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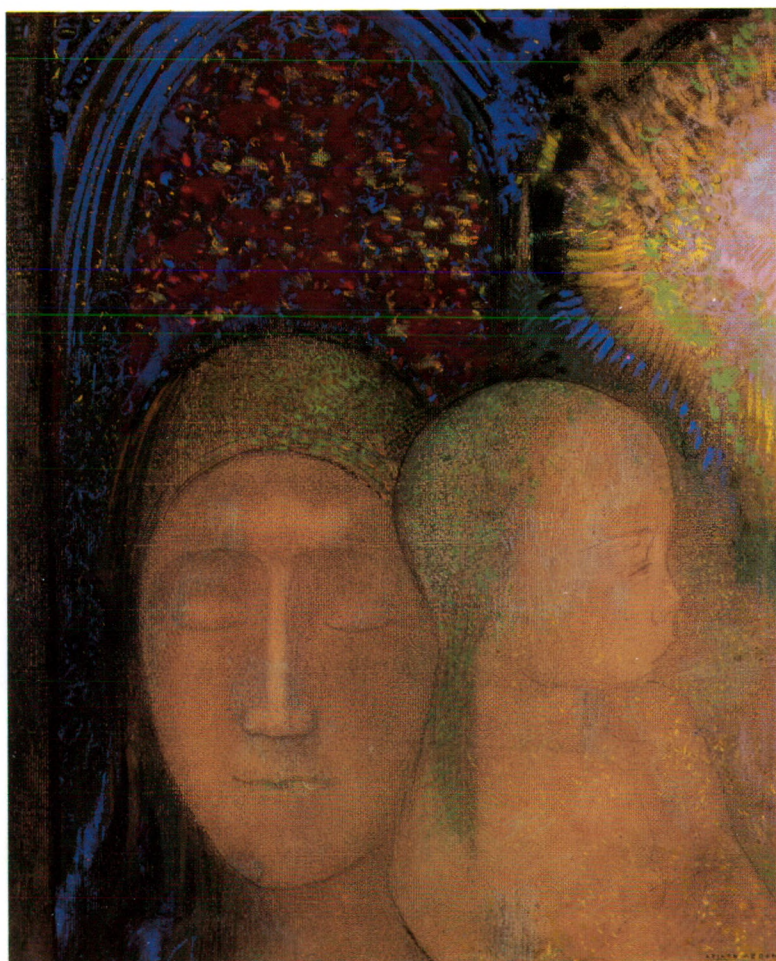
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HEALTH • FAITH • ETHICS



Women, Children, and Health Care • Obstacles to Voluntarism • Prayer and Well-Being • Global Health

A publication of the Park Ridge Center for the Study of Health, Faith, and Ethics

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Woman and Child against a Stained Glass Background. Pastel by Odilon Redon.

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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.

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.

SECOND OPINION

Volume 18, number 3* • January 1993

A publication of The Park Ridge Center for the Study of Health, Faith, and Ethics

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All inquiries, including editorial correspondence, research suggestions, manuscripts, subscription orders, and requests for information should be sent to the Park Ridge Center, 211 E. Ontario, Suite 800, Chicago, Illinois 60611.

* 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

Shifting the Burden of Proof

PLAGIARIST OF SORTS THAT I OCCASIONALLY AM, I borrow the title of this teaser editorial from one of the articles in this issue of *Second Opinion*. When editors borrow from the authors they publish, it is a sign of confidence in the writings and respect for the essayists. The phrase *burden of proof* is on loan here from Dena S. Davis, who wants to see it shifted from patients in persistent vegetative states, or PVS, who are not capable of giving voice to anything in such states but who, the law presumes, do *not* want life support withdrawn. "The burden of proof is [currently] on those, like the family of Nancy Beth Cruzan, who would have it removed." Davis tells why she wants this burden shifted. "*You would be wrong more than 80 percent of the time*" as a judge "if you followed our current presumptions and placed the burden of proof on those who wished to withdraw the feeding tube."

Burden of proof *n. Law.* The responsibility of proving a disputed charge or allegation.

That text for our meditation, from the dictionary, frames the issues in other articles within these pages. The Park Ridge Center is a center for study, not for advocacy, and *Second Opinion* reflects the stance of the Center it represents. But the non-advocacy charter does not imply that people invited to speak up here are not to have opinions

or to set forth arguments. Many important themes come labeled "controversial."

So authors Suzanne Holland and Karen Peterson, in our weighty opening article, would shift the burden of proof to those who wish to keep their ears shut when the cries for attention to poor women—especially the elderly and those of childbearing age—are voiced. A society that continues to shun such cries has worked out a system of "proof" to defend its policies, or nonpolicies, but this system does not match the avowed concepts of justice in the society.

The controversial voices in this issue continue in Margaret M. Poloma's discussion of prayer and well-being. As we read her, she pictures scientists and social scientists saying that the burden of proof is on the vast majority of people who believe that prayer has effect. She would shift the burden to scientists who do not hear the claims of those who pray, or read the evidence of its effects. Her citations of evidence may not make her case, in the minds of many readers, but they may well unsettle those who prematurely had their minds made up.

Then comes the voice of Dave Hilton in our interview. He has spent so much time listening to people around the world and being convinced of their need for empowerment that he would shift the burden of proof to those in our society

who believe that we can live out our religious and ethical commitments unmindful of the voices of the powerless. What he also says about congregations and their potential role in healing pushes the burden of proof to those who argue that congregations can live out their life unattentive to the roles they could play in helping produce healthy people and communities.

Robert Wuthnow attempts to shift the burden of proof in the case of those who think that “greed and selfishness . . . enacted daily” characterize our society. He suggests, with statistics and stories, that “an ethic of caring is still very much a part of America in the 1990s,” and he shows how this ethic can be developed, thus further enhancing care.

And Bernie S. Siegel, who has heard many a patient’s voice, speaks up with and for patients who have repressed anger, to their detriment. If you agree with Siegel, the burden of proof has shifted to those who think healing can go on only by suppression of “righteous” but presumably unwelcome expressions of feeling.

Sometimes, in these articles, the “proof” in question is legal; more often it belongs to the realm of morality, or faith, or personal or public opinion. In all cases, the authors assume that in the current state of society the majority of those who make it up have come to some conclusions

based on proof that they have gathered too casually. They might change, we read here, if they heard the voices of poor women; of people in PVS, back when they could speak; of those who pray for health; of the unempowered of the world; of those who care and volunteer; of the ill who are angry. Indirectly, at least, we get to hear some of those voices on the pages that follow.

A handwritten signature in dark ink, appearing to read 'M.E.M.', with a stylized, cursive script.

Martin E. Marty



The Spanish Family. Oil on canvas by Alice Neel, 1943 .

The estate of Alice Neel. Courtesy Robert Miller Gallery, New York.

The Health Care *Titanic*: Women and Children First?

Suzanne Holland and Karen Peterson

Introduction

PICK UP A NEWSPAPER, ANY NEWSPAPER, on any given day. You'll find more coverage on what, until very recently, was rarely front-page news: health care. We all know by now that more of us than ever before lack health insurance—37 million of us, in fact. We know this because, for the first time, the health care delivery system is failing the middle class. Finally, this failure has become a middle-class issue—*our issue*. What we forget is that *our issue* is not new to millions upon millions of Americans who are classified as “the poor.”

Those words, *the poor*, are inextricably linked with the words *women* and *illness*. The “feminization of poverty” means exactly this: the poor have become overwhelmingly female (McBarnette 1988:55–56). As many of us in the middle class are becoming frighteningly aware, a lack of financial resources goes hand-in-glove with illness. It stands to reason

that if you don't have enough money, you (and your children) are less likely to eat well, less likely to have the means to care for your body, less likely to go to the doctor when you are sick, and *far* less likely to seek preventive care of any kind. (This is particularly problematic in the case of poor women who are pregnant and who must usually forgo critical prenatal care. The result is often deadly, for either mother or infant.)

On the other hand, if you are poor, you are *more* likely to live in substandard housing or to worry about maintaining payments on the small home you might own. You are also more likely to work in service-sector jobs at close to minimum wage, more likely to suffer from chronic stress, more likely to work in substandard conditions, and more likely to have chronic or debilitating illnesses (Zambrana 1988; McBarnette 1988). If you are female, all these conditions often will be exacerbated, as Lorna McBarnette reports:

National surveys over the years have provided evidence of yet another connection—between poverty and ill health—as evidenced by the poorer health status of low-income people. . . . [A]lthough strides have been made in rectifying the disparity between poor and nonpoor

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women, economic deprivation is still associated with poorer health. . . . [In recent years] with the increasing number of women who are poor, there has occurred a convergence between class and gender that is unprecedented in American history. (1988:56–57)

These are the issues with which this essay concerns itself. We first look at the historical and contextual situation of two groups of the poor: poor women in their reproductive years and elderly women of limited income. We then consider the national furor over what constitutes adequate health care coverage in light of the three major types of proposals being advanced for health care reform: “pro-competition” plans, “pay-or-play” plans, and a national health care system.

We apply an explicitly feminist ethic to each of the plans to assess the adequacy of the proposed changes from a woman-centered perspective. We find, however, that none of these proposals for reform is morally adequate: in particular, none satisfactorily addresses the needs of women—especially poor women. Using the historical experiences of the two groups of poor women mentioned above, then, we begin to develop an ethic of justice that, we submit, ought to be applied to any proposal for health care reform.

Poor Women in Their Reproductive Years: A Structural Analysis

IN 1985, THE ALAN GUTTMACHER INSTITUTE conducted a study of Medicaid patients and of physicians specializing in obstetrical care and “concluded that the health of mothers appears to be suffering in large part because of compromised access to prenatal care” (McBarnette 1988:57). First, prenatal care is simply not available to many poor women because obstetricians and gynecologists have lower Medicaid participation rates than all other

primary care physicians (McBarnette 1988:57–58). Transportation and language barriers, low-paying jobs that do not provide health insurance benefits, and systemic barriers to specialist care within the Medicaid system itself also affect access to care for poor women, especially women of color.¹ Because of stringent income criteria, Medicaid covers only about one-third of the poor women whom federal family-planning programs target for assistance. It is highly ironic, as McBarnette points out, that “poverty means limited access to the very services that help to prevent poverty” (McBarnette 1988:68–69).

Furthermore, issues involving poor women and reproduction are now the subject of intense debate. In at least two states, California and New Jersey, the reproductive practices of poor women are being scrutinized and blamed for the high costs of welfare. Welfare, it is said, is bankrupting state budgets. Thus, in at least two instances, governors and legislators are targeting poor women and their children as prime redline “objects” in state budget cutting (Goodman 1992; Abramovitz and Davis 1992). In reality, welfare constitutes only 6 percent of the state of California’s general fund of \$43.8 billion (Heagerty 1992). In some states, legislators are proposing cash incentives for poor women who have the Norplant birth control device implanted and for poor men who have vasectomies (“Tennessee Eyes Reward” 1992). This is certainly consistent with previous state and national efforts to make funds available for sterilization of poor women (McBarnette 1988:69). It seems that our society would rather eliminate these women’s reproductive needs than attend to them.

Although most health surveys have not been gender, class, and race specific (generally lumping together either “the poor” or “women”), we know that clear linkages exist between lower socioeconomic status and women (Zambrana 1988:137–60). We also know that women are disproportionately poor and in poor health, especially regarding reproductive health (McBarnette 1988:56). Poor women are more likely to suffer from medical complications associated with cervical cancer and sexual-

ly transmitted diseases, for example. They are also more likely to die in childbirth. In fact, black women are *three times* more likely to die in childbirth than are white women, because of poorer living conditions and more limited access to prenatal care. McBarnette insists, and we concur, that “the health gap for poor women is significant to the larger society since the health status of women directly affects the health status of future generations” (1988:69–76, 76).

And what of future generations? What values are we upholding when we tolerate a health care industry where the infant mortality rate for non-white children is twice as high as that for white children (Zambrana 1988:141)? As Ruth Zambrana reports, “Ethnic minority women experience higher infant mortality rates, higher neonatal death rates and higher post-neonatal death rates. Low birthweight, which accounts for 60% of infant deaths, is higher among racial/ethnic minorities” (1988:142). Moreover, the recent and highly touted government findings that infant mortality in the United States has dropped to an all-time low belies the still-grim reality. As the *San Francisco Chronicle* reported, “the infant mortality rate in the United States fell to an all-time low in 1989, but the slight improvement still left this country ranked 22nd in the world. . . . The mortality rate dropped despite an increase in the percentage of babies with low birth weight” (“U.S. Improves” 1992).

Under such circumstances, lower infant mortality leaves little to cheer about, especially if you are a low-income minority woman. In that case, chances are you would not have been able to get adequate nutrition; you are likely to be suffering from one or more chronic illnesses, and certainly from chronic stress; and you are not likely to have had much at all in the way of prenatal care (Zambrana 1988:148). Furthermore, children born into such poverty will also suffer its effects. According to Health Access (a San Francisco-based health care coalition), “Low birthweight. . . is the single largest cause of infant death and can lead to permanent disability among infants who survive” (1987–88:2).

Moreover, when women are unable to obtain adequate prenatal care and nutrition, huge medical and social costs result from the use of postnatal technology to try and save their at-risk babies. As Joseph Liu of the Children’s Defense Fund notes, “we are relying on the miracle of modern technology to save very sick babies, while failing to provide (enough) up-front preventive care” (“Too Many Infants” 1992). One wonders whether one could all but eliminate the category of “at-risk children” with a shift in priorities that took seriously the health needs (both nutritional and reproductive) of mothers.

Elderly Women: A Structural Analysis

HEALTH CARE FOR TODAY’S ELDERLY PROVIDES another example of how women’s needs have been systemically ignored. Many charge that today’s older people are well off—indeed, perhaps *too* well off—and that we should begin to curtail public funding for their health needs. True, elderly people today are better off than in previous times. However, a significant number of elderly people *are* poor (13 percent in 1988), and others live on limited incomes and are “near poor” (Grau 1988:104–5). Still others are driven into poverty as they become ill and find themselves with inadequate health insurance to cover their multiple health needs. This illness-engendered poverty proves especially tragic when it is not only ill people *but also their spouses* who become poor as a result of the illness.

Who are the elderly? First, the majority are women. Because women tend to live longer than men, they make up the bulk of our society’s older generation. Even more significantly, older women are *disproportionately poor*: 60 percent of the elderly are women, but 72 percent of the elderly poor are women (Tallon and Block 1988:123). Especially vulnerable are single women; because many of these women have lower preretirement incomes than their male counterparts, they tend to receive lower Social



Last Sickness. Oil on canvas by Alice Neel, 1952.

The Estate of Alice Neel. Courtesy Robert Miller Gallery, New York.

Security payments and pensions (Grau 1988:106). Furthermore, women have traditionally worked at low-paid or unpaid jobs (e.g., child care), which offer no financial security in old age. In 1985, one out of five older women lived in poverty; this figure rises in the case of minority women (Grau 1988:105–6).

Those who are poor and old are also more likely to become ill. Aside from private insurance, health

care is primarily available to elderly people through Medicare and Medicaid—both of which have glaring inadequacies. Medicare, the federally financed health insurance system available to people 65 or older (and to certain disabled persons), covers less than half of the elderly's health care costs—45 percent in 1984 (Grau 1988:109). Significantly, Medicare fails to cover many of the health-

promotion interventions most needed by elderly women to stave off diseases such as breast cancer, osteoporosis, and diabetes (Grau 1988:108). Furthermore, Medicare fails to cover community or institutional long-term care adequately—the service that elderly people perhaps need most.² This glaring shortfall stems primarily from Medicare's exclusion of day-to-day routine care. Thus, only "skilled nursing care" is covered,³ and most nursing care does not qualify as "skilled" (Sommers and Shields 1987:66). Even most private insurance plans do not cover the long-term care needs of older people.

The alternative for these elderly is Medicaid. Medicaid is a welfare program, paid for by both the state and federal governments, designed for people with very low incomes and few assets. According to Grau, almost one-half of the nation's poor people do not qualify for Medicaid, due to strict state eligibility requirements (1988:109). Medicaid *does* pay for long-term care, but only for people who are *very* poor.⁴

What choices, then, are available for the chronically ill elderly person on a limited income? Often he or she simply cannot afford institutional care or adequate in-home help and may not (yet) qualify for Medicaid. Spouses and family members take on the daily tasks of caregiving, and approximately three-fourths of these caregivers are women (Sommers and Shields 1987:15). Moreover, these caregivers are often older wives, not in the best of health themselves, who must provide nonstop, round-the-clock care for ailing spouses. Such caregiving requires a staggering amount of work. Yet social stereotypes tell us that women are "naturally" more caring and that we need not question the adequacy of such an arrangement. As Tish Sommers and Laurie Shields point out, "For women, caregiving is an expected duty; for men, it is an unexpected expression of compassion" (Sommers and Shields 1987:16).

