome will occur when the patient and physician communicate about the disease and its therapy and together try to reach a decision. Even if they do not reach a harmonious decision, they may well have benefited from the effort.

**Michael Donlan**

Inland Northwest Genetics Clinic  
Spokane, Washington



## To the Editor:

As a clinician who also teaches a clinical ethics course at a large urban hospital, I feel that Kevin Coleman's article could easily be retitled "An Episode of Incomplete Understanding." In residency training programs as well as in actual medical practice an often neglected part of the medical history is the patient's social history. Residents, who already have an understanding and respect for the technological imperative of medical practice, could develop a better understanding of the patient's circumstances and choices by learning about the "whole person." What often appears to physicians as noncompliant behavior would then take on new meaning—a meaning that is consistent with the patient's life history, values, and goals. This new understanding is a strong justification for an "ethics of care" in clinical medicine, which is so clearly defined by Arthur W. Frank.

Those of us who have decried the loss of the medical profession's autonomy and the central role of beneficence in the patient-physician relationship should welcome an evolution toward narrative ethics. Reflecting on the stages of growth and development of modern medicine, especially in the last 60 or so years, should help make the reasons clear.

There are three stages in modern medicine's development to consider. The first stage was the prodigious accumulation of medical knowledge in the early half of the twentieth century. This required that physicians approach patients and their problems from a less personal and more empirical data base. Great advances resulted during this period—advances that appeared to justify the methods employed even though they distanced professionals from their patients. For a while it was believed that this approach was actually value free.

The next stage saw the growth of bioethics. Beginning with the Scribner shunt and the possibility of kidney dialysis came the recognition of value factors in medical decision making. Choices for the patient and society were based upon the current state of medical knowledge and the expressed values of the participants. Value conflicts were negotiated by an appeal to basic ethical principles.

We are in the midst of the second stage, but there is a growing recognition of its limitations. The emphasis on basic ethical principles opens medicine to

further criticism—criticism that it does not care as much for the "whole person" as it does for the patient's disease or the patient's autonomy. Thus the time is right for the development of the third stage of modern medicine, marked by its emphasis on knowing the "whole person." This could be achieved by a fuller understanding by physicians of the central role of the patient's narrative, or life history, and the impact of disease and suffering on the patient's life. While we should never diminish the importance of medical technology and bioethical analysis in our educational programs, we cannot ignore the whole person (or what physician Eric Cassell calls the "aesthetic judgments" of the patient). If we do, we risk failure in the clinical encounter. But the suffering patient demonstrates the limits of the ethical principle of autonomy. When the patient suffers, medicine may fail by its narrow focus on technology (disease), physicians may fail by depersonalizing treatment, and ethics may fail by its preoccupation with principles only.

Changing an episode of noncompliance (or incomplete understanding) to one of fuller understanding of the patient requires that we allow the patient to make himself or herself known. I am hopeful that as medicine and clinical ethics matures there will be an emphasis on caring as much as on curing. Clinicians must recognize that the principle of autonomy often fails to provide the direction needed to care for the whole person. By teaching and learning the skills of good listening, physicians can reclaim the ideal of medical beneficence and relocate it to a central role in the care of the patient.

*Ralph A. Capone*  
Jeannette, Pennsylvania

## To the Editor:

I responded to the case study with mixed feelings. I am a psychiatrist, and I see my role as listening to a patient's story and then recommending a plan of action that might help the patient work toward a healthier life. That may require psychotherapy or involve medication.

My patients who tend not to comply are those who either are afraid of medication or who want to get well



without medication—do it on their own. I see myself as a consultant to the patient. I lay out options and the patient can make his or her choice whether to follow the recommendation.

Ideally, a professional caregiver should work *with* patients—not to do something *to* them or assume a parent role. In reality that is at times a more difficult role to fill. It is difficult, for example, to see a person with a panic or depressive disorder not even try medication that is very likely to alleviate his or her symptoms.

The situation is more serious when individuals refuse medication and their illness affects not only themselves but family and society as well—sometimes resulting in destructive behavior or need for hospitalization. Sometimes the rights of the patient are at odds with the rights of others. But here, too, it is important, if possible, to work with the patient, not to do something to her. Where the consequences primarily affect the patients, they have the responsibility to make the choice—perhaps with the help of a caring support group.

I spoke with several physicians about Frank's recommendation that patients write in their charts. We agreed that that would be a great help in working with patients toward their healing—including physical, mental, and spiritual dimensions. Noncompliant patients may therefore experience healing even if they are not cured.

*Elsie Enns Steelberg*  
PrairieView Inc.  
Wichita, Kansas

### To the Editor:

Without a good patient-doctor relationship, any disagreement between doctor and patient is likely to result in both parties questioning the motives of the other. This can easily lead to misunderstandings that can in turn rapidly escalate into mutual attributions of evil intent.

It is clear that Kevin Coleman did not have a relationship of mutual trust with any of his doctors, whom he describes in impersonal terms like "the doctor on the phone," "my usual chemotherapy

specialist," and "the radiotherapist." The only person he seems to have trusted at the cancer center was a psychologist who was "not part of the treatment team." Kevin Coleman tells a story that no physician likes to hear and that no patient likes to experience.

Arthur W. Frank in his "Commentary" and "Overview" appears to accept at face value Kevin Coleman's story and seems to have concluded also that the problem is physician insensitivity. His solution to the problem is to expand the rights of patients while curtailing the rights and prerogatives of physicians. I doubt that this solution would do much to alleviate Kevin Coleman's dissatisfaction with the quality of his care, as it is not based on much understanding of the nature of his noncompliance.

The story Kevin Coleman tells us is incomplete. I would need to know much more about him before I could have a reasonable opinion about the causes of his noncompliance. For example, what was his life like before he had cancer? What does the cancer mean to him? How has it affected not only himself but the significant other people in his life? How did he get to this particular cancer center? Did he have any choice in the matter? Furthermore, we see the physicians' stories only through Kevin Coleman's eyes. It would help our understanding to get their stories as well. In my opinion as a physician, the possibility exists that Kevin Coleman's noncompliance may have more to do with his own feelings of resentment at being the innocent victim of a life-threatening disease than it does with the behavior of his physicians.

The bioethics literature has been dominated by the language of individual rights and the patient's personal autonomy. To some extent this was necessary to help offset the power imbalances and potential abuses inherent in the doctor-patient relationship. Yet, carried to an extreme, it is a flawed model. While we exist as individuals, we cannot be understood as such without reference to the significant others in our lives and the culture in which we live. It follows from this that to reduce the patient-doctor relationship to nothing more than a legal contract between two autonomous individuals is to deprive both patient and doctor of something that is extremely valuable to both.

Physicians, too, have contributed to devaluing the importance of the doctor-patient relationship by their overemphasis on technology and knowledge. Anyone



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who has been sick knows that we need more than knowledge from our physicians.

**Patrick R. Staunton**

Lutheran General Hospital  
Park Ridge, Illinois

### To the Editor:

The provocative and timely story of Kevin Coleman's frustration and unhappy experience with his physician confirms the growing suspicion that doctors are so focused on disease that they have forgotten that the central role in the drama of health care is played by the patient.

The power of medical science and technology to cure or control most of the devastating diseases has become a two-edged sword. Daily news accounts and TV documentaries proclaiming the success of tissue transplants, heart surgery, joint replacements, et cetera, have convinced patients that doctors should be able to cure whatever ails them. Physicians influenced by unreasonable expectations too often carry out treatments or procedures with marginal likelihood of success.

The widely publicized case of Karen Quinlan, the young lady who was kept alive in a vegetative state for many years, and stories of lonely, unhappy, often helpless, senior citizens spending their last days in a nursing home has precipitated a national feeling of guilt and remorse. Society is demanding a new model of doctor-patient relationship that balances the concerns, desires, and rights of the patient with the responsibilities of the physician.

As bioethical issues became more controversial and complex, the responsibility of dealing with them has moved away from the abstract, theoretical scenario of academic institutions to the clinical setting of physicians' offices, outpatient clinics, and medical centers where crucial, often agonizing, decisions should be made.

My involvement in bioethics organizations and medical societies has convinced me that the challenge facing the medical profession is to remind physicians, nurses, chaplains, and hospital administrators that national, regional, and local bioethics organizations,

especially hospital ethics committees, have the resources to help solve the dilemmas that face health care providers, patients, and their families. It is essential to emphasize, however, that hospital ethics committees *should not* make decisions but serve only as an educational and consultative forum.

It is time we listen to the words of Francis S. Peabody, eminent Harvard professor of medicine who 65 years ago wrote: "The essence of the practice of medicine is that it is an intensely personal matter—the treatment of a disease may be entirely impersonal; the care of the patient must be entirely personal."

**Herlan O. Loyd**

Sacramento, California

### To the Editor:

There is an ancient maxim in medicine: "To cure rarely, to relieve often, to comfort always." It is a beautiful rubric. The essence of good physicianship has always resided in a relationship of mutual trust, respect, and affection. At best there is a partnership between doctor and patient. One is offering him- or herself to the other as one in need of particular care. The other responds by offering all that he or she knows to be helpful. Since medicine is an imperfect study and is always changing, both doctor and patient need to appreciate the limits of "what is known."

There is an ever-present need for *both* physician and patient (or the patient's surrogate) to weigh the pros and cons of everything that is done or *not* done in the professional arena. Every diagnostic and therapeutic procedure carries a risk.

Currently there are problems presented by a pathologically litigious atmosphere, cost containment, relentless competition for patient contacts, incessant monitoring of professional services in an increasingly impersonal environment, and multiple, conflicting groups of professionals.

Ownership of one's own body, one's own mind, and one's own fate is vitally important. But there may be antagonistic relationships between doctor and patient. The laity may be poorly informed and incapable of making complex medical decisions, and there are problems of "territoriality." The basic prob-

## READERS' RESPONSES

lem is “who is doing what to whom for what reasons and with what authority and with whose *well-informed* consent?”