Alternatively, a couple may be forced to "spend down" into poverty in order to obtain long-term care coverage under Medicaid. Consider the case of Sam and Martha, a couple in their mid-60s:

Sam's federal civil service pension was \$600 per month, Martha's Social Security benefit was \$300 per month, and their \$50,000 bank certificate of deposit gave them interest income of \$500 per month. Because they owned their home (valued at around \$100,000), their total income of \$1,400 per month was minimally adequate. When Sam had a stroke that left him unable to walk or speak, Martha began to care for him at home. She quickly learned that neither Medicare nor their supplemental health insurance policy were much help once Sam came home from the hospital. She was able to get Medicare to pay for a home health agency to send someone to provide periodic physical therapy and to give Sam injections, but only for a short time.

No other home care was covered by Medicare or their supplemental health insurance policy. . . . The long period of care after a stroke patient has been "stabilized" is considered custodial [not "skilled"].

Martha could not even afford to hire someone to come in and watch Sam while she shopped, kept medical appointments, or went to her granddaughter's first birthday party. She cared for Sam alone, 24 hours a day, until she had a mild heart attack a year later. Her physician said she should take it as a warning, and that it was time for Sam to go into a nursing home.

But there wasn't enough money. While Sam and Martha could get by on \$1,400 a month when Sam was at home, they couldn't afford the cost of the nursing home, which was \$2,000 per month. Neither Medicare nor Sam's supplemental insurance policy covered any of it, either. . . .

Martha looked into Medicaid. Medicaid does pay for nursing home care, but only for the very poor. She was appalled to learn that for Sam to qualify for Medicaid, they could have no more than \$2,500 in savings. That meant she would have to spend their savings of \$50,000 before he would become eligible. Once that money was gone, they would no longer have the interest income (\$500 per month) to live on.

Their monthly income would then be \$900 (Sam's pension plus Martha's Social Security),

of which Martha would be allowed to keep about \$500 for herself. . . . Medicaid would then pay for the remainder of the cost of Sam's nursing home care.

. . . Martha could see a bleak future for herself after Sam's death. Since their savings would have been spent, she would no longer have \$500 in interest income each month. And she would no longer receive his \$600 civil service pension. (Like so many couples, they had chosen not to have Sam's pension pay a survivor's benefit because that would have meant lower monthly income while he was alive.) Though Medicaid did not require Martha to sell her house as long as she lived in it (either while Sam was in the nursing home or after his death), Martha knew she couldn't pay taxes and insurance on the home with her small Social Security income. But if she sold the house and rented an apartment for herself, Sam would not be eligible for Medicaid until all proceeds from the sale of the house had been spent. While caring for Sam at home might cost Martha her life, putting him in a nursing home meant that the rest of her life would be spent in poverty. (Sommers and Shields 1987:60-63)

Sommers and Shields sum it up well: "It is poor public policy indeed that permits—or worse, requires—the permanent impoverishment of the spouse of a severely disabled person" (1987:76). Not only do older women tend to live longer—and thus to experience more chronic, multiple, and increasingly debilitating disease (Grau 1988:106)—they also tend to be physically and financially responsible for the care of an ill spouse, too often resulting in their own impoverishment.⁵

These health care dilemmas that so many face in old age are not confined to the poor; as the story of Sam and Martha illustrates, the middle class is also vulnerable. For all but the rich, any uncovered illness could mean eventual poverty. Furthermore, *this vulnerability is particularly faced by women*.⁶ Women are more likely to be poor, sick, and caring for others in their old age. Having faced occupational segregation and unjust wage structures for their entire lives,

these women now face inadequate provision for their health needs. Any proposed health care reform must face this inadequacy squarely.

Three Proposals for Health Care Reform*

SUCH GLARING INADEQUACIES PROMPT US to examine our health care industry and its failure to work for women like those described above. Indeed, health care reform has become the hot topic of the 1990s, and legislative proposals abound, in and outside Congress. In general, there are three types of proposals: (1) "pro-competition" proposals, seeking reform primarily through the marketplace; (2) "pay-or-play" proposals, seeking reform through employer-purchased insurance; and (3) proposals that advocate a national, single-payer health care system. A brief description of each follows.

Pro-Competition Plans: The Bush Administration's Proposal

PROPOSALS THAT PROMOTE CHANGE through the marketplace generally advocate tax subsidies for the purchase of private health insurance. Such tax subsidies theoretically force people to "shop around" for

*The recent election of Bill Clinton brings his proposal for health care reform into the foreground. At the time of publication, it appears that President-elect Clinton has shifted toward a "managed competition" approach. Earlier in his campaign, the Clinton proposal was most easily located in the pay-or-play category. Therefore, we did not examine "managed competition" proposals in this article (which was written prior to the election). We refer the reader to the work of Alain C. Enthoven (for example, 1988, 1992) of Stanford University for a fuller discussion of this approach.

the best health care plan. Shopping around, of course, benefits those with more time, knowledge, language skills, and economic savvy. The most visible of these has been the Bush administration's proposal, though other pro-competition plans exist.⁷

Basic Features

UNDER THE BUSH ADMINISTRATION'S PLAN, poor individuals, couples, and families would receive tax credits—via vouchers—to pay for health insurance. Others (with incomes up to \$80,000 for couples) would receive tax deductions to help pay for health insurance costs not covered by employers.⁸ Significantly, these figures would rise to meet *overall* inflation but would not keep pace with the higher rate of inflation in medical costs. Thus, the value of the tax benefit is likely to decrease over time.

The Bush plan would also legislate certain insurance reforms in order to make the health insurance industry more equitable. These reforms include a restriction on preexisting-conditions clauses (which limit coverage) and a prohibition of practices that curtail coverage for higher-risk persons or groups (Wines 1992:A15). Thus, a person could no longer be refused insurance—or have his or her insurance rates raised—simply because of poor health.

Financing and Cost Containment

THE BUSH ADMINISTRATION HAS NOT SPECIFIED exactly how such a plan could be financed. One suggestion has been mentioned: a per-capita ceiling on the growth of federal Medicaid payments. As the *Washington Post* points out, "The clearest suggestion [President Bush] makes is to finance part of the increased care for the poor by cutting the main existing form of care for the poor" ("President's Health Care Plan" 1992:26). President Bush argues that this ceiling would force states to cut costs by turning to HMOs and other forms of managed care. The plan also advocates changes in medical malprac-

tice and antitrust laws to lower insurance costs. Finally, the plan encourages small businesses and individuals to band together into larger risk pools in order to lower their insurance premiums.

Evaluation

THE BUSH ADMINISTRATION'S PLAN MINIMALLY disrupts the current health care industry. Furthermore, the federal government plays a weak role, as it largely shifts the burden of cost containment to the states (because of federal Medicaid caps). This shift, along with the emphasis on *private* insurance, reflects a traditionally conservative effort to limit federal bureaucracy and promote "efficiency" through competition. It is not clear, however, that efficiency will in fact increase. Certainly some amount of competition already exists in the health care industry, and few would argue that it is economically efficient. Economist Uwe E. Reinhardt frames the issue this way:

Surely the elderly and small business firms [currently] have the incentive to act as prudent purchasers. If even they cannot seem to discipline the health-insurance market, what makes us think that harried working mothers with children or other low-income families will be able to drive the market toward greater efficiency? Yet that is precisely the assumption underlying proposals such as the [Bush] administration's. (1992:11)

Another core value of the Bush administration's proposal is to preserve *choice* of health care insurers. However, the plan maintains the value of choice for the nonpoor only, since the poor would be *forced* into managed-care facilities—resulting in a two-tiered system of care. Under such a system, tight regulation (of private insurance companies) would be needed to ensure that the packages affordable to the poor are not substandard.

Pay-or-Play Proposals

A SECOND GENERAL CATEGORY OF PROPOSALS for health care reform is known as the pay-or-play approach. Under this type of plan, employers would be legally required either to “pay,” by contributing money to a governmental plan that covers all uninsured people, or to “play,” by purchasing private health insurance for employees. Among the various versions of the pay-or-play approach, two in particular stand out: the proposal of the U.S. Bipartisan Commission on Comprehensive Health Care—the Pepper Commission (Rockefeller 1991),⁹ and S. 1227, sponsored by Senate Majority Leader George Mitchell (Fuchs, Lundy, and Sokolovsky 1991:85–99).

Basic Features

IN GENERAL, PAY-OR-PLAY PLANS WOULD PHASE in health insurance coverage over a period of time, with the government requiring first large and then small businesses to provide coverage.¹⁰ As an alternative to purchasing private insurance coverage, most pay-or-play plans would allow employers to purchase coverage from a newly established federal program (which would partially or fully replace Medicaid). This program would also cover non-workers and the self-employed.

Most plans of this type also call for various insurance reforms, such as the setting of adequate minimum standards of coverage. For example, both the Pepper Commission’s recommendations and the Mitchell plan include standards that emphasize preventive services, including prenatal care, well-child care, mammograms, Pap smears, and other procedures. The Pepper Commission also makes a specific recommendation for long-term care coverage.¹¹ Other insurance reforms include the limiting of preexisting-conditions clauses (Mitchell) and the standardization of eligibility requirements (Pepper Commission).

Financing and Cost Containment

PAY-OR-PLAY PLANS GENERALLY PROPOSE A variety of financing and cost containment measures. Most plans would finance health costs through existing government sources and some new taxes (the Pepper Commission specifies that these taxes should be “progressive” in nature). Most would also promote cost sensitivity by requiring nonpoor individuals and families to contribute some portion toward the cost of health care (subject to ability to pay). In addition, pay-or-play proposals encourage cost containment through greater use of HMOs and other forms of managed care. The Mitchell plan also seeks to contain costs by establishing a “federal health expenditure board” to set national health spending goals. Finally, the Pepper Commission emphasizes the need for malpractice reform in order to control rising health costs.

Evaluation

PAY-OR-PLAY PROPOSALS IN GENERAL ALLOW for more governmental regulation than purely pro-competition proposals. Therefore, they can more closely oversee *which* benefits get covered, providing a more stable “floor” beneath the feet of the currently uninsured. To their credit, both the Pepper Commission’s proposal and the Mitchell proposal emphasize some preventive care. Furthermore, pay-or-play proposals build on the current system, so they are not as destabilizing as single-payer plans (below). This gives them the strength of political feasibility.

The most commonly cited weakness of pay-or-play proposals centers around financing; a disproportionate amount of the burden falls on small businesses (many of which do not currently purchase health insurance for employees). Despite tax incentives, inflationary health costs could potentially drive many businesses into bankruptcy, increasing unemployment. In the face of such rising costs, one might well question the effectiveness of using managed care as the main tool for cost containment.



The Adolescent. Lithograph by Raphael Soyer, 1956.

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National, Single-Payer Proposals

THE THIRD GENERAL CATEGORY of health insurance reform is the national single-payer health care system, similar to the Canadian system. Several proposals currently exist; among the most visible are the Physicians for a National Health Program (PNHP) proposal (Grumbach et al. 1991:2549–54) and H.R. 1300, sponsored by Representative Marty Russo (Fuchs, Lundy, and Sokolovsky 1991:27–29).

Basic Features

UNDER MOST SINGLE-PAYER APPROACHES, the government would pay for all health care services deemed “medically necessary.” The PNHP proposal specifies that these services would include prescription drugs and long-term care. Russo’s bill specifies not only hospital and medical services, but also nursing care, home health services, hospice care, preventive services (including pre- and postnatal care), services for the disabled, prescription drugs, and other services determined by the government. Under a national health care system, consumers would still have a choice among private doctors, hospitals, and nursing homes when seeking care; the single, government-backed insurer, however, would pay all fees for medically necessary treatment.

Financing and Cost Containment

PROPONENTS OF A NATIONAL HEALTH PLAN hold that it would bring about significant administrative savings as insurance was streamlined. To contain costs further, the government would set fee schedules (for doctors) and global budgets (for hospitals and nursing homes). The PNHP suggests that government finance the proposal by combining current tax revenues with new progressive payroll taxes and new, “healthier,” socially beneficial taxes.¹² Russo, on the other hand, would fund a national

health program through premiums for the nonpoor elderly, increases in income taxes and some employer payroll taxes, and general revenues.

Evaluation

THE STRENGTHS OF SUCH A NATIONAL PLAN are clear: guaranteed universal coverage, rational (and controllable) financing, and a clear method of cost containment. Its financing structure is potentially the most progressive, since it may be determined independent of market forces. Although businesses would likely be taxed to support the plan, small businesses would carry less of a burden than under a pay-or-play system.¹³

Critics argue, however, that such a system would encourage people to seek unnecessary care since they would have no incentive to act prudently. Furthermore, such a system *may* lead to shortages and waiting lines—and to the need for rationing of care (particularly for expensive procedures¹⁴ of questionable effectiveness). Under the current system, of course, de facto rationing of care already occurs; those uninsured and underinsured persons who cannot pay for care do not get it. It is not universally accepted, however, that national health care necessarily leads to long waiting periods.¹⁵

The basic value underlying single-payer proposals is equality of care. Furthermore, efficiency and profit give way to protection for *all* people. Choice (of doctors, hospitals, and nursing homes) is maintained as a value but extended to all people, not just those who can afford it. Because there is no hierarchy in levels of care, wealth does not hold absolute sway; as Ian Morrison has said, under a single-payer, Canadian-style system, “even if you earn \$100,000 a year, you can’t jump the [waiting] line” (Holzman 1991:51). Certainly, under such a system, wealthy people might purchase private care at their own expense (or seek it in other countries). It is significant, however, that *public* resources are not allocated this way.

Toward a Feminist Ethic of Health Care

IN THE FACE OF SUCH AN ARRAY OF PROPOSALS for health care reform, how are we to evaluate them from a feminist perspective? In the past two decades, a considerable body of literature has emerged on feminist theory; for the purposes of this essay we are most interested in the feminist theory that arises out of theology and ethics. While feminist ethicists vary greatly in their approaches to justice, certain “base points” do appear that are particularly relevant to health care reform. These are (1) the “epistemological privilege” of the societally marginalized, (2) a historical and contextual analysis of structures of oppression, and (3) a vision of justice as “right relationship.”

What, in the first instance, do we mean by the “epistemological privilege of the societally marginalized”? This phrase is a feminist adaptation of the essential point of liberation theology—that theology is always the second step in any process (Gutierrez 1988). Parting company with mainstream European theology, the liberation theologians of Latin America articulate a radical reconfiguring of how theology (in our case, ethics) should be done. We must begin not with theory, but *first of all* with the stories of those who are oppressed. In Latin American liberation theology, the oppressed are the poor. The world over, the poor are predominantly female.

To say that the poor have an epistemological privilege means that we who are nonpoor must begin by according a place of honor and respect for what the poor *know*. The majority of you who are reading this essay, and we who are writing it, are not poor. Were poverty our present reality, we would not have the luxury of reading this analysis. This fact itself underscores the need to give primary consideration to the poor and marginalized. We who stand in any position of advantage (by accident of birth, education, race, gender, class, or sexual orientation) simply cannot know the reality of being poor and, for purposes of this paper, female.

This is not an issue of liberal guilt and hand-wringing. It is fact: we cannot know what the poor know unless we first give priority to listening to the very voices our structures effectively mute. In a feminist ethical appropriation of this base point of liberation theology, Karen Lebacqz explains:

I am white in a world where whites oppress blacks. As I look at the rupture of justice in the world. . . an oppressor mentality will inevitably enter my picture. It will distort my perceptions, destroy my convictions, and pervert my conclusions. Because I am an oppressor, it will be all too easy for me to deceive myself—to think, for example, that the crumbs falling from the tables of white folk are really adequate for others, or that they are all that others deserve, or that they are “unfortunate” but not unfair and that justice requires no more. Because I am an oppressor, my very efforts to see injustice and to move toward justice are in jeopardy. . . . As a white, well-educated, middle-class American, my life connotes cocktail parties rather than slums. How different it is from the extreme poverty that afflicts many in our world. How different from the racism that surrounds many with daily violence. Can I still hear the tears? How do I keep my ears open? One way is to let oppressed people speak for themselves. (1987:12–13)

The essential starting place, then, is that place where the muted voices receive special amplification. This is axiomatic to any feminist ethic.

Giving credence to the epistemological privilege of the marginalized (defined as poor women in this paper) necessarily leads to a second step: analyzing both context and history of the very *structures* of oppression. Though persons can and do certainly oppress one another, to focus interpersonally would be to miss the point. Persons participate in structures of oppression, and those structures have histories; often they have names (patriarchy, totalitarianism, racism, and so on). The point of structural-historical analysis of context-specific oppression is to expose the systems we uphold, often

uncritically. It is not enough to stop and listen to the stories of the oppressed; we must next ask what is the *cause* of the oppression?