The doctor should always try to be several things: teacher, advocate, and treater—to the extent that his or her intervention is requested. The doctor should always strive to make his or her role and function

obsolete as quickly as possible—liberating the patient to live fully and freely in an optimal balance with his or her environment.

*William Dablberg*

Denver, Colorado



# LITERATURE DIGEST

## Health care in the African-American community

Annette Dula, "Toward an African-American Perspective on Bioethics," *Journal of Health Care for the Poor and Underserved* 2, no. 2 (Fall 1991): 259–69.

ADVANCES IN MEDICAL TECHNOLOGY and increasing health care costs in the past 20 years have stimulated growth in the field of bioethics. The mainstream bioethics literature, however, has fallen behind in consideration of race, class, and gender differences. Dula points out that "the field is dominated by white, male, middle-class professionals and academics. These men decide what is important, they frame questions, and they make policy recommendations." As a result, those who are "marginal"—racial minorities, the poor, and women—are subject to paternalism or victimization. Dula's solution is strongly phrased: "Articulation and development of professional bioethics perspectives by minority academics is necessary to expand the narrow margins of the debate."

Dula attributes the well-documented health disparities between African-Americans and whites to at least three factors: institutional racism, economic inequality, and attitudinal barriers to access. Institutional racism has its roots in the unequal power structure in society and, more specifically, in the medical profession. It is manifested in the poor treatment of individuals (for example, long waits, patients' inability to shop for services, and poor-quality and discontinuous care) and in the lack of government programs targeting African-Americans as a group.

Economic factors also contribute to health inequalities: Poor people are more likely to have poor health, and a disproportionate number of poor people are black. Inadequate employment may limit the care received, and substandard housing may actually cause ill health.

Attitudinal barriers that contribute to inadequate access include racism as perceived by the consumer, different cultural perspectives on health and sickness, and beliefs about the health care system. The access dilemma challenges people in the field of bioethics to expand beyond their roots in abstract Western philosophy, which has not traditionally addressed cultural and societal issues or advocated societal transformation.

In contrast, black philosophers, influenced by their perspective as "unequal partners," "have purposely elected to use philosophy as a tool not only for naming, defining and analyzing social situations, but also for recommending, advocating and sometimes harassing for political and social empowerment." Dula cites the birth control movement and informed consent as examples of bioethical issues to which the African-American perspective may add important understanding.

In each of its three phases, according to Dula, the American birth control movement "implicitly or explicitly served to exploit and subordinate African-American as well as poor white women." In the middle of the 19th century, advocates of "voluntary motherhood" asserted that women ought to refuse their husbands' sexual demands in order to limit the number of their children. But slaves could not refuse the sexual demands of plantation owners, and women's market value in fact was related to their potential as "good breeders."



During the second phase of the movement, birth control became associated with political opportunities created by women's new right to vote. The women's movement also, however, became associated with the eugenics movement. To curb white "race suicide" eugenists sought to impose "a moral obligation on middle class white women to have large families and on poor immigrant women and black women to restrict the size of theirs."

In 1942, with the establishment of Planned Parenthood, a third phase of the birth control movement began. Planned Parenthood continued to define undesirable "stock" by class or income level. Dula notes, "Many blacks were suspicious of Planned Parenthood; men, particularly, viewed its policies as designed to weaken the black community politically or to wipe it out genetically." In the 1960s, studies and family planning services subsidized by the government focused on poor and minority women. Dula cites staggering statistics on sterilization among women of color. Between 1973 and 1976, for example, almost 3,500 Native American women were sterilized at one Indian Health Service Hospital. Anecdotal information also fostered black suspicions. In 1973, for example, it came to light that 11 adolescent girls, 10 of whom were black, had been sterilized in Montgomery, Alabama, without their parents' consent.

Another issue that illustrates the conflict between conventional bioethics and black philosophy is the unequal patient-provider relationship, which erodes informed consent. At the extremes, those in positions of power have not even attempted to obtain consent, as, for example, in the Tuskegee experiment that focused on untreated syphilis in 400 poor black men. Such medical abuses continue today. The author cites a study from the *American Journal of Public Health*: Of 52,000 Maryland women screened for sickle cell anemia between 1978 and 1980, 25 percent were screened without their consent.

Dula observes that professional perspectives can change society's perceptions and policies, and subordinated groups can best define their own perspective. For example, black psychologists have successfully made efforts to encourage "self-definition, consciousness and self-worth." These efforts have undermined the deficit-deficiency theory that historically was used to validate negative black stereotypes. The women's

movement further demonstrates the impact of minority perspectives. Black feminists active in abortion rights and the National Black Women's Health Projects, for example, have had a significant influence on issues important for black men and women.

The successful influence of new perspectives in other fields and widespread concern about health care access lead Dula to conclude that "opening the debate can only enrich this new field [of bioethics], thereby avoiding the moral difficulties of exclusion."