Writing about the health care industry and the need for a feminist bioethic that insists upon a political analysis of context, Susan Sherwin makes this argument:

Feminist ethics requires that any evaluation of moral considerations attend to the power relations that structure the relevant interactions. Political analyses of the unequal power of women and men, of white people and people of color, of First World and Third World people, of the rich and the poor, of the healthy and the disabled, and so forth are central to feminist ethics. To date, that sort of analysis has been almost entirely absent from the literature of mainstream medical ethics. (1992:84)

Sherwin is adamant that health care analysts take a structural point of view in doing their history. Only such a standpoint can uncover "the effect of . . . larger [medical] practices on women's pursuit of greater power in a society that currently subordinates them" (1992:91). Uncovering the site of the power is crucial in Sherwin's feminist ethic of justice, as it is in our own.

Third, a feminist ethic means attending to "right relationship" as, in some ways, both means to and ends of justice. *Right relationship* is a term first used (so far as we are aware) by feminist theologian Carter Heyward (1982). Many feminist theories have since appropriated it because relationality seems to be at the heart of the social experience of living life as a female.¹⁶ Beverly Harrison is one of the chief advocates of a feminist ethic of right relation. It is for her both practical and "utopian." She argues that "above all else a feminist moral theology insists that relationality is at the heart of all things. . . . It is, above all, to insist on the deep, total sociality of all things. . . . Our life is a part of a vast cosmic web, and no moral theology that fails to envisage reality in this way will be able to make sense of our lives or our actions today" (1985:15–16).

Alice Walker's heroine, Celie, in *The Color Purple* echoes this thought: "one day when I was sitting quiet and feeling like a motherless child, which I was, it come to me: that feeling of being part of everything, not separate at all. I knew that if I cut a tree, my arm would bleed" (Walker 1982:168). This expresses exactly what Harrison means when she "insist[s] on the deep, total sociality of all things." We are interrelated, whether we realize it or not.

In our opinion, to hold an ethic that insists not just upon relationality, but upon right relationship, implicitly affirms our essential dignity as human persons. In fact, we understand our essential dignity to include our interrelatedness. To be *essentially* human is to be relational (Mead 1934; Niebuhr 1963; Winter 1966). Indeed, it is part and parcel of the essential dignity of humanity. We do not minimize the reality of human pluralism; obviously, persons differ from one another and have different histories and differing needs. We do assert, however, that each person has an essential dignity and that part of our common humanity is our interrelatedness (Farley 1986:82).

Right relationship has a second and equally important aspect: a call to right relation is a call for social arrangements that seek to *redress* the current injustices in our world. Karen Lebacqz argues for an understanding of justice in which

the formal principle of justice is. . . not to give to each what is due but to correct injustices. This simple shift in starting point has profound implications for a theory of justice. If justice begins with the correction of injustices, then the most important tools for understanding justice will be the stories of injustice as experienced by the oppressed and the tools of social and historical analysis that help to illumine the process by which those historical injustices arose and the meaning of them in the lives of the victims. (1987:150)

The redress of injustice is the creation of right relationship; it is the movement toward a social order that takes essential human dignity seriously.

Such an ethic demands the liberation from social structures of oppression to social structures that reflect and respect what we have named as constitutively human. To right wrong relationship is “what we call ‘doing justice’ ” (Harrison 1985:19).

In this way, right relationship becomes a matter of redressing injustice within this present historical context. It is never enough to identify matters of injustice, nor simply to shift our moral theory to account for historical and structural patterns of oppression, nor, even, to hear the stories of the oppressed. Justice will be a hollow concept indeed if we do not act to minimize, if not eradicate, the presence of injustice. And if we take seriously the feminist tenet of relationality, we must act; for all injustice has to do with us whether or not we stand to benefit from its presence. Once we accept that we are caught up in a great web of relationality, then to redress injustice for the oppressed is to increase justice for us all.

This commitment to bring about change in our historical context is what Harrison means when she writes, “It is not that it is wrong for any of us to ask: ‘What does all this mean for me?’ That is a good question. But in feminist moral theology, good questions are answered by *something we must do*” (1985:21).

“What We Must Do”

A FEMINIST ETHIC, THEN, ASKS WHAT WE MUST do to foster health care that (1) amplifies the voices of the poor, (2) reflects an analysis of the structural and historical roots of oppression, and (3) fosters right relationship. While we do not intend to offer an alternative health care reform proposal, we raise the following challenges in the hope that those who are defining social policy might take seriously the implications of a woman-centered perspective on justice.

First, justice mandates that we listen to the voices of marginalized people, those with inadequate health care, before making any proposal for health

care reform. In other words, it means treating the marginalized (in our case, women) as if they *know* something about what they need, about what justice (vis-à-vis health care) would look like for them. At least one proposal that begins to honor this commitment is that of the Pepper Commission. Before constructing its recommendations, this commission held public hearings around the country, listening to testimony from “numerous witnesses.”¹⁷ A commitment to the epistemological privilege of the poor would mean taking seriously the needs that emerge—from the poor—during such hearings. For instance, it would mean listening to the needs of Martha, the older woman described earlier. It would mean listening to the abominably high statistics of infant mortality and chronic disease among poor people. Finally, it would mean seeking to incorporate what these stories teach into our health care priorities.

Second, a structural analysis (like that at the start of this essay) of health care in the United States reveals that the current approach feeds the power imbalance in which women are enmeshed. A feminist ethic of justice calls us to uncover the connections between inadequate health care and the other factors that deny power to women in our society. This process includes exposing the deeper roots of the problem—for example, making the connections between low pay, poor nutrition, poor housing, and illness. As Howard Moody affirms, “Poor people are sick from bad housing, bad nutrition, and no jobs!” (1991:268). The above analysis demonstrates that this is especially true for women.

An adequate approach to health care reform will begin to name these connections, even if it is unable to address them directly in one piece of legislation. None of the proposals examined above do this to any significant degree, though some emphasize preventive care—which is at least a start at addressing some of the deeper problems. A feminist ethic, however, calls for sweeping reforms, reforms that would also point to the need for adult nutrition programs, housing provisions, and even pay equity. Certainly,



The Cradle. Charcoal on paper by John Biggers, c. 1950.

The Museum of Fine Arts, Houston; 25th Annual Houston Artists Exhibition, Museum Purchase Prize, 1950.

a piece of health care legislation cannot fully address the myriad ways women are oppressed in our society; nevertheless, legislation as a whole must begin to do this if the health needs of women are ever to be met substantively.

A proposal could begin to apply a structural analysis to health care reform by requiring that any health plan be financed progressively, so that the poor—who are disproportionately female—are not further burdened by health care costs. In our judgment, the most explicitly progressive financing of all the proposals we have examined is that of the Physicians for a National Health Program. The

Pepper Commission proposal also encourages progressive financing, but the actual bills are less progressive than the specific suggestions made by the PNHP. The PNHP plan makes a direct effort to distribute costs more evenly so that the poor are not saddled with payments grossly out of proportion with their incomes. This approach begins to address some of the underlying injustices in our current system, injustices that (disproportionately) cause women to become and to remain poor.

Third, a feminist ethic requires us to examine the implications of justice as right relation. For instance, honoring each person as essentially valu-

able (dignified) might first entail ensuring a basic amount of health care to all, regardless of ability to pay. Some would argue that all the above proposals, while not always equalizing access to health care, do guarantee a “decent minimum” of affordable health care. The Bush administration’s proposal, for instance, promises to make sure that an affordable “basic” package is available in each state.

Everything depends, of course, on what *basic* means. The Bush administration’s plan does not spell this out, leading one to assume that the term probably includes little more than current Medicare or Medicaid coverage—which, as we have shown, is often not sufficient, particularly for women. The pay-or-play proposals are more specific about minimum required benefits, and they do include some preventive care (as detailed above). A national health plan is likely to provide the most comprehensive (basic) benefits, particularly since the same benefits would apply to all persons, regardless of ability to pay. An argument might be made here that in a free society, rich people will generally find ways to obtain more and better services, beyond what is “basic.” We do not wish to contend with this point. It is our argument, however, that *public* policy must at minimum reflect morally *just* priorities.

It is not only respect for the essential dignity of persons that must govern our structures of health care, however. Right relation as *redressing current injustices* requires avoiding any system that effectively gives a lesser degree of care to the poor (who are mostly women). Thus, we must question any system that provides a lower level of care to those with less money or power. Both the Bush administration’s proposal and the pay-or-play proposals maintain a distinction between public and private insurance, automatically encouraging a two-tiered system. These plans may go a long way toward providing health insurance, but inevitably, more people will “slip through the cracks”—and, more than likely, these will be the least advantaged of our society: the homeless person, the non-English-speaking immigrant, or the single mother who has little time to “shop around” for the best plan.

But it is not even enough merely to avoid a system that provides less care for poor women. Redressing current injustices would entail creating a health care system that actively addressed the specific health needs of poor women—women who thus far have *not* had adequate access to health care.¹⁸ In the case of rationing, for instance, redressing past injustices might mean that poor women would actually receive *priority* in access to care, as long as structural injustice still exists. For example, this might hold as long as data show that poor women experience higher rates of maternal death or that elderly poor women become ill more often. Thus, instead of rationing care according to ability to pay (as is currently the case), we might begin to understand rationing as a tool for correcting injustice.

Concretely, our ethic insists that whatever reform is undertaken, it must provide for preventive care that will foster the health of these women and not just fight their disease. A plan that takes seriously the wellness needs of women, especially poor women, will recognize that the needs of children are the needs of women as well. As such, it will specifically fund coverage for prenatal care, including nutrition education, and if necessary, provide special vouchers for supplemental pregnancy nutrition. Health care reform plans also must provide for postnatal, well-baby, and well-child care. If truly adequate prenatal care is ensured, infants may not need the disproportionately expensive postnatal technology currently in use. To provide prenatal care, it may even be necessary to divert funds from more expensive procedures.

Moreover, attending to preventive care for women also means drafting a health care plan that factors in the reality of poor women’s greater risk for complications associated with cervical cancer, ectopic pregnancies, cesarean sections, and sexually transmitted diseases. The redress of injustice here requires that more money be allocated to preventive care for such at-risk women. Coverage should specify, for example, screening for diseases of the reproductive system as well as for older women’s

diseases like breast cancer. To their credit, both pay-or-play plans explored in this article specify coverage of Pap smears and mammograms. Both national health proposals also emphasize preventive services, though this term is sometimes vaguely defined and does not specifically mention the particular preventive health needs of women. Still, none of the three types of plans goes any further than this; given the larger picture we have painted, none of them goes far enough.

Finally, concrete attention to women's health needs must not neglect the issue of long-term care. Chronic illness and the need for long-term care will affect most of us, but they strike directly to the heart of elderly women's lives. As we have pointed out, elderly women care for most chronically ill elderly persons, and many of those caregivers either are, or will become, impoverished in the process. No plan can be considered morally adequate if its adoption forces elderly women into a life of full-time caregiving or poverty or both.

Justice as right relation is particularly poignant here, for surely honoring human relationality means that health care coverage must exist not just for nursing home care but also for full *in-home* care (in cases of chronic illness), so that human relationships might be disrupted as little as possible. Some national health plans (including Russo's) provide "home and community-based services for disabled individuals." We assume this includes the elderly ill, though the plan does not state that explicitly. It does place some specified limitations on these services, however, and the nonpoor elderly are expected to pay a premium. Aside from national health proposals, none of the other plans accords particular attention to health needs of the elderly at all; much less has any plan mentioned the elderly poor, most of whom are women.

Conclusion

IN SUM, APPLYING A FEMINIST ETHIC OF JUSTICE to current proposals for health care reform makes it

all too apparent that we have a long way to go toward "what we must do." In this article, we begin the journey by establishing a connection between women, poverty, and ill health. It has been our intent to locate that reality at the nexus of the debate over health care policy reform in the United States. We have advanced the thesis that any call for change must explicitly consider the health needs of poor women (especially in their reproductive and elderly years); no plan for reform can be considered morally adequate if it fails to do so. Further, we have maintained that moral adequacy can be evaluated against a feminist ethic of justice that includes (1) the "epistemological privilege" of the societally marginalized, (2) a historical and contextual analysis of structures of oppression, and (3) a vision of justice as right relationship.

While we find the call for health care reform itself laudable, and while each plan examined here represents at least some advance over the current malaise, no plan meets our threefold criteria for justice. In terms of the first criterion of a feminist ethic of justice, the Pepper plan (a pay-or-play proposal) does indicate that it actually held hearings of some kind, presumably to hear from the people whom its call for reform would affect. Even so, it is not clear that poor women were actually sought out and invited to speak at these hearings. Nonetheless, we find the process at least a first step toward listening to, albeit not necessarily privileging, such persons.

Plans for a single-payer national health care system come closest to meeting our second criterion of justice—analyzing the historical and structural causes of oppression. In truth, none of the plans actually includes such analysis, though national health plans do clearly represent a radical restructuring of the current approach, including program financing. Such a radical restructuring is predicated upon historical and structural analysis, but not one that crystallizes the connections we have made between poor women and health care. In fact, the main structural issue on the table is that middle-class, working people suddenly find themselves unable to

afford health coverage. That is deplorable, but it should not obscure the fact that for at least two decades women have been getting poorer and sicker, and this has not seemed a serious enough matter to warrant reform of the health care system.

Finally, we applaud all the plans for taking seriously an ethic of justice as right relation to this extent: the call for at least a basic minimum (“universal coverage”) implicitly contains the value of essential human dignity. Moreover, because the very creation of the plans is an indication that we as a nation are admitting at least a minimal responsibility to assure health care coverage for all persons,

each plan implicitly affirms a web of relationality. If the plans for reform approximate this much of justice as right relation, however, all fail to *redress* injustice fully; none gives sufficient priority to the health needs of poor women.

In the end, no plan that fails to take *primary* account of the myriad voices of women in poverty deserves to become social policy. Unless and until the needs of these women on the margins are placed at the forefront of proposals for change, plans for health care reform in the United States will be neither ethical nor just. ☹

NOTES

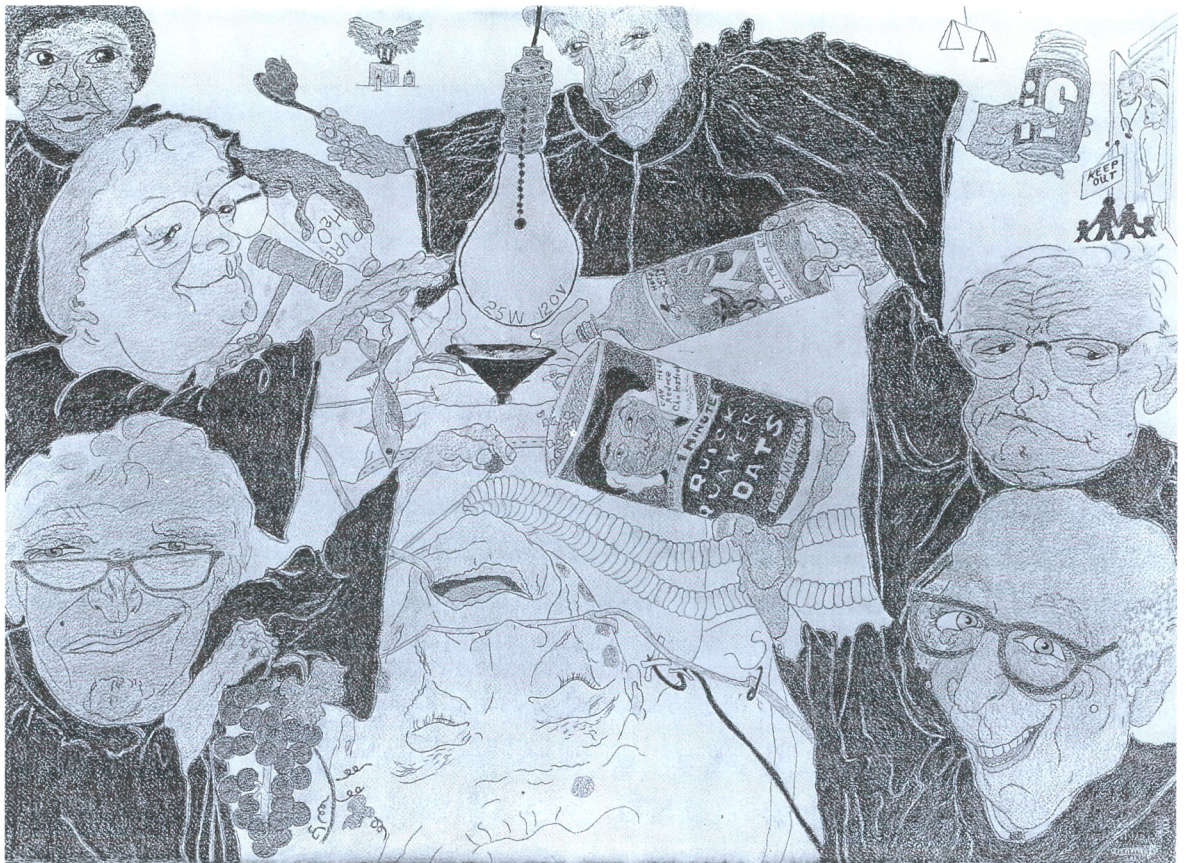
1. In a 1986 study in New York State, for example, McBarnette (1988:57) reports that “the Medicaid maximum allowable fee is such that, in the market place, specialist care for poor women is almost unavailable.” This would appear to be a national trend, since at the time of this writing, May 1992, newspaper accounts are filled with stories on specialists and greater numbers of primary care physicians dropping out of the Medicaid system, which pays far less than private fee-for-service arrangements.
2. In fact, Medicare pays only 2 percent of the nation’s nursing home costs (Sommers and Shields 1987:66).
3. Actually, it is only partially covered; Medicare pays for only 100 days of skilled nursing care, and the patient pays a substantial part of the cost for 80 of those days.
4. In general, Medicaid covers people with assets of less than \$1,700–\$3,400 (in 1987), depending on marital status, and with income levels that are well below the poverty line (Sommers and Shields 1987:67).
5. It should be noted that some states are experimenting with legislation aimed at preventing spousal impoverishment in such cases. However, the story of Sam and Martha still holds true throughout most of the country.
6. According to Grau, two-thirds of middle-income single women aged 65–74 (and three-quarters of women over 75) who live alone fall into a lower–middle income range; they are without benefit of “Medigap” (supplemental health insurance offered by private insurance companies) and in-kind housing subsidies, and they rely on Social Security as their primary source of cash income. These women have no choice but to “spend down” to qualify for Medicaid (1988:108).
7. Another pro-competition plan, relying even *more* heavily on the private insurance market, is that of the Heritage Foundation. This plan advocates the elimination of employer-based insurance altogether. Instead, individuals would receive refundable tax credits for health expenses (Butler 1991).
8. These vouchers would be worth up to \$1,250 for individuals, \$2,500 for married couples, and \$3,750 for families.
9. Some of the recommendations of the Pepper Commission have been embodied in bills introduced by Senator Rockefeller (S. 1177) and Representative Waxman (H.R. 2535).
10. The Pepper Commission’s plan would provide special incentives for small businesses, including tax credits and reforms in the private insurance market to guarantee the availability of an affordable minimum-benefit package (Rockefeller 1991:2508).
11. This recommendation is not incorporated into the concrete bills proposed by Senator Rockefeller and Representative Waxman, however.
12. Such taxes would “reduce income disparities and discourage the use of harmful and polluting substances” (Grumbach et al. 1991:2552). They might include taxes on cigarettes, alcohol, or sources of air and water pollutants, as well as new and more progressive federal income taxes. However, some of these taxes—for instance, alcohol and tobacco taxes—could actually end up being *regressive* with respect to income, penalizing most heavily those lower-income individuals who partake of such “vices.”