—Mary M. (Daisy) Boehm  
Research Assistant

## African-Americans and holistic pastoral care

Christine Y. Wiley, "A Ministry of Empowerment: A Holistic Model for Pastoral Counseling in the African American Community," *Journal of Pastoral Care* 45, no. 4 (Winter 1991): 355–64.

CHRISTINE WILEY WRITES as a "womanist pastoral psychotherapist" and black clergywoman. As a womanist she observes the many dimensions of black women's experience of oppression. Upon entering training for pastoral counseling she was surprised by the white, male orientation of the program. She observes that the field of pastoral care has "not been immune to the effects of racism, sexism, and classism."

As a black clergywoman, Wiley is struck by the many forms of oppression that assault the black church, including the racism of society from without and the sexism from within. Wiley says, "My sensitivity to these forms of oppression convinces me that a very real inner experience of liberation must be effected if persons are to become whole and thus empowered to address outward systems of oppression." She views pastoral counseling as a potentially powerful agent of this liberation and believes that in the process, pastoral counseling itself will evolve because it will be informed by a greater variety of professionals.

Wiley characterizes the black church as a "community of caring," but she urges that this phrase not



be interpreted simplistically. Black churches, she says, embrace "dialectical tensions" without forcing them into synthesis. These tensions exist between faith and action, individuality and community, sacred and secular, and inner experience and outer reality. An inclusive, holistic mind-set best fosters an understanding of these dialectics and the church's ministry.

A strong faith in Jesus Christ as personal caregiver is part of the black church's tradition. At the same time, Jesus Christ is perceived as a "liberator who empowers [people] to struggle in the midst of racism and oppression." This concept of empowerment is the theoretical basis for practical action. In fact, the attraction and power of the black church stems from its actions addressing the corporal needs of its members and their spiritual need for freedom and justice. In contrast to the European ideal of individualism, African-Americans have survived as a community. An integral part of this broad secular community is the sacred community, which has historically been a key support system for African-Americans in their struggle with oppression.

Pastoral care has not been easily accessible to the African-American community because of socioeconomic barriers and the community's lack of "confidence that the cultural and traditional strengths of the community would be understood, appreciated, and used for empowerment." Despite low incomes and difficult living situations among individuals and social problems in the community, the black church must respond. Wiley disagrees with those who hold that psychotherapy is inappropriate in the African-American community; she contends that it is a viable ministry. She cautions, however, that pastoral therapists and counselors must recognize that individual wholeness and healing is best achieved by a holistic approach. For example, the community's strength in the face of oppression and racism makes a focus on empowerment "a central part of any treatment plan."

Pastoral services must define which modalities best serve the needs of the community. Wiley outlines several programs of the Center for Holistic Healing, which she acknowledges is only one model of many possible within the African-American community. With help from black churches, the Center offers individual and family counseling, self-help and support groups, health and nutrition counseling, and

education in the community about pastoral counseling and about the Center in particular. Referral resources like the Family Crisis Center enable the Center to focus on clinical pastoral concerns. Thus the Center seeks to "bring persons to wholeness by addressing the whole person—body, mind, spirit, tradition and culture," while keeping in mind family and community systems.

Wiley encourages African-American counselors to engage in dialogue with the larger pastoral counseling community to address oppression and racism. Concretely, she believes that cross-cultural counseling and gender issues should be incorporated into Eurocentric pastoral training programs. Volunteerism and "creative funding" are also needed to "help assure that therapy and pastoral counseling can be a ministry to all of God's children and not just to middle-class suburbia."

Wiley outlines a multidimensional struggle for wholeness. The Center for Holistic Ministry seeks to address all the needs of individuals through its services or through referral. It strives to serve all people within the African-American community regardless of socioeconomic status. The Center's approach acknowledges the past and present experiences of the whole community as a key to individual identity and therapy. Finally, the broader field of pastoral ministry can only approach wholeness and integrity by welcoming into its ranks "different" people and addressing their concerns.

—D.B.

## Healing the earth

William J. Wood, "The Stairway to Recovery," *Health Progress* 73, no. 2 (March 1992): 54–59.

Thomas Berry, "A New Era," *Health Progress* 73, no. 2 (March 1992): 60–63.

COMPARING OUR MODERN ATTITUDE toward the earth to a drunken driver's blind, destructive hubris, Wood argues that we can heal the environment only if we personally and communally undergo a conversion as profound as that of a recovering alcoholic. Why this striking, even discomforting comparison? Wood



believes that we have been viewing the earth's resources from a comfortable, objective distance, as ignorant of the damage inflicted on creation as the drunken driver is unaware of the damage inflicted on accident victims. The comparison is all the more apt, Wood believes, when other facets of addiction and pollution are examined.