13. Small businesses could pay a tax proportional to their size, rather than the flat-rate premium of a government plan (under a pay-or-play system) (Grumbach 1991:284).
14. An analysis by the National Academy of Sciences indicates that "the use of new technologies and the overuse of existing technologies account for as much as 50 percent of the annual rise in health care costs" (Booth 1991).
15. In some European countries—France, Germany, and Belgium, for example—long lines for service have *not* accompanied universal health care (Holzman 1991:50).
16. We are not here entering the debate about essentialism. Rather, we hold that human beings are primarily gender-socialized, as a consequence of sociohistorical and cultural factors.
17. The commission does not specify who, exactly, these witnesses were. We assume, however, that they would at least include individuals most directly affected by the health care crisis (Rockefeller 1991:2508).
18. The pay-or-play proposals we have examined do especially address the needs of poor women to the extent that uninsured pregnant women and young children are among the first covered during the phase-in period. However, nonworkers are among the last to be "phased-in" under these proposals. Many of the poor and near-poor are in this category.

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The Courtroom. Drawing by Elizabeth Layton, 1990.

"The sign on the door to the courtroom says KEEP OUT. The doctors, nurses, and family are not allowed in. The comatose patient on the consulting table has a funnel leading directly into her stomach. Black-robed Justices pour in nutritious foods—
artificial grapes, fish, oats, peanut butter, pure H₂O, 7-Up.
The 25-watt light bulb symbolizes the dim illumination perfect strangers may have on the case."

Shifting the Burden of Proof

Dena S. Davis

I AM WRITING THIS ON MY TRUSTY word processor. Although I don't think of myself as a high-tech person, I am able to use it easily because of a system of defaults that makes choices all the way down the line. Some of these defaults are built into my software, and some were installed just for me by the genius who runs our school's computer system. I am often amazed at how well my preferences fit the software's presumptions. How could it predict that I would want margins of a particular size, or page breaks after so many lines? (It is easier to understand why it saves text automatically at regular intervals and insists on asking me twice before it erases a document.) But it's really not so surprising. Whoever made my software figured out their market, did some research into the basic needs and writing patterns of people like me, and came up with defaults that reflect majority preference. I can change the defaults easily, but the "burden" to do so is on me.

Our legal system includes many such presumptions, or "societal defaults": if you do not state a

preference, the law presumes a preference for you. For example, if you do not name someone to make decisions for you should you become unable, the law assumes that your spouse will play that role. When we make health care decisions at the end of life, we often are also working in a context of societal defaults. Unfortunately, as our society's needs and our perspectives on health care have changed, we have not always changed the "defaults" to keep pace. That describes the current situation regarding removal of nutrition and hydration from patients in persistent vegetative states (PVS).

At present, the law presumes that patients in PVS do *not* want life support withdrawn; thus the burden of proof is on those, like the family of Nancy Beth Cruzan, who would have it removed. This assumption is strongly defended by legal scholar John D. Gray:

[S]ince our experiences in life teach us that all creatures strive hard to continue life, it should follow that a patient would also want life preserving procedures continued, not discontinued. Thus, in a right to die case involving an incompetent or comatose patient, the court ought to start out with the presumption that the patient would wish to continue, not end,

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his life. As a result, the burden should be placed on the party seeking to act against this natural assumption. (1990:40)

Three recent polls have asked Americans what they would want done for them if they were in a persistent vegetative state. Although opinion-poll results must always be received with caution, the evidence cannot be ignored: most Americans do *not* want artificial nutrition and hydration under those conditions. In a study reported in the *New England Journal of Medicine*, 405 primary-care outpatients and 102 members of the general public were asked to choose among 13 specified interventions in four clinical scenarios. When the diagnosis was PVS, 83 percent rejected intravenous fluids, and 85 percent rejected artificial nutrition (Emanuel et al. 1991). In a 1990 *New York Times* poll, 81 percent supported removal of a feeding tube for a person described to fit the profile of Nancy Cruzan, and 85 percent would want removal of a feeding tube if they themselves were in that condition ("Right to Die" 1990). And in a 1991 poll conducted by the *National Law Journal*, 80 percent of respondents said they would want life support discontinued ("Bioethics Debate" 1991).

It is true that public opinion polls must be viewed with caution. Nevertheless, if we were able to peer behind the percentages and talk with the people polled, I believe we would find the numbers rising even higher in favor of withdrawal. The two most common misconceptions about this issue are first, that people might miraculously wake up even after months in a PVS, and second, that dying from lack of nutrition and hydration must involve discomfort (see Cranford 1988).

Unfortunately, our current legal standard favors life support by placing an extremely heavy burden

In cases where one cannot make an honest judgment about the patient's wishes, one is much more likely to "get it right" by leaning toward withdrawal.

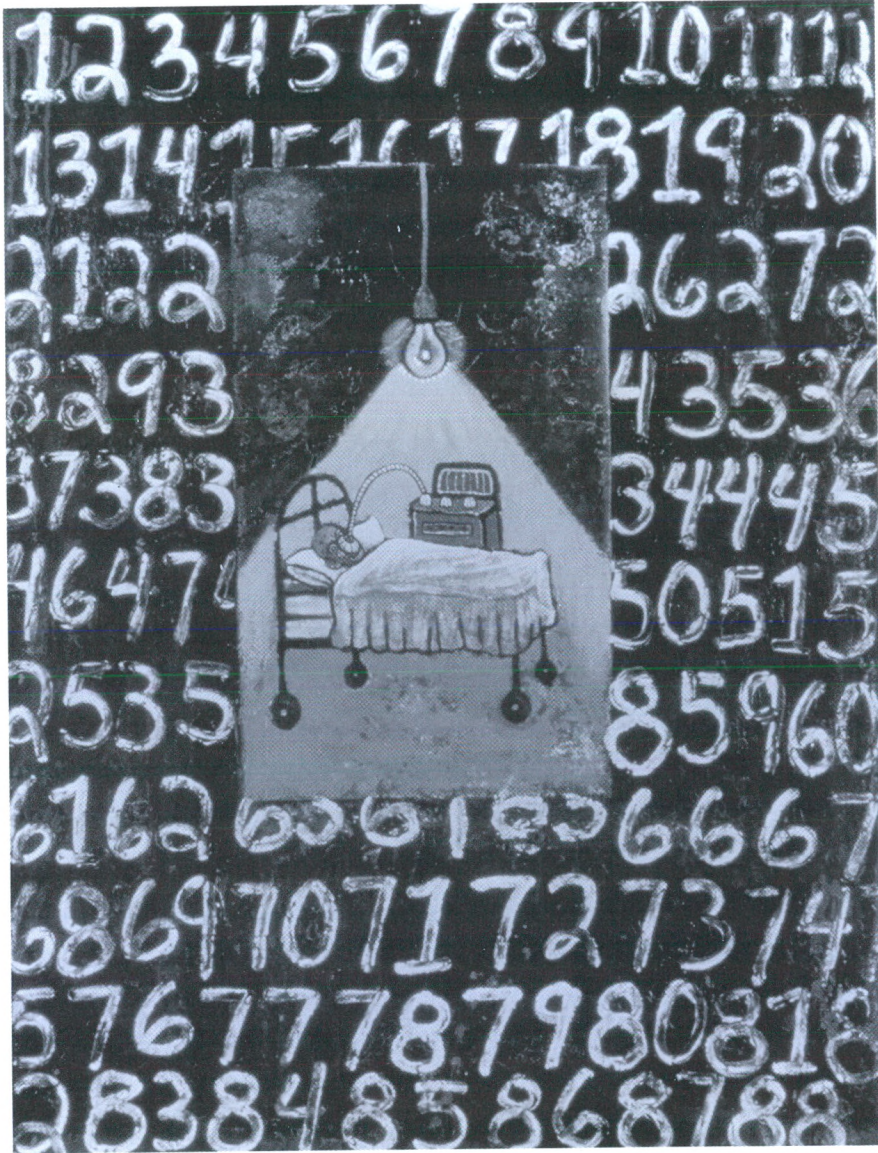
of proof on those who would remove life supports, even for those patients in persistent vegetative states. In the *Cruzan* case, the Supreme Court allowed the state of Missouri to insist on "clear and convincing evidence" of the patient's wishes before acceding to the family's request to withdraw life-support measures; there, even the unanimous testimony of Ms. Cruzan's clearly loving and devoted family, describing her basic values and occasional conversa-

tions about end-of-life issues, could not meet that standard (*Cruzan* 1990). In Ohio, a patient in a PVS must be kept alive for 12 months unless she has signed a form in which she has specifically requested the withdrawal of nutrition and hydration, with the appropriate phrases in capital letters (lower case will not do). Many other states have equally exacting policies. These presump-

tions are ethically wrong and, ultimately, destructive of human autonomy.

I am making two arguments in this essay. First, the evidentiary standard applied in this area should be the same as that applied in other noncriminal cases: namely, the preponderance of the evidence (Feinberg 1991), defined as "more likely than not." Where the question is continuation or withdrawal of medical treatment, the challenge is to discover and honor the patient's wishes. In order to meet this challenge in difficult cases, the parties must examine all the evidence—written, verbal, and biographical.

Although we would always wish for the evidence to point with total certainty in one direction, that will often not be the case. Obviously, the best evidence of a patient's wishes is a thoughtfully executed advance directive. If the relevant phrases are in capital letters, so much the better. But a realistic assessment of human nature must remind us that cases like those of Karen Quinlan and Nancy Cruzan will not go away. Healthy young people who have



AIDS Patient. Acrylic on canvas by Luis Cruz Azaceta, 1989.

Courtesy Frumkin/Adams Gallery, New York.

never had a serious encounter with the medical system and who arrive at the hospital after a trauma are not likely to have written an advance directive. Consider that most Americans have never even executed a “regular” will. Thus, where evidence is mixed or scanty, we must weigh it as carefully as possible and act as the preponderance of the evidence indicates, whether that points to withdrawal or continuation of treatment.¹

Second, when evidence of the patient’s wishes is truly murky or simply not available, the presumption for the patient in a persistent vegetative state should be in favor of withdrawing life support. To illustrate my point, I ask you to imagine a patient about whom we know nothing. Perhaps, like Ms. Cruzan, she is a young American who was healthy until injured in a car accident and is now incontrovertibly in a persistent vegetative state. Imagine that she has no family and that we can discover nothing that sheds any light on her personality, value system, or thoughts about treatment withdrawal. We have a moral and legal obligation to determine what she would want, though we have to face the fact that we are guessing. The one piece of information we do have—and it is very powerful information indeed—is that over 80 percent of Americans say that they would refuse life support in such a situation. In other words, if you were the judge being forced to give your best guess about the wishes of our hypothetical patient, *you would be wrong more than 80 percent of the time* if you followed our current presumptions and placed the burden of proof on those who wished to withdraw the feeding tube.

Three major objections to my argument can be made. A first objection is that a decision to remove nutrition and hydration is irrevocable, while an erroneous decision to continue support can always be reversed. But this objection is fallacious. Once a patient is reliably diagnosed as being in a persistent vegetative state, the decision to continue support is almost always irrevocable for the length of the patient’s life, which may well be decades. No new data will be forthcoming from the patient herself, and the family is not likely to go back to court every

few months. Either the patient will have life support removed and die, or she will remain on artificial nutrition for the foreseeable future, perhaps, as Justice Brennan pointed out in *Cruzan*, for as long as 30 years.

A second objection is that the patient suffers an injury if her life is taken against her wishes, while keeping her alive does not harm her. After all, precisely because she is in a persistent vegetative state, she doesn’t know what is going on and is not experiencing pain. So, the argument goes, one should err “on the safe side” and continue support unless one is absolutely convinced that the patient would have opposed it. In my view, error on either side is equally injurious. Being kept on life support against one’s wishes is an injury in two ways. For one thing, the way in which one’s body is displayed and handled is always of great ethical significance whether or not one is conscious, or even alive. That is why organ donation requires consent and why there is serious ethical deliberation over the use of comatose, terminal patients as practice material for medical students (Shelp and Fost 1980). As legal scholar Susan M. Wolf points out, “What is immediately at issue in this case is how Nancy’s body will be touched, handled, invaded. There is no neutral, ‘safe’ decision; she either sustains bodily invasion and years in a vegetative state, or she does not” (1990:38–39). Moreover, one is grievously harmed when the plans and hopes for one’s life—including life’s end—are interfered with. Legal philosopher Ronald Dworkin argues the point this way:

If the only things people worried about, or wanted to avoid, were pain and other unpleasant physical experiences, then of course they would be indifferent about whether, if they became permanently comatose, their bodies continued to live or not. But people care about many other things as well. They worry about their dignity and integrity, and about the view other people have of them, how they are conceived and remembered. . . . These various concerns explain the horror so many people feel at the idea of existing pointlessly

for years as a vegetable. They think that a bare biological existence, with no intelligence or sensibility or sensation, is not a matter of indifference, but something bad for them, something that damages their lives considered as a whole. (1991:16)

Although it may seem logically odd to claim that one's selfhood and dignity can be wounded by events that happen after one is rendered permanently unaware (Feinberg 1984), we act on that assumption all the time. Perhaps what we are protecting here is not so much Nancy Cruzan's interest in having her wishes followed even after she is unaware, but our own need to feel that our wishes will be followed when *we* die or become unconscious. Whatever the logical argument, it is clearly a universal assumption in our culture that we should honor the wishes of the dead (unless those wishes bring serious harm to others), whether or not the dead know that their wishes have been frustrated. We would consider it a terrible thing if a person who felt strongly about being buried were cremated instead, or if a person of one religion were laid to rest with the rituals of an alien tradition. And we go to great lengths in this society to see to it that people's wills are followed and their property distributed according to their wishes.

A third objection is that the state has a stake in preserving the life of its citizens, which should mandate a definite "tilt" toward life unless a patient's wishes clearly point otherwise. But why does the state have an interest in protecting the life of its citizens? Surely it is because the citizens themselves *want* that protection. In fact, according to the social-contract theory of the state, protection of one's

life is the prime reason that one would form a state and submit to a government. That is very different from having the state protect one's life *against* one's wishes. The right to life is but one aspect of the right to self-determination: "[S]ubstitute decision-makers must seek to respect simultaneously both aspects of the patient's right to self-determination—the right to live, and the right . . . to die of natural causes without medical intervention" (Conroy 1985:1227).

Let me make very clear what I am *not* saying. I am not suggesting that because 85 percent, or even 99.9 percent, of Americans appear to prefer death to PVS, we should be any quicker to remove feeding and hydration from any patient. Each individual has the right to have her wishes heard and to be treated according to our best understanding of those wishes, whether or not they happen to fall in with the majority opinion. Families, health care personnel, ethics committees, and courts have an absolute obligation to peruse every scrap of available evidence, ranging from clearly executed advance directives to discussions with friends and family members to the patient's "value history" throughout her life and so on. I am, however, arguing against the stricter evidentiary standard that exists when one asks for the court to remove life support. Further, in cases where one cannot make an honest judgment about the patient's wishes, one is much more likely to "get it right" by leaning toward withdrawal. After all, most of you, reading this essay right now, would choose not to be fed artificially if you were in a persistent vegetative state. Shouldn't that fact count for something? 🌐

NOTE

1. A separate but related issue involves people who want treatment that the medical personnel consider inappropriate or futile. Although most of our legal and ethical focus has been on people whose families wish to withdraw support, a more difficult ethical and economic challenge may be seen in cases like that of Helga Wanglie, an 87-year-old woman who was respirator-dependent and in a PVS. Wanglie's husband insisted that she be maintained on maximum life support indefinitely, because it was certainly what she would have wished (see "Helga Wanglie's Ventilator" 1991).

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The Effects of Prayer on Mental Well-Being

Margaret M. Poloma

"IF YOU TALK TO GOD IN A SYNAGOGUE OR church, your behavior is regarded as perfectly normal; if you talk to God in a busy restaurant, or if God talks back to you, you are considered mentally disordered" (Robertson 1987:192). The author of a leading introductory sociological text offers this illustration to make the point that a person's action may be interpreted differently depending on its context. But prayer in either context has been neglected by most pulse-takers of modern public life, scientific and lay alike, despite decades of reports from American pollsters that nearly 90 percent of Americans pray. The survey data discussed below show that millions of Americans do claim to "hear" God speaking to them regularly; and millions more silently pray to God as they go about their daily affairs in public places.

My own experience with prayer has involved a personal odyssey. I was raised a Roman Catholic in a tightly controlled pre-Vatican II church. My prayer as a child could be characterized as a ritualized

one-way communication with a God-out-there. Although I delighted in the stories of saints who walked and talked with God, I felt that this privileged communication could be hoped for only by the priests and sisters whose black habits symbolized a "true faith" beyond the grasp of laypersons. I came of age with Vatican II, just as the Church (seemingly overnight) abandoned its traditional stance in search of a truce with modernity.

The light of modern scrutiny was enhanced by my study of sociology, which revealed formerly unnoticed cobwebs and cracks in Catholicism. During my transition to agnosticism, I read Émile Durkheim's *Elementary Forms of Religious Life* and concluded that this sociological master was correct: the "old gods" indeed were dying or already dead, and the new ones were yet to be born. I put aside the traditions of my childhood and entered the spiritless world of contemporary social science.

About seven years later, a religious experience (actually a series of them that continues to this day) moved me to a different understanding. The distant God-out-there who delighted in human rituals seemed indeed dead, but the void was filled by a God who lives and acts among and within God's people. Through a personal involvement in the charismatic

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movement of the mid-1970s, I came to know prayer as an intimate relationship with God. Not only did I talk with God, but I began to discern how God spoke with me. It was this relationship, not some obtuse doctrine, that was the lifeblood of my newly found faith. My research on charismatic (Poloma 1982) and Pentecostal Christians (Poloma 1989) assured me that I was not alone.

Charismatic-Pentecostal Christians, with their practices of glossolalia (speaking in tongues), divine healing, and prophecy, comprise no more than 10 percent of the American population, and I soon began to raise questions about the affective dimension of religion for non-charismatics. Sociologist-priest Andrew Greeley had collected data in the mid-1970s indicating that mysticism, an ecstatic experience of the transcendent, was an accepted phenomenon on Main Street (Greeley 1974, 1975), but his research said little about prayer, the practice that I felt was the medium for mysticism. The opportunity to explore prayer in some depth presented itself in 1985 when I became the faculty investigator for the Akron Area Survey (AAS), which explored the general quality of life for residents of the greater Akron region in northeastern Ohio (see Poloma and Pendleton 1991). In 1988 I was able to study these issues among a wider population when I helped construct a questionnaire for a national Gallup Poll (see Poloma and Gallup 1991).¹ These surveys provide the data for answering two questions central to this article: Who are the people who pray, and what do they do? and, Does prayer make a difference in the health and well-being of Americans?

Americans are a praying people, but they seem to prefer the privacy of their prayer closets (which may be their automobiles) to communal prayer in their family rooms.

Prayer in Its Social Context

GALLUP REPORTS FOR OVER FOUR DECADES have shown little change in the percentage of persons who respond affirmatively to the question, "Do you ever pray?" Ninety percent of those surveyed in 1948 said they prayed; 30 years later, 89 percent acknowledged that they prayed to God. In the 1985 Akron Area Survey, only 8 percent said they had never prayed during the previous year; in the 1988 national Gallup Poll, 12 percent said they never prayed (Gallup and Jones 1989). It seems safe to say that 9 out of 10 Americans, at least on occasion, engage in the practice of prayer.

According to Andrew Greeley (1991), Americans (along with the Irish) are the most praying people in the modern world. In the U.S. (as in Ireland) some 80 percent of respondents claim to pray at least once a week.² For Italians and New Zealanders this figure drops to 70 percent; for Spaniards, Australians, and Germans, to between 60 and 70 percent; and for the British, Danish, and French, to between 40 and 50 percent.³ Fifty-seven percent of Americans say they pray daily, with women being somewhat more likely to pray than men, older persons than younger persons, blacks than whites, and less educated persons more than those with higher levels of education.

The various surveys and polls that include a question about the frequency of prayer consistently report that the overwhelming majority of Americans do, at least on occasion, pray and that a majority or near majority prays at least once a day (Gallup 1985; Princeton Research Center 1985; Gallup and Jones 1989:100). In analyzing responses to the AAS I learned further that less than half (43 percent) of those who pray set aside a special time for private prayer. The vast majority of pray-ers did at least



Isenheim Altarpiece: Crucifixion (detail of Mary Magdalene). Matthias Grünewald, c. 1512.

Giraudon/Art Resource, New York (PEC 5030). Colmar, Musée Unterlinden.

some of their praying while they were performing other activities like housework, jogging, or driving. Very few (only 6 percent), however, limited their private prayer to these times "on the run." Praying with others in church is the most common practice; only 10 percent prayed with friends or family regularly (weekly or more often) outside a church setting.⁴

Earlier survey research on prayer generally provided simple descriptive data on the frequency of prayer, showing seemingly little interest in the content or efficacy of prayer practices (see Finney and Malony 1985). From the experience of my own prayer journey from ritual to relationship, I gleaned that prayer meant different things to people. I therefore sought measures that would reflect the distinct types of common prayer and assess the degree of intimacy with the divine experienced by different pray-ers. Statistical analyses of these questions indicated that I had measured four different *forms of prayer* and had developed a scale of *prayer experiences*.

Types of Prayer

WHEN RESPONDENTS TO THE AAS and the 1988 Gallup Poll indicated that they prayed at least occasionally, they were asked an additional series of questions that distinguished among the different forms of prayer used. (Fourteen additional questions on private prayer activities were included in the AAS and 11 in the Gallup.) In both cases, four different dimensions of the phenomenon were measured. I labeled these dimensions or types of prayer *colloquial*, *petitionary*, *ritual*, and *meditative*.

Colloquial Prayer

THE COLLOQUIAL OR CONVERSATIONAL PRAYER style is practiced nearly universally by pray-ers; in this mode the person talks to God in his or her own words. Colloquial prayers regularly take the form of intercession for guidance, general blessings upon the

world, or forgiveness from sin. They also can include simply "telling God how much you love him" and "thanking God for his blessings."

Nearly three-fourths of the AAS respondents said they engaged regularly in colloquial prayer; only 2 percent of those who prayed never did so in this manner. It seems safe to say that virtually all those who pray talk to God regularly in their own words about a variety of things. It is also clear that colloquial prayer may be a one-way conversation. Pray-ers may or may not experience a God who dialogues with them. For example, although 91 percent of those who prayed said they asked God for guidance in making decisions, only 57 percent acknowledged that they had ever experienced God's leading or directing them.

Petitionary Prayer

SOME PRAYERS OF PETITION OR INTERCESSION, as we have already seen, clustered with colloquial prayer; but two measures used in the AAS helped us to make a further distinction. Some intercessions were for concrete personal needs, and some were for more remote spiritual ones. Praying for personal guidance and forgiveness or praying to alleviate world suffering is deemed an acceptable practice by the overwhelming majority of pray-ers. Praying for material things, whether for oneself or for friends and family, is less frequently practiced. Only 42 percent of Gallup respondents and 43 percent of AAS respondents claimed ever to pray for material things.

Perhaps no form of prayer is as difficult for moderns to accept as praying for concrete, material needs. Those who pray prayers of petition have been described as being in a "state of crisis . . . brought about by scientific and technical power over nature" (Duquoc and Geffré 1972:8). The ascendancy of science and technology in modern culture has stimulated in many people an understanding of prayer that does not include asking for material needs. Those who object to the use of petitionary prayer seem to do so for two primary reasons: (1) such prayer is

thought to be childish and immature, and (2) petitionary prayer requires the image of a God who is willing and able to intervene in the daily affairs of humans.

Despite the majority's reluctance to practice petitionary prayer, the number of pray-ers who seem to be heeding Jesus' instructions to "be as little children" and to petition their Heavenly Father for their daily bread is not insignificant. Those most likely to employ petitionary prayer are persons who profess to be "born again," those over 50 years of age, those who are nonwhite, and those with less than a high school education. Material deprivation and a faith that God will provide for those who ask seem to be strongly correlated with the practice of petitionary prayer.

Ritual Prayer

RITUAL PRAYERS INVOLVE READING or reciting a prepared script—prayers that have been committed to memory, the Catholic rosary, devotional psalms from the Bible, the prayers that appear in daily devotional booklets. Two questions were used to measure this form of prayer: Do you read from a book of prayers? and, Do you recite memorized prayers?

Half of those in the Gallup Poll who prayed, at least occasionally, said they recited memorized prayers, but only 22 percent ever read from a prayer book. Only 19 percent used both forms of ritual prayer.

Definite denominational differences may be observed in the use of ritual prayer. Catholics are more likely to use a prayer book than are Protestants (29 percent versus 16 percent); Catholics are also more likely to recite prayers they have memorized (72 percent versus 40 percent). When Protestants are divided into "evangelicals" and "non-evangelicals," the evangelicals are much less likely to engage in either ritual prayer practice.⁵

Meditative Prayer

MEDITATIVE PRAYER IS QUALITATIVELY different from the other three types. Colloquial, petitionary, and ritual prayer are all forms of verbal prayer which could, in effect, be one-way conversations with God. Meditative prayer could be described as taking the stance of a listener—of being still and knowing that God is God. Meditative pray-ers in the Gallup Poll acknowledged that they spent time "quietly thinking about God," "feeling the presence of God," "trying to listen to God speaking," and "worshiping and adoring God." All four of these prayer activities are more passive than those found in the other types of prayer. They include a focus on the deity (as opposed to concern with self) and a stillness that allows for an inner response.

Gallup figures demonstrate that a majority of Americans who pray engage in these meditative practices at least occasionally. Sixty-eight percent of those who prayed spent time worshiping and adoring God; 70 percent tried to listen for God's voice; 66 percent spent time just feeling the presence of God; and 75 percent included in their prayer times moments of quietly thinking about God. Fifty-two percent engaged in all four of these prayer activities; only 8 percent did not engage in any meditative practices.

Respondents in the AAS were asked an additional question concerning the practice of reading the Bible and thinking about what was read. Only 20 percent never meditatively prayed with the Bible; 28 percent did so regularly. Although the response choices for the AAS allowed for the reporting of frequencies (in contrast to the "yes/no" categories used by Gallup), the findings from the two surveys are very similar.⁶ Clearly, a passive prayer form that allows the pray-er to be silent before God is widely practiced.

Prayer and the Experience of Intimacy with the Divine

SURVEY RESPONDENTS WERE ALSO ASKED about their perceptions of their relationship to God: "Where on a scale of 1 to 7, with 1 being very distant and 7 being very close, would you describe your relationship to God?" In the Gallup survey, 19 percent of the respondents indicated a distant relationship, choosing numbers 1, 2, or 3. Seventeen percent selected the median number. The majority, 60 percent, chose 5, 6 or 7, indicating a close relationship. Some 20 percent of the respondents selected 7, describing a very close relationship; 4 percent responded with "don't know."

All four types of prayer are related positively to feeling close to God. Those who pray more frequently, regardless of the type of prayer analyzed, seem to experience a deeper intimacy with the divine. There are decided differences, however, in the strength of the relationships between each of the four prayer types and feeling close to God, as bivariate correlations show. (A *bivariate correlation* measures the strength of the relationship between two specific variables—in this case, between a feeling of intimacy with God and a particular prayer type. The closer the correlation [r] is to 1, the stronger the relationship.)⁷ Meditative prayer has the strongest relationship with a felt closeness to God ($r = .43$), while colloquial prayer ($r = .25$), ritual prayer ($r = .15$), and petitionary prayer ($r = .14$) all demonstrate much weaker relationships. Put another way, the quiet and passive practice of meditative prayer is very likely to be the prayer form of those who feel the closest to God.

Bivariate statistics, however, tell only part of the story. Many persons, if not most, engage in more than one form of prayer. One pray-er may use colloquial (the most common prayer form) together with ritual prayer, while a second may employ colloquial prayer and intercessory prayer, a third pray-er may combine colloquial, ritual, and meditative prayer in a prayer regimen, and a fourth may use only medita-

tive prayer. The forms of prayer are *multidimensional* (there is more than one type) and *multivariate* (with each type representing a separate variable). Bivariate analysis can analyze only one prayer form at a time. It is unable to recognize that people combine prayer forms and therefore unable to determine which (if any) prayer form is *really* making the difference in a person's "feeling close to God." Multivariate analysis, more specifically *multiple regression analysis*, sorts out the differences that may be attributed to each type of prayer activity. When all four prayer types are used in a single multiple regression equation, only meditative prayer still demonstrates a positive relationship with feeling close to God.

In the example of the four pray-ers mentioned above, those who used meditative prayer—with or without other prayer forms—were more likely to feel closer to God than those who did not. Those who engaged in ritual, petitionary, or colloquial prayer, but who did not also use a meditative prayer form, were less likely to report feelings of intimacy with the divine.

To elicit more information on why some people describe their relationship to God as closer than do others, the survey included questions about five possible *prayer experiences*: "a deep sense of peace and well-being," "the strong presence of God," "receiving a definite answer to a specific prayer request," "a deeper insight into a spiritual or biblical truth," and "feeling divinely inspired to perform some specific action."

These experiences (presented in Table 1) may be scaled according to degrees of intimacy. The most common prayer experience (and the least intimate) was a deep sense of peace and well-being, with only 12 percent never having had this experience and 32 percent reporting this to be a regular occurrence. The most intimate experiences implied a kind of partnership with the divine—being shown spiritual truths and being led to specific actions. A significant minority never had these two experiences, and only a decided minority regularly had them.

Again, all four types of prayer correlate with religious experiences during prayer, but meditative

Table 1
Prayer Experiences*

The questions below are about some experiences that you might have had during prayer. How often have you experienced the following?

	Never ⁺	Once or twice	Occasionally	Regularly
Experienced a deep sense of peace and well-being:	12%	19%	38%	32%
Felt the strong presence of God:	21%	20%	33%	26%
Received what you regarded as a definite answer to a specific prayer request:	27%	25%	32%	15%
Received what you believed to be a deeper insight into a spiritual or biblical truth:	39%	21%	28%	12%
Felt divinely inspired or "led by God" to perform some specific action:	43%	22%	26%	9%

*Percentages may add up to more than 100% due to rounding. Based on those 911 respondents who ever pray to God: weighted base = 1,738.

⁺"Never" includes those who "did not know" or "were not certain," as well as those who gave a negative response to the question.

Source: Poloma and Gallup 1991:47.

prayer demonstrates the strongest relationship ($r = .51$). The bivariate correlations for colloquial ($r = .36$), petitionary ($r = .26$), and ritual ($r = .12$) forms of prayer are all much weaker.

Multiple regression analysis provided a similar ordering, with three of the four prayer types helping to account for the differences in prayer experience scores. Persons who engaged in meditative prayer were the most likely to have the highest scores on prayer experiences. Those who practiced either colloquial or petitionary prayer (but not meditative prayer) had significantly fewer prayer experiences. Ritual prayer alone had no effect on religious experience.

It must be kept in mind that these prayer types are not mutually exclusive; many people who pray employ all four major types of prayer. What my analyses suggest, however, is that the use of verbal practices alone does not bring about a sense of intimacy with the divine. Those who have a greater

sense of closeness to God as well as those who report a higher level of prayer experiences are much more likely to engage regularly in all of the meditative prayer practices.