Moral exhortations—like Hans Küng's list of environmental danger signals in *Global Responsibility* and the U.S. Roman Catholic bishops' consideration of the environment as a social justice issue in *Renewing the Earth*—help establish a consensus on the need for real healing of the earth but are not causing a marked change in personal, corporate, or national habits. What is needed, Wood maintains, is a new political will. This can be achieved only by recognizing the powerful collective habit, established over centuries, of seeing ourselves as "the self-sufficient and autonomous master of 'inanimate' nature" (p. 56). Wood advocates a new worldview or new story, a changed perception of the cosmos, in which it is understood that the universe was created by God and that "'man,' whether humankind or the male of the species, is not God nor the master of the land community" (p. 56).

Before recovery can begin we need to pay attention to what we are doing to nature. Citing Wendell Berry's warning against "global thinking"—the tendency to become so abstracted from everyday, particular reality that we regard the earth presumptuously—Wood says that we cannot begin to love and care for the earth until we come to know it.

The healing of the earth will begin only with individuals because individual actions harm the earth. As part of this healing process, Wood proposes that we follow a rule combined from the physician's primary commitment to do no harm and from the recovering alcoholic's determination not to take a drink today. We start healing the earth, says Wood, when we resolve not to harm her today. To Wood, the consumerism and individualism saturating our culture are signs of addiction, and he suggests that we learn from the most basic wisdom of Alcoholics Anonymous (AA). This means being repentant, being turned upside down in the way we think, and taking on a rigorous spiritual program one step at a time, day in and day out. Translated into ecological terms this would mean not using styrofoam cups today, or walk-

ing or taking public transportation when driving is not necessary. Most important, Wood notes that for AA, "fellowship" or community is the source of God's power. There is no "rugged individual" in AA.

Finally, we must take this perspective from the personal level to our public lives as citizens and agents in the marketplace. Wood believes we can start up the "stairway" to recovery by admitting that we are powerless in our inability to stop doing violence to the earth. Individual efforts will not save the earth, however, and Wood concludes by saying, "Only when our citizenship in the community of creation is reflected in our institutions and embodied in our social structures will God's will be done on earth as it is in heaven" (p. 59).

LIKE WOOD, BERRY MAINTAINS THAT HUMAN arrogance has altered and radically harmed the natural world. He finds the idea that nature should accommodate humans expressive of the human pride that has created so much of the planet's desolation. Berry contends that the earth is sick and dysfunctional, suffering from an imbalance in chemical constitution created by humans. Future health care providers should not ignore this larger context; even now many human illnesses can be attributed to environmental disorders.

As we near the end of the Cenozoic era—the 65 million years in which the earth and its flora and fauna came into being—two opposing epochs are vying to succeed it. Berry notes that medical and other professions tend to favor entering a "Technozoic" era. In this age an increasing dependence on scientific skills would impose mechanistic and manipulative processes on the earth's biosystems. In contrast, Berry advocates an "Ecozoic" era, in which humans would live on the earth in a reverent, mutually enhancing manner.

Berry outlines three principles for the Ecozoic era:

1. Humans must see the universe as a "communion of subjects" rather than as a collection of objects. This means respecting the natural, spontaneous activities of plants and animals that guide them in obtaining food, mating, feeding their young, adapting, and migrating; and respecting the human inner spontaneities of knowledge, judgment, and relationship. These capacities for self-direction and intimacy serve as the basis for a conception of the universe as a communion of subjects, each with its own



role to fulfill, its own habitat, and its own right to exist.

2. The earth is primary; humans are derivative. Since the earth set up the conditions for human well-being, we must either respect the earth and its conditions or endure the penalties of the abuse we inflict on the planet.

3. The planet will never again function without human responsibility. As Berry puts it, "in the future there is liable not to be a blade of grass unless humans accept, protect, and foster it" (p. 63). Beyond this, there is the need to remedy the damage already inflicted on the environment.

Finally, Berry reminds us that every field of science and technology must attempt to view the world in a new way. Putting aside the analytic, reductive approach, the sciences must use holistic, qualitative, and organic methods. We must all recognize the consequences of human intrusion on natural systems. We must renounce past arrogance and adopt the example of the indigenous peoples who respect and comprehend the larger context of human affairs.

—Agnes Coveney  
Research Assistant

## Practice and principles in rationing health care

Robert Steinbrook and Bernard Lo, "The Oregon Medicaid Demonstration Project—Will It Provide Adequate Medical Care?" *New England Journal of Medicine* 326 (30 January 1992): 340–44.

THE GOAL OF OREGON'S NEW MEDICAID PLAN is to provide basic health care benefits to a substantially greater number of poor people while controlling expenditures by limiting the number of services covered. The Oregon legislature has approved the prioritized lists of covered health services. Oregon hopes that its plan, currently being reviewed by the U.S. Health Care Financing Administration, will be implemented in 1992 as a five-year demonstration project. Although the authors credit the proposal with calling attention to many shortcomings in the state's current

Medicaid program, they question whether the redesigned plan will offer adequate medical care.

In 1991 the Oregon Health Service Commission prepared a list of 709 health services, ranking them in terms of their benefit to the overall population. Basic health care was defined as "a floor beneath which no person should fall." Included within this parameter were all services considered "essential" and most of those considered "very important." All beneficiaries should receive diagnostic services and a recommendation of appropriate treatment. Treatments would be reimbursed only to the extent that the legislature funds the list of health services. The Oregon legislature created a standard benefit package for Medicaid from the first 587 items on the prioritized list. According to the plan, if expenditures are higher than budgeted, the services of lowest priority will be eliminated.

Most excluded services are not expensive high-technology procedures like organ transplantation but tend to be standard treatments for everyday medical problems. The essential services include treatments for acute conditions that can be fatal, maternity care, preventive care for both children and adults, and comfort care for the terminally ill. Expensive procedures deemed essential include heart and liver transplantations for specific conditions. Of the "very important" services, 19 percent are excluded, and of the 68 services classified as "valuable to certain individuals," 63 are excluded.

As the Oregon commission has acknowledged, a list created primarily from a societal perspective may not meet the desires of specific individuals. The authors note, however, that health problems are experienced by individuals, and commentators stress the difficulty of devising general rules for medical care that take individual circumstances into account. If health insurance is meant to protect against unpredictable health problems, excluding beneficial treatments for many conditions does not safeguard the people who are unlucky enough to need those services. The distinction between health services that contribute to the overall well-being of society and those that are valuable only to certain individuals is often arbitrary. Also, the process of setting priorities does not account for variations in the severity of illness among patients with the same diagnosis. Finally, the Oregon plan does not consider coexisting conditions.



Waiting for higher priority conditions to develop before treating patients may put them in jeopardy and may be more costly than earlier care. Conversely, a therapy that is highly beneficial, like treatment for bacterial pneumonia, may offer little benefit for some patients with a severe coexisting condition like metastatic cancer.

While many physicians applaud aspects of the Oregon plan, they may object to practicing medicine according to a list that excludes many standard therapies. Physicians have a duty to act in the best interest of their patients and a duty to practice in accordance with professional standards. There is a related ethical obligation to inform patients that they may be denied beneficial services for financial reasons. When patients in Oregon require services that fall below the cutoff line, physicians may be torn between the limits of their responsibilities as defined by the state and their ethical duties. Immunity from criminal prosecution, civil liability, or professional disciplinary action for failing to provide unfunded services does not relieve physicians of their obligation to meet professional standards and their ethical duty to individual patients.

There will likely be pressure for physicians to try to beat the system in favor of their patients. Such pressure could be particularly strong in treating patients with important coexisting conditions or severe illness and might lead to the diagnosis of a covered condition instead of an excluded one. This "priority creep" would be similar to "DRG creep," in which hospitals alter their reported case mix to improve reimbursement from Medicaid. There may also be pressure placed on the bonds of the physician-patient relationship; people might blame their physician, not the system, for denied coverage.

Patients who gain coverage under the expanded eligibility may be satisfied with the system, and better reimbursement rates may improve access to care by encouraging more providers to accept Medicaid patients. Some people, however, will be hurt by the exclusion of services that are now covered. Also, the plan as submitted does not describe educating patients about the process of setting priorities and the limits of coverage. Will patients receive a list of the covered services and a clear explanation of those excluded? Will patients receive information about appeals procedures when services are denied? Such educational efforts are important because many Medicaid

beneficiaries are not sophisticated health care consumers.

As an example for national health care, the Oregon plan appears lacking. It consigns a lower level of care to Medicaid patients who need standard treatments that rank below the cutoff line. Because that line is financial, not medical, the level of coverage can vary from year to year. A treatment may be basic one year but not the next—this makes little clinical sense. The approach is as arbitrary as current methods of dealing with budgetary shortfalls in health care.

Thus, while the authors believe that aspects of the plan represent steps in the right direction for health care reform, the state's final proposal does not offer a complete basic health care package. According to Steinbrook and Lo, the medical profession aims to provide one standard of care to all Americans, regardless of what kind of health insurance they have or where they live. Therefore, in light of the Oregon experience, they challenge the medical community to develop a basic health care package that will offer adequate care to all.

Nancy S. Jecker and Robert A. Pearlman, "An Ethical Framework for Rationing Health Care," *Journal of Medicine and Philosophy* 17 (February 1992): 79–96.

BECAUSE OF THE TREMENDOUS GROWTH in the cost of health care, various proposals for the rationing of health care have been discussed in recent years. Jecker and Pearlman critically review several alternatives for rationing publicly financed health care and propose their own ethical framework for such rationing.

Rationing takes place whenever health care resources are insufficient for all who could benefit. Despite continued debates about the just distribution of health care, there appear to be no generally agreed on principles to serve as the ethical basis for rationing. The authors propose to group different ethical criteria under two categories. The first set of criteria, under the category of resource-centered rationing, treats specific aspects of health care resources as ethically important, ignoring differences between persons and resting rationing decisions on features of health services themselves. For instance, it might be argued that Medicaid dollars should be invested in basic or preventive care rather than in costly acute care services. This method of rationing is appealing because it avoids



controversial comparisons between persons.