The Connection with Well-Being

LARSON AND LARSON (1991) HAVE DOCUMENTED well the neglect of the study of religion by mental health professionals. Even those studies that have included measurements of religiosity have tended to use nonrepresentative samples and poor measurements. Larson and Larson trace the dearth of good studies on religion and mental health to the indifference, and sometimes hostility, of mental health practitioners, noting that "while the majority of Americans appear to give religion a major place in



Silence. Oil on gesso paper by Odilon Redon, c. 1911.

Collection of the Museum of Modern Art, New York. Lillie P. Bliss Collection.

their lives, mental health professionals generally do not" (1991:35).

This lack of interest in the relationship between religion and the larger field of mental health is mirrored in the more specific quality-of-life (QOL) surveys. Extensive research conducted over the past 20 years has explored objective and subjective indicators of QOL. Such studies have looked at specific domains (income, family, health, employment) and at more general forms (life satisfaction, happiness, emotional well-being). Until very recently, however, measures of religiosity have generally not been included in most models linking specific domains to general forms of QOL (Poloma and Pendleton 1991, esp. chap. 1).

The neglect of religiosity measures by QOL researchers is part of a larger neglect of religious dimensions by social scientists. Most behavioral science projects have failed to incorporate religiosity into their research studies. Even when religion is targeted for study by health researchers, measurement has been a serious problem. Evidence of late suggests that scholarly interest in the study of the effects of religion on behavior is increasing and that more researchers are attempting to apply what sociologists of religion have long known about religion's multidimensional nature. Psychologist Allen Bergin's (1983) call to move beyond using denomination as a measure of religiosity is finally being heeded, and the inconclusive results of some early studies on mental health and religion can be checked now that the multidimensional nature of religion has been recognized.

The work of social psychologist Melvin Pollner (1989) moves away from using the traditional measures of denomination, belief, or ritual to tap religiosity; he conceptualizes religion instead as a relationship between God and ego. Using data from the National Opinion Research Center's General Social Survey, Pollner investigated the extent to which relationships with "divine others" affect psychological well-being. He found that participation in a relationship with the divine is the strongest correlate for three of four measures of well-being,

surpassing in strength such usually potent predictors as race, sex, income, age, and marital status.

Pollner's finding of a positive impact of relationships with the divine on psychological well-being received additional backing from an investigation of the impact of spiritual support (perceived support from God) and stress. Social psychologist Kenneth Maton (1989) reported that although spiritual support was not significantly related to well-being for people with low life-stresses, it was positively related to the personal emotional adjustment of people with high life-stresses. The findings of both Pollner and Maton suggest a difference between institutional religious involvement and personal relationship with a deity, and the AAS and Gallup studies offer additional data on the impact of the relationship facet of religion (specifically prayer and prayer experiences) on quality of life.

In the AAS, four commonly used measures tapped subjective perceptions of a general state of well-being. These included overall satisfaction with life, general happiness, negative affect (sadness, loneliness, depression, tension, and fear), and existential well-being (having a sense of meaning and purpose in life). Using multivariate analysis, the effect of the religious domain was assessed in relation to 10 other domains (including health, marital status, and standard of living) on each of the four QOL measures (see Poloma and Pendleton 1991, esp. chap. 2). A person's satisfaction with his or her religious life was found to be positively related to general satisfaction with life and with existential well-being. Religious satisfaction was the leading determinant of existential well-being and the fifth ranking factor in predicting life satisfaction (after satisfaction with standard of living, health, household composition, and marital situation). Religious satisfaction was not found to be a good predictor of general happiness or negative affect.

(Quality-of-life researchers have found that some respondents may be "satisfied with life" without being "happy"—and vice versa. "Satisfaction" appears to elicit a cognitive response, while "happiness" suggests an affective one. The terms are

related to one another but are not identical. Religiosity appears to have a greater impact on satisfaction than upon happiness [see Poloma and Pendleton 1991].)

Satisfaction with religion is not, of course, an actual measure of religiosity. A nonreligious person may be very satisfied with his or her nonreligiosity, just as a single person may be satisfied with his or her marital status. The question on religious satisfaction was framed to be comparable to questions measuring other aspects of well-being, including health, income, marital status, and residence. When bona fide measures of religiosity are used in place of satisfaction with religion, however, the findings are similar. In repeated computer runs using different models, prayer measures are consistently related to life satisfaction and existential well-being. Moreover, prayer was found to be positively related to reports of overall happiness with life. The relationship between measures of negative affectivity and prayer, however, are somewhat less clear.

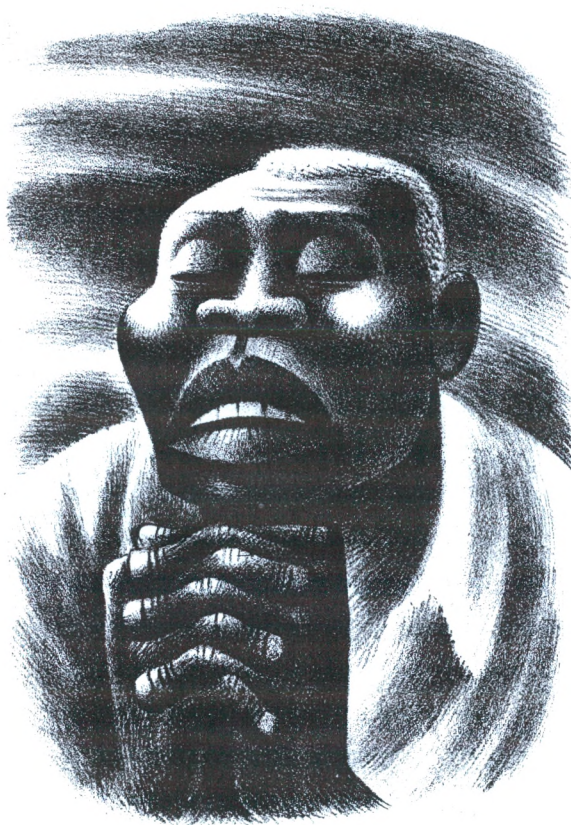
In summary, high scores on the prayer experience index were found to be an important indicator of life satisfaction, general happiness, and existential well-being. This finding held even when controls were set in place for common demographic factors (age, income, sex, education, and race) found to influence general

perceptions of well-being. How, then, does prayer affect these different facets of mental health?

Indicators specified in a survey research model to explain a phenomenon provide only a small piece of the puzzle. In this case, prayer, although clearly a factor in general well-being, is only one determinant of a subject's perception of mental health. Other demographic factors (including a greater income and being male), medical factors (being physically and mentally whole), and social factors (like having a strong network of social support) also contribute to subjective perceptions of having a high quality of life. The statistical finding I wish to emphasize here is that prayer is only one element—albeit an important one—in accounting for general satisfaction with life, happiness, and existential well-being.

When we summarize the major findings on the relationship between life satisfaction and prayer, a discrepancy becomes evident. It is clear that prayer experience contributes as much as does a comfortable income and contributes more than does gender, education, or age to one's sense of being satisfied with

one's life. From multivariate analysis, however, it is equally clear that it is not the frequency of prayer or even the types of prayer that help to explain the differences in life satisfaction. The determining factor among those related to prayer was the extent and depth of intimacy with the divine. Respondents who



Negro Praying.

Lithograph by Miguel Covarrubias, 1936.

had more frequent prayer experiences and a wider range of them were decidedly more satisfied with their lives than were those who had fewer religious experiences (Poloma and Pendleton 1991, esp. chap. 3).

Paradoxically, there is some indication that frequent prayer, particularly frequent colloquial prayer, may actually have a negative relationship to life satisfaction. This finding must be qualified through a closer inspection of the results of statistical analysis. Those persons who pray frequently but who do not have prayer experiences are less likely to be satisfied with their lives than those who pray less frequently but who experience intimacy with the divine. An attentive study of the statistical results suggests that this negative relationship between prayer and life satisfaction is not due to the practice of prayer but rather to other problems. People who previously prayed only infrequently may increase their prayer activity upon experiencing the loss of a job, some physical illness, or a marital breakdown. If they turn to prayer, they are likely to engage in the most generic of the prayer activities, namely colloquial prayer. The problems affecting life satisfaction may remain, and these pray-ers have not developed skills in meditative prayer that could position them for religious experiences. As a consequence, they are less likely to enjoy the intimacy with the divine that may comfort more skilled pray-ers who are victims of similar adversities.⁸

A similar pattern was found for general happiness scores. Again frequency of prayer showed a slight negative relationship to happiness, while prayer experience was definitely positively related. The results of multivariate analyses suggest that prayer experience is as important as income in accounting for differences in happiness scores.

The relationship between religion and existential well-being is reflected in some definitional statements about religion. Religion has often been defined by social scientists according to its ability to provide a sense of meaning and purpose in life. It has been credited with the power to fill the void left by science because it provides answers to ultimate ques-

tions that science is unable to answer. "A system of beliefs and practices by means of which a group of people struggles with the ultimate problems of life" (Yinger 1970:7), "symbolic forms and acts which relate man to the ultimate conditions of his existence" (Bellah 1964:359)—these are classic definitions of religion.

Analyzing the relationship between different measures of religiosity and existential well-being suggests not only that existential needs are best met by religion but that the way religion meets them is by providing a forum for intimacy with the divine. Meditative prayer and prayer experiences appear to be the most important factors (more important than any of the five standard demographic variables) in predicting high scores on existential well-being. Those who engage in meditative prayer, whether or not they have frequent prayer experiences, are more likely to have a greater sense of meaning and purpose in life than those who do not employ this form of prayer. Other forms of prayer were not found to be related to existential well-being.

What is it about religion that leads to a greater subjective sense of well-being? Analysis of the AAS findings indicates that it is a perceived relationship with God as measured by the prayer experience index. Institutionally based measures of religion, including religious belief, church attendance, and denominational affiliation, are clearly much less important to mental well-being than is one's perceived relationship with God.

There is yet one other issue that has bearing on the relationship between prayer and mental health, namely, prayer for physical healing and its relationship to mental well-being. Unfortunately, a question about private prayer for healing was not included in either the Gallup study or the AAS. The AAS did ask questions, however, about attending religious healing services and having any experience of healing as a result of prayer.

Symbolic Healing

SOCIOLOGISTS ANSON SHUPE and Jeffrey Hadden (1989:75) employ the term *symbolic healing* to designate unconventional healing, including the practice termed “faith healing,” “miraculous healing,” or “supernatural healing.” They call for “the established health care professions of Western culture to re-examine this ancient phenomenon.” Data from the AAS suggest that Shupe and Hadden are correct to ascribe importance to unconventional healing practices. Symbolic healing, especially prayer for healing, appears to be widely believed in and practiced in midwestern America.

A clear majority (72 percent) of the AAS respondents said they believed that “people sometimes receive physical healings of disease, injuries or other medical problems as a result of prayer.” Moreover, 44 percent of those who claimed to believe in symbolic healing (34 percent of the total number of respondents) claimed to have personally experienced being healed through prayer. Forty-five percent of those who claimed such an experience (10 percent of the total sample) said it was from a condition that was “life-threatening.” (For further discussion see Poloma 1991; Poloma and Pendleton 1991, esp. chap. 4.) Although it was beyond the scope of the Akron Area Survey and beyond my expertise to evaluate these alleged healings, it is possible to use the AAS to explore the relationship between symbolic healing and mental well-being.

I divided the AAS sample into two groups—those who were experiencing some physical disability (whom I’ll call the “sick” group for ease of discussion) and those who were not (the “well” group). (People were placed in the “sick” group if

they had missed work because of some illness, were physically impaired in some way, or had physical problems that limited their activities.) With multivariate analysis, I statistically tested for possible relationships between the belief, practice, and experience of symbolic healing and measures of well-being for both groups.

One curious statistic emerged: those in the sick group were more likely to claim they had received a physical healing in the past than those in the well group. In other words, those who were in some way “disabled” were more likely to claim a past healing than those who were well! (For the statistical analysis and discussion see Poloma and Pendleton 1991: chap. 4.) Many people from the well group had participated in healing rituals.

Some of them claimed to have received healing in the past. However, because I did not have data collected over a span of years, I was unable to determine which respondents in the well group had been in poor physical health, had experienced a healing, and thus were now appearing in the well group. People in the sick group also alleged healings, but—as their very placement in the sick group indicates—they continued to experience health problems.

Prayer for healing appears to contribute to greater life satisfaction and existential well-being for those who are in poorer health, but not for those in good health. (The healing rituals did not have an effect on happiness or negative affect.) Attendance at healing rituals contributes to feelings of satisfaction with life and a sense of meaning and purpose in life for persons who are physically limited in some way.

Prayer for healing also had an impact on the reported satisfaction with health. Those in poorer health who attended healing rituals reported a

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greater satisfaction with their health status than those in this group who did not attend healing rituals. Once again, members of the well group did not report increased satisfaction with their health status.

These findings suggest that the sick seem to benefit from spiritual healing practices and experience some mental health benefits from participation in communal prayer for healing. These benefits include a greater sense of overall life satisfaction, a greater sense of meaning and purpose in life, and a greater satisfaction with their health status (despite their physical or medical impairments).

Prayer in the Contemporary World

PRAYER, AS I HAVE TRIED TO SHOW, merits more attention than it has been given by modern social scientists. On the infrequent occasions that religion has been part of research models dealing with mental health, the focus has tended to rest on institutional and attitudinal religious measures. This focus needs to shift to include religious experience and the practices that foster them. From the findings presented in this article, I would suggest strongly that *relationship*, not *religion*, is the important religious factor in mental well-being.

Over 90 years has passed since William James quoted the liberal French theologian Auguste Sabatier in *The Varieties of Religious Experience*:

Religion is an intercourse, a conscious and voluntary relation, entered into by a soul in distress with the mysterious power upon which it feels itself to depend, and upon which its fate is contingent. This intercourse with God is realized by prayer. . . . This act is prayer, by which term I understand no vain exercise of words, no mere repetition of certain sacred formulae, but the very movement itself of the mysterious power of which it feels the presence—it may be even before it has a name by which to call it. Wherever this interior prayer is lacking, there is no religion; wherever, on the other hand, this prayer rises and stirs the soul, even in the absence of forms or of doctrines, we have living religion. (James [1902] 1961:361)

The meditative pray-ers depicted in this article experienced this “living religion” described by Sabatier. They were common folk who walked and talked with a God who appeared to them eager to interact with people. This communion with God made a decided difference in their attitudes and thinking. Although doctrine and ritual may have predisposed some respondents to pray, neither religious beliefs nor public religious practices influenced their perceptions of well-being. What made the difference in subjective reports of well-being for participants in both the AAS and the Gallup survey was the degree to which they were able to participate in meditative prayer, to be still and know that God is God. ☸

NOTES

1. Both the Akron Area Survey (with 560 respondents) and the Gallup Poll (with 1,030 respondents) were random samples, one representing the greater Akron, Ohio, area and the other the United States. Details on the sampling and methodology of the studies are given in Poloma and Pendleton 1991 and Poloma and Gallup 1991. Although the studies had common items, the Akron Area Survey (AAS), a longer survey, contained many more questions on prayer and well-being. The Gallup Poll, however, offered nationwide representation and some questions not found in the AAS. The two surveys are complementary and are used in tandem as resources for this article.
2. Greeley's figures for weekly prayer by Americans are comparable to findings in *Gallup Reports* and the AAS. For example, 77 percent of the respondents engaged in private prayer at least weekly. Greeley's figure for those praying at least once a day (57 percent) is higher than the AAS figure (45 percent). This difference may be due to the fact that the AAS question excluded ritual prayer before and after meals.