One form of resource-centered rationing holds the success of recent medical technology chiefly responsible for problems of distributive justice in health care. "High technology" in this context usually refers to apparatus and procedures based on modern sciences and connotes new, scientifically complex, and costly services. Advocates of rationing publicly financed high-technology medicine believe that much technically curative medicine costs more than other health services. They charge that high technology needs to be more carefully assessed and applied. Further, they believe that to deny public support for the leading medical technology does not imply an unjust health care system.

Despite its appeal, Jecker and Pearlman fault the proposal to ration publicly supported high technology on several grounds. First, although certain forms of health care are above what society is morally obligated to provide, the practical difficulty lies in identifying these forms of care. Second, much of the criticism directed against public support for high-technology medicine is directed at the unwarranted use of technologies in clinical practice, not against technology *per se*. Finally, a major drawback of rationing publicly financed high technology is that today's high technologies are tomorrow's low technologies; developing new technology is a pathway to improving the overall level of health care in society.

A second form of resource-centered rationing involves nonbasic services above a certain established level. Those who support this form of rationing must establish a ceiling for necessary resources. The floor is then defined in a variety of ways. Some people define the government's minimum obligation as providing the fewest health services to individuals that the public feels compelled to provide. Others would include those services most people use most of the time. Still others argue that the floor should be primary care generally or at least less technologically sophisticated services.

Following philosopher Norman Daniels, the authors define basic health care as health services that prevent, cure, or compensate for deficiencies in the normal opportunities persons enjoy at each stage of life. The normal range is defined *biologically*, in terms of typical species functioning, and *socially*, in terms of the level of health care resources available in society at

large. In contrast to basic care, nonbasic care either aims to improve conditions unrelated to normal opportunities (for example, performing face-lifts) or aims to correct or compensate for deficiencies in normal opportunities—even when it is ineffective in doing so (for example, maintaining a patient in a permanently vegetative state on a respirator).

Rationing nonbasic health care is justified by arguing that government is responsible for providing only basic health care and also that society must ration publicly financed nonbasic care in order to prevent the cost of basic care for all citizens from becoming prohibitive. Another way of mounting an argument for rationing nonbasic health care is by appealing to the idea that persons have no right to receive extravagant health services in the first place.

In contrast to resource-centered criteria for rationing, patient-centered criteria highlight specific characteristics of individuals and regard these as the ultimate support for rationing policies. These policies would provide scarce services to individuals likely to receive the greatest medical benefit while denying them to patients likely to gain the least. Medical benefit, not disease category, is the basis for such rationing.

Under rationing by medical benefit, certain groups may be denied specific treatments because these treatments can be more beneficial, on average, to other patient groups. For example, the rationing of intensive care according to medical benefit may result in the denial of these services to elderly persons in chronically poor health and with poor short-term survival rates.

Arguments supporting this kind of rationing stress, first, that selection criteria avoid making comparisons between persons in terms of social worth. Second, because no one group is excluded outright from medical consideration, discrimination against particular groups is avoided. Finally, the grounds for care increase as the quality and likelihood of benefits increase, and physicians are not obligated to provide futile care.

Those who object to rationing based on medical benefit stress the difficulty of designing accurate tools for assessing benefit. They also argue that persons engaging in unhealthy behaviors like excessive drinking are less deserving of medical benefits. A final objection is that because this approach stresses medi-



cal benefit, measurable by the goals and standards of medicine, it does not incorporate patients' goals and perspectives.

The authors respond to these objections by urging research into the development of more accurate methods for assessing medical benefit. In response to concerns about unhealthy life-styles or behaviors, they point out that much illness occurs at random and much is generic. Moreover, focusing on individual responsibility for health can mask deeper social ills. Refusing health services to persons who live unhealthy life-styles is at odds with considered judgments about ethical medical practice. Finally, a medical benefit standard, properly understood, takes into account the patients' values and goals.

A principle of equality focuses on similarities rather than differences between persons. If all individuals have equal worth and dignity, then all persons are equally entitled to receive health services. Equal access follows from equal entitlement. Such an approach would seek to eliminate differences in non-basic care.

The authors conclude by submitting a four-point proposal for rationing services. First, they reject resource-centered rationing that calls for limiting the development of publicly financed high-technology medicine. Second, although it is difficult to determine which services fall under basic and nonbasic categories, they endorse resource-centered policies that place limits on publicly financed nonbasic health services. Next, the authors believe that a medical benefit standard should be used to distribute resources among persons. Finally, they submit that equality is the goal of basic health care. Thus, departures from equal basic care will require a special justification, and generally, the justification for support of nonbasic services would have to be linked to improvements in basic care. By resting on the ideals of equality and inherent worth of persons, the authors' analysis appears sensitive to differences between patients at any stage of life and supports funding basic health services for all groups.

—Edwin R. DuBose

## Futility, autonomy, and the case of Helga Wanglie

Steven H. Miles, "Interpersonal Issues in the Wanglie Case," *Kennedy Institute of Ethics Journal* 2, no. 1 (March 1992): 61–72.