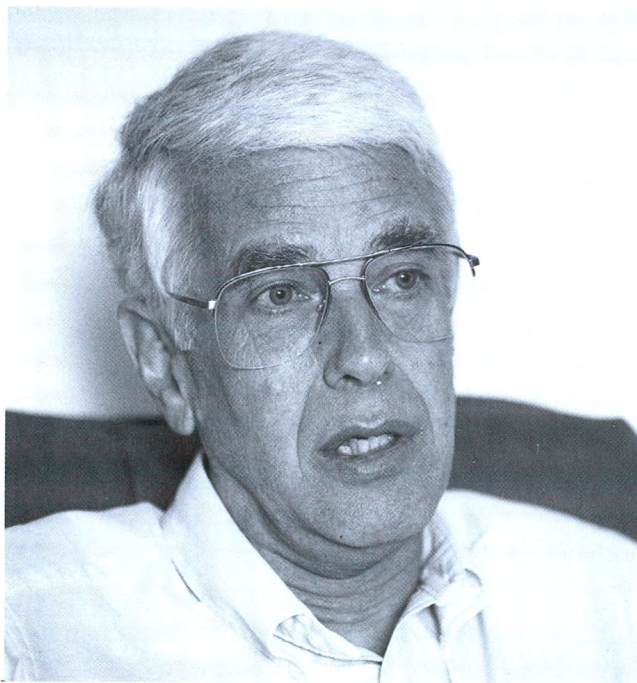
3. Although Greeley does not provide figures for the percentage of Canadians who pray, Canadian prayer patterns seem to resemble those of the British. Sociologist Reginald Bibby (1987:68) reports that 39 percent of Canadians say they pray once a week or more; 23 percent say they never engage in private prayer.
4. This figure excludes ritual prayer before and after meals. Four percent prayed with family or friends monthly, and another 25 percent prayed with others on occasion. The majority (62 percent) of AAS respondents, however, never prayed informally with others.
5. Fourteen percent of evangelicals say they read from a book of prayers, compared with 25 percent of the non-evangelicals. Similarly, 55 percent of the non-evangelicals recite prayers they have memorized, but only 38 percent of the evangelicals do so.
6. Twelve percent of the pray-ers in the AAS did not employ any of the meditative practices, while 5 percent used all five on a regular basis. The mean for the five-item meditative prayer scale for the AAS sample was 2.5; the median, 2.6; the standard deviation, 1.
7. An r of 1 is, statistically speaking, a perfect correlation. Theoretically, correlations can range from .01 to .99, but most relationships in social science are far from the perfect $r = 1$. Statistical tests are routinely run to determine whether a correlation is strong enough to warrant being reported as a research finding. All correlations reported here are statistically significant at the .01 level, indicating that the finding is due to more than some random occurrence.
8. This line of reasoning receives additional support when we look at the relationship between prayer and negative affect. In the AAS, no type of prayer (not even meditative prayer) was associated with decreased feelings of sadness, loneliness, tension, depression, or fear. In fact, ritual pray-ers actually scored higher on negative affect than those who did not engage in this prayer form. In my judgment, it is not that ritual prayer *causes* these feelings but rather that persons who are emotionally afflicted may be more likely to turn to this prayer form.

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“Sixty percent of Americans say they go to church every week, and yet we’ve sold out completely. In the prophets Jeremiah and Amos you’ll find almost exactly the same situation in Israel then that we have in the U.S. right now—the wealthy oppressing the poor in this country and everywhere else. Unless we Christians raise up some prophets who say, ‘This is not the kind of world God had in mind, and we are responsible to do something,’ then ultimately the whole system will just collapse.”



Global Health and the Limits of Medicine

An Interview with Dave Hilton

Now working as a consultant in international and congregation-based health programs for Ecumenical Health Ministries (in Atlanta), Dave Hilton brings to that position his experience as associate director of the Christian Medical Commission at the World Council of Churches for 6 years and more than 17 years of working in health care in Nigeria (including 10 years specializing in tropical medicine and surgery at Ginter Memorial United Methodist Hospital in remote, rural north-eastern Nigeria). In the U.S. he has worked in family practice at a Wisconsin clinic, and he served for 7 years as clinical director for the Seminole Tribe of Florida Health Program. In his years of service to others as a physician, Hilton has discovered how deeply health problems are rooted in the prevailing materialist worldview. As he noted in his address to the American Public Health Association in 1989, “health is not primarily medical. . . . While medical education trains ever more expert ‘body mechanics,’ it is becoming clear that health is to be found elsewhere. I propose that we consider here four major nonmedical aspects of health. They are justice, peace, integrity of creation, and spirituality.” In July 1992 Dr. Hilton spoke with *Second Opinion*, expanding on these themes and calling on Christians to become healing communities and speak up for human values.

Second Opinion: You noted in your address to the American Public Health Association in 1989 that “the problems posed by international ill health are rooted in the ethical system now dominating centers of national and world decision making.” Could you explain that?

Hilton: The number-one cause of illness in the world is poverty. I don’t think anyone would argue with that. At this moment, and for the last 20 years, the net flow of capital has been from Africa, Latin America, and Asia to the United States and Europe. In spite of all the so-called aid, the net flow of capital has been to us, which means that they’ve been getting poorer while we’ve been getting richer. Their getting poorer means that they’re getting sicker. Sending people over there to immunize the children or to build clinics often looks ludicrous to them. They say, “You’re doing this to us, and then you’re throwing us a few pennies to keep us quiet.”

If we’re really concerned about health among the people of the world, we first have to stop robbing those people. That’s basically what Third World people are saying: “We appreciate your trying to help us, but first we’d like for you to stop robbing us.” Brazil is a good example, with 12 million children living on the

streets, 12 *million*. Why are there so many homeless children in Brazil? Because back in the 1970s, when money was cheap, Brazil borrowed for development, for building roads and bridges and things like that, and suddenly interest rates went skyward. Now Brazil has paid the principal on that debt nine times, and even today, 75 percent of their GNP goes to pay the interest on the remaining debt. They don’t have any money for social services! They don’t have any money for anything! They’re using all their resources to pay us. Yet we sent a team down there to vaccinate the children.

This just doesn’t make sense. We need a restructuring of the world economic order. The rich countries have to stop using their political and economic power to keep other countries down. Somehow we have to reorganize and let countries use their resources for their own development instead of for ours.

Second Opinion: That’s a big agenda. Do you see ways to bring this about?

Hilton: When enough people become empowered, institutions are going to change, and this is just as true in the U.S. as in places like India or Romania. Everyone’s talking about health care reform, but I’m not expecting any significant change to come out of Washington. Washington is controlled by corporations, and it’s not in the interests of the corpora-

tions—including the American Medical Association—to change anything. I’m putting my personal efforts into empowering people to take their lives and their health into their own hands.

That’s basically what the Aroles did in India. Two American-trained Indian doctors went back to this community and said, “We don’t have any money, we don’t have any medicine, we don’t have anything, but we’re here to help you.” They used participatory learning methods with the people and transformed the whole district of Jankhed—and not just in the area of health. The whole society changed. Women were no longer required to cover their faces and look down when there were men around and be subservient. People of all castes sat down together to plan. A wealthy landlord divided his land up among his laborers.

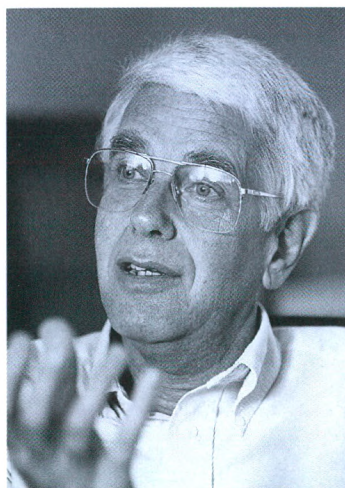
Another example is Romania. Ceausescu was determined to increase the population. Abortion and family planning were forbidden. At the same time, Romania was isolated from the West. Not even the doctors had the opportunity to read medical journals or to learn anything about family planning. Doctors told me that they hadn’t seen a medical journal for 40 years. As soon as Ceausescu was kicked out, abortion was legalized. Nobody knew anything about other methods of family planning, so abortion became a method of family planning. And now that knowledge of other family planning methods *is* avail-

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able, there's no hard currency to buy it. Contraceptives are very scarce and also very expensive. Doctors in Romania are poorly paid, so abortion is not very expensive. It's not uncommon to find women who have had five, six, seven, eight abortions. I found a lot of guilt, especially in devoutly religious people. But what could they do? Romania has as many orphanages as it does because women had babies they couldn't care for. Whole families live in one-room apartments. If a family already has five kids and another one comes along, what can they do? They take the baby to an orphanage, which is already filled.

I asked some leaders of the Orthodox church, by far the largest church, what they were doing about it. They said, "Oh, we have issued a statement saying that abortion is a sin." When I asked what suggestions they had made as alternatives, I was told, "Oh, we don't believe in family planning either." I replied, "Then you're condemning women to have children they can't afford and don't have the ability to raise." We talked for a long time, and out of that discussion came a workshop bringing together people from many congregations. I brought to that workshop my background from working as a facilitator, using participatory learning instead of lecturing and "providing information." We tried to get people talking ecumenically about their own issues. I was very apprehensive at

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the beginning because I knew Romanians had been taught for 40 years not to trust anybody and not to tell anybody anything. But the method we call "training for transformation" was very effective. Within a very short time people were exchanging information. They were saying, "This is just what Romania needs. We need to learn to do things for ourselves; we've had the Communist party doing everything for us for the past 40 years. We need to learn to communicate with each other. We need ecumenical sharing."

"Training for transformation" is based on Paolo Freire's *Pedagogy of the Oppressed*. Freire is a Brazilian educator; he used these methods in Brazil but had to flee for his life and was in exile from Brazil for 10 or 15 years. He sees two kinds of education. *Domesticating education*, the kind that we are all taught, is designed to fit a student into the world the way it is so that the world can use that student for its purposes—whatever they might be. That's what we give students in grade school, high school, college, medical school, seminary.

Liberating education, on the other hand, is designed to help the student to analyze the world, to see what it's like and decide what he or she likes and doesn't like about it, and to change what he or she doesn't like about it. Freire used liberating education for literacy training all over Brazil, and I think that's partly why Brazil has gotten rid of a military dictatorship and produced a new

constitution designed from the grass roots up.

Two Sisters of the Grail in East Africa took Paolo Freire's ideas and put them into action in several countries in East Africa and, after 15 years, saw the community transformed. On the basis of that experience, they wrote a set of three workbooks called *Training for Transformation*. The first explains the theory and process, the second describes specific activities, and the third tells how to get a movement started.

For Freire, the issue comes down to empowering people who have no power. Instead of going into a place and saying this is what's wrong and this is how to fix it (which is basically what I did for 10 years in a hospital in Nigeria—handing out pills to sick people and changing nothing), you go in and listen for what Freire called “generative themes.” These are themes that generate feelings in people, that people get upset about or have strong feelings about. You spend a lot of time (three months to three years) just listening for generative themes in a community. When you hear what people's generative themes are, you find ways to reflect those back to people so that they can discuss them in a detached manner. This may be accomplished through a story, a picture, a drama, a riddle, anything that gets people thinking and talking about these generative themes.

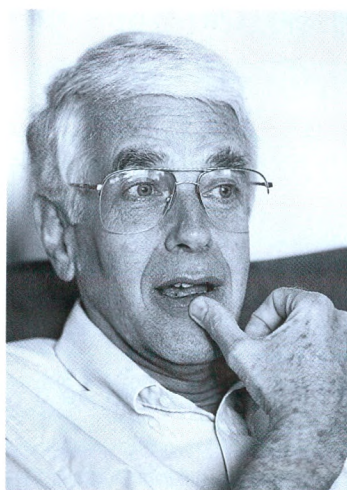
The role of the facilitator is not to give answers but to keep asking questions, to keep people

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moving toward a solution to the problem. They reach a stage Freire calls “critical awareness.” It's really uncanny when you see that happen. Within a group, people start looking at each other and saying, “Why don't we do something about this? And that's the stage of critical awareness. No matter how apathetic people are, no matter how long they've been oppressed or in poverty, when they reach that stage they just take off and start doing something about their problems. That's the Training for Transformation process.

What I've done in Romania and elsewhere is to say, “We're going to have a one-week workshop.” People ask, “Where's the agenda?” When I say, “You're going to make the agenda,” I usually get a lot of flak: “Oh, you can't do that, you have to have a schedule, you can't have a workshop without a schedule.” But I'd stick to it, asking people about their expectations for the workshop, and that would be the agenda for the week. The facilitator simply helps people deal with their agenda. Our hope in Romania, of course, was that the need for family planning would come out in these workshops.

Second Opinion: Did it?

Hilton: Tangentially it did, but the people never reached a consensus that they wanted to deal with it. We had to let it go. And this is one of the cardinal principles of liberating education. I think, for

example, of the story of Carroll Behrhorst, who used these ideas in Guatemala. He asked the people, What are your issues? They didn't come up with any health or medical issues for a long time. They wanted a football field, and they wanted lights on their football field—these kinds of things. He just stuck with them, in spite of all his medical training, and helped them get a football field and lights for the field. After a long time they got around to health-related issues. But by then, you see, they were empowered. They had discovered that they could do something together. So when they came to health, they weren't asking, What can *you* do for us? They were saying, What can we do for ourselves? That's really where health comes from, and that's the kind of program I was working with in Africa.

Second Opinion: Could you apply this approach in the United States?

Hilton: It's clear that we desperately need the same approach in this country. We have a health crisis here because we're trying to bring health by curing sick people, and that's not where health comes from. Health comes from empowering people to take responsibility for their own health. That's what I'm working on now.

For years the surgeon general has been saying that 85 percent of the disease in this country is preventable. Doctors are paid

when people are sick: the more people are sick, the more doctors make. It's the market orientation, where there's money to be had for sickness, not for health. A good example is coronary bypass surgery. This is passed off as high-quality health care, but that's poppycock. It's not necessary for anybody to get coronary artery disease. If we had a really good health care system that was helping us know how to live and how to avoid coronary artery disease, there wouldn't be any need for coronary bypass surgery. But that's not the kind of system we have. So we need to empower people to find out for themselves how to stay well; then they won't need to depend on doctors and hospitals for their health. That's the solution to "the health care crisis."

Second Opinion: Do you see a role for the churches in that effort?

Hilton: No question. Churches are one of the few remaining communities in this country, and if we can get a health promoter in every congregation, as we did in many villages in Nigeria, we'll have the solution to the health care crisis. Many churches are moving in this direction, and I'm working with several denominations to develop programs for the congregational level.

Second Opinion: How can congregations be a resource and a health-promoting center without offending the people they want to welcome?

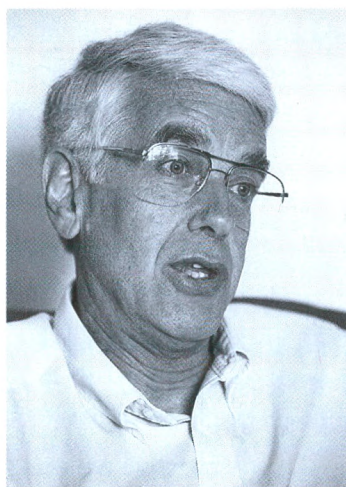
Hilton: This is where the participatory learning process is crucial. We know that telling people things doesn't change behavior. An article in a medical journal within the last year noted that despite the plethora of information about healthy life-styles available to Americans on television, in newspapers, in magazines, less than 14 percent of Americans have changed their life-styles. This confirms what we've known and what I learned in Africa: simply giving lectures to people, or dispensing information, doesn't change behavior. Behavior changes when people discover for themselves what they're doing to themselves. The light bulb goes on and they say, "Aha! That's what's happening!" Then people change their life-styles, or communities change their codes of behavior. It has to be on a community scale.

For example, I attended an alumni association breakfast in Indianapolis last month, where we were served bacon, eggs, sausage, baking powder biscuits, all that stuff. If the community doesn't change, there's tremendous pressure on me to conform to the community rather than for the community to conform to me. And if we go on serving McNuggets, when will things change? Not until enough people say, "We don't want to do this to ourselves." Life is too important for us to be polluting our bodies all the time.

Second Opinion: Can you say more specifically what the church as a healing community might look like?

Hilton: For me, the model of a place that welcomes people as they are is Alcoholics Anonymous. Everybody who goes says "I've blown it," and everyone else smiles and says, "Yeah, we know what that's like. Come on in and join us." Nobody tells anybody what to do; they just share what their struggles are and what they've found that helps and doesn't help. Everybody's open about their brokenness and failure, and they heal. That process is the only thing I know of that heals addictions. What happens in most of our churches is just the opposite. We all get dressed up on Sunday, and we go there and we say, Isn't it great, all these good people! So I don't dare share my pain and my brokenness with you because you might reject me. We sit there with our pain and our brokenness, and we never share it and we don't heal. Our churches are just the opposite of a healing community. For me the church's real challenge in the next decade or two is to find out how we can change from being congregations of pretense to being healing communities; we have to work toward becoming the kind of communities where it's safe to tell your life story. If there are any good things about AIDS, one is that it's bringing churches to the point where people have to begin to share their brokenness with

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each other—they can't hide it any longer.

At an AIDS meeting in Brazil last month, I met a pastor's wife from a church in the U.S. She and her husband had two sons with AIDS, and at first they could not tell their congregation. They were afraid of what would happen. Finally, one of the sons died, and then the other one. They had to start telling people what was going on. They found that the pretense in that church melted away, and the whole church became a healing community. When people began admitting to each other their brokenness and telling their life stories, it transformed that church. So how can we facilitate that transformation without having to go through such a crisis? That to me is the key.

Of course we have Jesus for a model. Jesus approached people, he listened to people, he respected people—the prostitutes, the tax collectors, no matter who they were and no matter how bad the community thought they were. He accepted all human beings, and he helped them to deal with their brokenness. When the church finds out how to do that, there will be renewal in the church, and the church will grow again. And that will be the solution to the health care crisis in this country: people will be taking responsibility for their own health, and the core of the health care system will be communities of people empowering each other to stay well. Hospitals and doctors

will be on the periphery to catch the ones that fall through the cracks. Right now doctors and hospitals are the core of the system, and everything else is tacked on.

Second Opinion: Are you optimistic? Who's going to spark this change?

Hilton: It's already moving so fast that I can't keep up with it.