John J. Paris and Frank E. Reardon, "Physician Refusal of Requests for Futile or Ineffective Interventions," *Cambridge Quarterly* 1, no. 2 (Spring 1992): 127–34.

Fennella Rouse, "Mrs. Wanglie and 'Doctor Knows Best' and Making Decisions for Those Who Cannot Decide for Themselves: Autonomy in Two Cases," *Cambridge Quarterly* 1, no. 2 (Spring 1992): 165–68.

THE CASE OF HELGA WANGLIE, an 87-year-old woman whose lungs became irreversibly unable to sustain her life without a respirator, has caused controversy and debate since May 1990 when Wanglie's condition became apparent. Her physicians, recognizing that her condition would not improve, concluded that the respirator was not benefiting her.

In late August 1990, a conflict between Mr. Wanglie's wish to sustain his wife's vegetative state using a respirator and the physician's refusal to continue prescribing the respirator prompted the mediation of Steven Miles, an ethics consultant. Miles attempts to clarify, through his article, some of the "misunderstandings" the press published regarding the case. He states that the medical staff had used every possible means to resolve the disagreement and to avoid court, including counseling and transferring the patient to other providers. In the article, he stresses that legal action was taken by individuals and not by the medical center *per se*, and such action was taken to clarify what was required of individual practitioners in a particular dilemma, not to make a general public policy.

Many difficulties in maintaining a private doctor-patient relationship during the highly publicized trial compounded problems surrounding the case. The hospital stated its three objectives during the trial: to maintain a private, clinical relationship with the family, to maintain confidentiality about the patient's treatment or illness, and to explain fully the hospital's position within those constraints. The trial did not



expand the public record of medical facts, and because the family did not release the results of diagnostic testing, some in the media attempted to second-guess the medical conclusions about the irreversibility of her condition. During the trial the judge disallowed testimony about the beneficial or nonbeneficial effects of Wanglie's respirator, stating that such evidence would not be given until the second part of the trial. During the first part the judge ruled that the hospital had failed to prove Mr. Wanglie incompetent as a guardian. But providing such proof, according to Miles, was never the intention of the hospital. Many reporters mistakenly reported the scope of the decision. The judge only reviewed Mr. Wanglie's suitability as a guardian and noted, "No court order to stop or continue any medical treatment for Helga Wanglie has been made or requested at this time."

Fenella Rouse disagrees with the hospital's court action, pointing out that the patient's autonomy should take precedence in every case. Eighty-four percent of adult Americans, according to the Gallup poll cited in her article, would not want life-supporting treatment if they were in this condition. Rouse states that the whole purpose of honoring autonomy is to allow individuals to make their own decisions, however unpopular, when to do so does not endanger anyone else. Though Miles states that the hospital was only trying to obtain an independent conservator (guardian) and never tried to prove Mr. Wanglie incompetent, he failed to realize a Minnesota law. The Minnesota Guardianship law requires that the decision maker for an incompetent person be an individual who will act in the best interest of the incapacitated person, with kinship a factor to be considered. Rouse further supports her position by citing an Indiana Supreme Court case (*In re Lawrance*) in which parents petitioned a trial court to terminate tube feeding after their daughter became persistently vegetative in July 1987. "Respect for patient autonomy," the court wrote, "does not end when the patient becomes incompetent. In our society, health care decision making for patients typically transfers upon incompetence to the patient's family."

On the other hand, when can patient autonomy be abused or inappropriate in the treatment regimen

of a critically ill patient? John Paris and Frank Reardon raise several questions about how much autonomy patients should have over their own treatment regimen. They agree with ethicist Edward Pellegrino that a patient or surrogate can decide to withhold or withdraw treatment and that the physician cannot independently arrive at such an opinion. If the treatment were demanded by the patient against the physician's recommendation, however, autonomy, not futility, would carry the moral burden.

The authors refer to a New York state statute as an example of a law that supports inappropriate patient autonomy. The statute requires physicians to obtain the informed consent of a competent patient or the family of a patient incapable of making decisions before they may legally write a do-not-resuscitate (DNR) order. In this instance, they believe the physician is reduced from a moral agent—one with professional responsibilities and limits on what may legitimately be done—to an extension of the patient's fantasy, whim, or unrealizable hope. They also point to a 1983 study that revealed 98–100 percent mortality in resuscitated patients with metastatic disease, acute strokes, sepsis, renal failure, and pneumonia. The same statistics applied to those for whom resuscitation took longer than 30 minutes. In another study cited in the article, none of the 488 babies who received CPR in the first three days of life survived. In such instances CPR is a "non-validated" therapy and need not be provided.

Paris and Reardon suggest that the problem arises in defining *futility*. Some invoke futility only if the success rate is zero percent, whereas others declare treatment futile when the success rate is as high as 18 percent.

The authors believe that their ideas are not revolutionary and have even been put forth by Hippocrates: "Whenever therefore a man suffers from an ill which is too strong for the means at the disposal of medicine, he surely must not expect that it can be overcome by medicine."

—Srinivas Reddy  
Research Assistant



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