Second Opinion: You refer in your writing to the model of the New Testament church. What does that model look like?

Hilton: People in the New Testament church were getting together and sharing their lives intimately with each other. A more recent example is the base Christian communities in Latin America and in East Africa. After Vatican II, Roman Catholics were suddenly allowed to read the Bible, and there weren't always priests at hand to tell them what it meant. Groups of Roman Catholics began reading the Bible, and they asked each other, "What is the Scripture doing in your life?" and shared what it said to them in their lives. In the process, they were transformed. These groups grew by leaps and bounds all over Latin America and East Africa and Asia, and similar things are happening in this country in groups like AA. To me, AA is the real church. The real church is not the people who are gathering for an hour on Sunday

morning. The question now is, How can denominations facilitate this process of sharing? If they institutionalize it, of course, they'll kill it. Part of the genius of AA is that it has no superstructure whatsoever, no organization. The church would do well to learn from AA.

Second Opinion: Can you be more explicit about how this sharing of their life stories affects peoples' health?

Hilton: Medical studies on the immune system are again and again confirming the connections that feelings and relationships have with health. In January 1992, for example, I ran a computer search on medical literature using the term *psychoneuroimmunology*; 61 articles had appeared in nine months, whereas in the preceding year there had been only 15 or 20. Psychoneuroimmunology has of course become a legitimate subspecialty now, and they're discovering that a lot of things besides AIDS suppress the immune system, and some of them as much or more than AIDS. A couple of good studies done in this country showed that most of the people who got AIDS already had suppressed immune systems.

Second Opinion: Caused by what?

Hilton: They're still working to identify the causes, but they've found that a major suppressor of the immune system is feelings—

unresolved anger, guilt, resentment, meaninglessness. Studies also show that the immune system is strengthened by loving relationships and community. I contend that in the laboratory they're affirming the gospel, which deals with unresolved feelings and relationships. Antonovsky's "sense of coherence" is relevant to these findings. Antonovsky is a Jewish sociologist on the faculty at Ben Gurion Medical School in Israel. About 20 years ago he examined studies showing that about 75 percent of disease occurs in only about 25 percent of the population. If disease is really caused by germs, he thought, it would be evenly distributed in the population, so there had to be another factor. After years of research, he came up with that other factor, what he called the "sense of coherence." That sense is a feeling that something ties all of us together and that all the parts of one's life are connected. *Connectedness* is another word he used. People who feel connected tend to be the ones who stay well. People whose lives are fragmented, who don't have a sense of meaning, who don't have something that ties them together seem to constitute the 25 percent of the population that gets 75 percent of the illness. What seems to help is the idea that it's not me alone against the world: I'm a part of something that began centuries ago and will go on for centuries, and I'm a part of something that's moving through history. Antonovsky doesn't make a spiritual

point, but one seems obvious to me: the word *religion* comes from the Latin words *re* and *ligio*, meaning “to bind together.” Religion tends to make people healthier.

Second Opinion: Do you think that increased acceptance of these findings will make the medical establishment a little more open to the importance of spirituality?

Hilton: I’m not optimistic.

Second Opinion: Do you see medical education as being antagonistic to this approach?

Hilton: Definitely. Not only is it very conservative, expending a great deal of its energy maintaining the status quo, but it also idolizes science, or what it thinks is science. Medical educators won’t take a look at anything that’s not proven. Add to that the market-system factor in medicine, namely, that there’s no money in staying well or in pursuing spirituality.

I wouldn’t put any energy into trying to convince the medical establishment that they’re on the wrong track. I’m going to the people, and I think the people will ultimately drag the medical establishment along with them. There are notable exceptions, of course, like Bernie Siegel and Paul Pearsall and Deepak Chopra and some others who have written books along these lines.

When the Hungarian obstetrician Ignaz Semmelweis came up with the germ theory of disease

around 1850, he was laughed out of his hospital and forced to resign from the obstetrics department. It was a hundred years before medical science accepted the germ theory. That’s the way medical science is; it claims to be scientific, but it starts out trying to prove only what it already knows and throwing out anything that doesn’t fall within that parameter.

Second Opinion: Would you say, then, that the proposals now being put forth in Washington for reforming our health care system are missing the point?

Hilton: I’m not saying we shouldn’t reform the system. If some people want to spend their energy trying to get access for everybody to the system we have, that’s OK. But let’s recognize that getting universal access to a *disease-cure* system is not going to bring health to this country. We should be putting some efforts toward developing a true *health care* system in this country.

Second Opinion: You think this begins with small groups in the churches when they empower people?

Hilton: Yes. And a number of churches are getting involved—the Lutherans, the Brethren, the Mennonites. The Seventh-day Adventists, of course, have been involved for years, and the United Methodists are moving in that direction.

Second Opinion: In the denominations is the interest coming from the top or from the bottom?

Hilton: There are some notable exceptions, but I’d say more from the bottom. I’ve talked to denominational executives and educators at theological schools. They’re all excited about the idea, but when they get back to work on Monday morning they’ve got so much on their desks that the idea just gets lost in the shuffle. At the local level, wherever I go people say to me, “We know this. This is just common sense. What we want to know is what we can do. How do we put this into practice?” That’s our real challenge—to develop some models and some methods that we can put into practice.

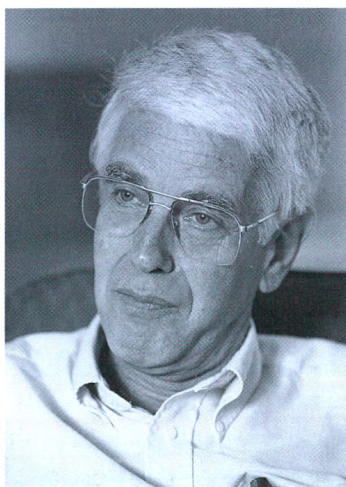
Second Opinion: If people from a middle-class North American church or synagogue asked you what they should do, what would you say?

Hilton: To be true to the principles of participatory learning, I wouldn’t want to tell them what to do. I would say get involved in some process where you can be empowered, where you can be assisted in discovering what your problems are and what you can do about them. I’m helping the Church of the Brethren put together a workbook for congregations, but I often say to individuals, Just go to an AA meeting and see the process. You’ll be convinced that this

process is what we all need. Then go home and start an AA group or a 12-step group for whatever reason or for no reason at all except that you just want to do it. I think a group that's brought together around Bible study can be even more effective. I don't mean the kind of Bible study where the leader points to a Greek word and tells what it means. I mean groups where people ask each other, "What does this verse say to you?" In sharing what a Bible verse says to me, I'm sharing my life, and that requires trust. Developing that trust is an important part of the process.

When I was in family practice, every day, and sometimes two or three times a day, someone would say, "I've never told anybody this in my life," and they would blurt out some terrible story. After 15 minutes they would say, "Oh, thank you. I feel so much better. You're wonderful. You really helped me a lot." And all I did was sit there and listen. I thought, why do people have to come to sit in my waiting room and pay my fee just to have someone to listen to them? If we can develop communities for each other where we can find that trust and openness, we can tell our life stories, we can heal, and we can stay well. And that to me is the key. We don't need to professionalize it. We're training pastoral counselors and psychologists, and these people can help in some of the more difficult cases. But what we really need is to become healing communities. One

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problem I have with the parish nurse program is that it puts a burden on one person to be the healer in the congregation. All of us need to be healers, and all of us need to be healed. Studies show that people who have had a death in the family have a greatly increased chance of getting cancer within the next few years. I'm convinced that if people are part of a small, caring support group that can help them express their grief and get their lives reorganized, those cancers can be prevented.

Second Opinion: That seems plausible, but what about the fairly common tendency to blame the ill person for being sick?

Hilton: That must be avoided at all costs. But that risk doesn't mean we should throw out the baby with the bath water. The idea is not at all to blame people for their illness but to help them deal with it.

I think of it this way: illness is not something the patient is doing to himself or herself; this is the way our bodies work. If you meet a thief in the dark, your heart starts pounding in your chest, but you don't go to the heart doctor and say, "I want a cardiogram. There's something wrong with my heart." You know that's just the way our bodies respond to fear. If somebody says something that embarrasses you, your face turns red, but you don't go to a dermatologist and say, "There's something wrong with my skin; I

need some medicine.” You know that’s the way your body responds to embarrassment. And so if you get cancer, this doesn’t mean you did it to yourself. Rather, this is the way your body responded to whatever life situation you happened to be in. The immune system was suppressed, and that allowed the cancer to grow. One now widely accepted theory of cancer is that we all get cancer cells every day, cells that are abnormal, but our immune system destroys them as fast as they develop. If something suppresses the immune system, those cells grow. AIDS patients get Kaposi’s sarcoma, a form of cancer, because their immune systems are not eating up the cancer. Whatever it might be that’s suppressing your immune system—whether you’re working 70 hours a week and not getting enough rest or you’re living in the slums and don’t have enough to eat—allows you to get ill.

Western medicine deals very superficially with illness. Let’s say you come to me with pneumonia. I give you an antibiotic to kill the germs in your lung, your fever goes down, you stop coughing, and I say, “Another triumph for scientific medicine.” But I have never asked you the most important question: “Why did *you* get pneumonia?” All your friends have the same germs in their body. What’s different about you? Maybe your spouse is impossible to live with, or your son is in jail for using drugs. That’s what you really need help with. I have cured

you, but what you need is to be healed.

Second Opinion: Do you believe that other, non-Western medical systems take this need for healing into account?

Hilton: All the traditional healing systems that I’ve run across deal with healing. When I was working for the Seminole tribe in Florida, for example, one patient was a young boy who had fallen from his bicycle and broken his ankle. Of course I put him in the hospital, took an X ray, set his ankle and put a cast on it, and when the swelling had gone down after a few days, I sent him home. Later I went to talk with the medicine man—I did this every chance I got. He said, “You know that boy with the broken ankle? I went to see him when he got home, and I asked him why he had broken his ankle. He answered that he had fallen off his bike. I said, ‘No, I mean what’s the reason you broke your ankle?’ And the boy said, ‘I don’t know.’ So we sat down and started talking, and after awhile I asked, ‘By the way, how are you getting along with your mother?’ The boy started to cry and said, ‘I’m not getting along with my mother at all. In fact, we’re not even speaking to each other.’ I picked the boy up and carried him to his mother, and they sat and talked about the problem until they got it resolved.” Then the medicine man said to me, “That’s why the boy broke his ankle.” I asked, “How

did you know it was his mother?” And he replied, “In the Indian worldview every part of the universe is represented by a part of the body, and the left ankle is the female.”

That’s not logical, it doesn’t make any “sense,” and we’re raised to think that logic is the only thought form. But the fact is that although I cured the boy, the medicine man healed him. And what we really need is healing.

Second Opinion: How can we get beyond curing to healing? And do you think there’s more receptivity to that distinction among nurses?

Hilton: Definitely, much more so than among doctors. Most doctors don’t listen, and people don’t talk to somebody who won’t listen. When I was in family practice, the management consultant always told me, “You’ve got to generate more income here. You’re not seeing enough patients.” When I told him that some of the patients needed somebody to talk to, he’d reply, “If they need a shrink, send them to a shrink. You don’t have time to do that. You have to generate more income.” Finally, I just quit. I said life is too short to spend it generating income. Yet even nonprofit hospitals must be market oriented to survive. At a recent Carter Center conference one of the bishops stood up and said, “We’re doing things every day in our church hospitals that are ethically questionable in order to make the bottom line. We desperately need help with this.”

After about 15 seconds of silence, somebody got up and changed the subject.

Second Opinion: How can those hospitals survive in our health care system?

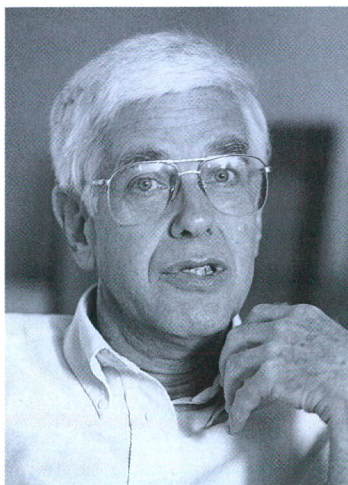
Hilton: There are no easy answers for those kinds of hospitals as long as we have a market-oriented system. Personally I'm convinced that Americans will never get good health care until doctors are put on salary. The medical literature offers abundant proof, for example: a physician who owns his own lab is six times as likely to order laboratory tests as one who doesn't. And a doctor who owns her own X-ray machine is four times as likely to order X rays as one who doesn't. And these aren't even doctors who are out to milk the public; that's just the way the system works.

Second Opinion: What do you see as the major health issues today, both in this country and abroad?

Hilton: When you say "health," a medical person, even a public health person, will start talking about disease. But health is not primarily medical. The number-one cause of illness in the world is poverty. The second is probably violence. Militarism on a global and a local scale displaces millions of people from their homes to refugee camps or whatever place they can find—there's no way those people can be well even if

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you provide all the medical services they need. And abuse in the home is also part of violence: child abuse, spouse abuse, and so on. Third would be environmental causes—not only the way we pollute rivers and lakes and the sky but also the way we pollute our own bodies with sugar water and caffeine and tobacco smoke. The illness caused by pollution is best addressed not by medicine and hospitals but by changes to the situation.

Having said all that, I should add that diseases like malaria are obviously still a major health issue. In Africa alone there are nearly a million deaths a year from malaria, and something like 10 or 15 million people in the world have malaria all the time.

Second Opinion: Does the potential to control that disease exist?

Hilton: The potential has been there for a long time, and Third World people are raising this failure to act as a justice issue. In Asia, Africa, and Latin America, huge numbers of people have been dying of malaria for over a century, and the industrialized societies can't seem to find the money to fund the research and do something about it. Many Third World people are saying this is an issue of racism, an issue of power. Malaria could have been eradicated a long time ago had there been the will to do it.

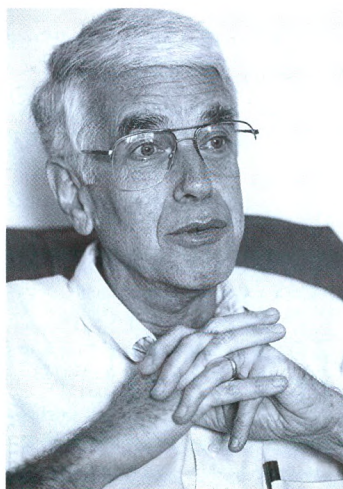
But the problem of poverty figures in here, too. Malaria was widespread in the U.S. in the

1800s, as far north as Ohio and Indiana, but it disappeared long before there was any treatment simply because the standard of living rose. You hear about the epidemics of cholera in Latin America, but it's mostly the poor who are dying of cholera. If you or I went down there and drank a glass of water contaminated with cholera bacillus, it's not likely we would get cholera. We would get some abdominal cramps, develop a little diarrhea, and the illness would be gone within 24 hours because we're healthy. Our immune systems are much stronger. The immune systems of people who are in poverty and under great stress don't have the resistance, so those people die of cholera. Flying in vaccines and providing wells is a legitimate part of the response, but let's do something about the poverty.

Right here in our own country there's a resurgence of tuberculosis, and it's directly related to the increase in poverty. Yet how is the public health community responding? They're saying we need more funding, more medicine, more places for these people to be treated; nobody's saying we've got to do something about the poverty.

Worldwide, something clearly has to be done about population growth, but that's also directly related to poverty. When people begin to have the standard of living that they need to survive comfortably, population slows down automatically.

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Second Opinion: Do you see a willingness among Americans to give up anything to deal with these problems?

Hilton: Superficially Americans are generous, but when it comes to getting below the surface, as a rule they're not. Even their giving often is very selfish; I know people who won't give money for missions, for example, unless they know exactly what it's going to be used for, who's going to be benefiting. In the average traditional African community or the traditional Native American community, people are openly and freely generous. We desperately need to recover the value of generosity, especially in Christian communities. That's a Christian value.

Second Opinion: Is it because of the value Americans place on money that they part with it much differently than do people who are not obsessed with the bottom line?

Hilton: I'm not sure. I think money is very seductive. Jesus said that it would be harder for a rich man to enter the kingdom of heaven than anybody, and I think Jesus knew what he was talking about. Money can hoodwink us into thinking that we're generous, into thinking all kinds of things that aren't true. And that's why it's an enemy that we need to be on guard against at all times.

Sixty percent of Americans say they go to church every week, and yet we've sold out completely.

In the prophets Jeremiah and Amos, you'll find almost exactly the same situation in Israel then that we have in the U.S. right now—the wealthy oppressing the poor in this country and everywhere else in the world. Unless we Christians raise up some prophets who say, “This is not the kind of world God had in mind, and we are responsible to do something,” then I think we're going to go the way Israel went. If we Christian people don't raise justice issues and speak out for human values, then ultimately I think the whole system will just collapse.

Second Opinion: How?

Hilton: It's hard to say, but it seems that the enemy is us and that our society is rotting from the core. It will go the same way Rome went, and all the other societies that became affluent, became greedy, and ultimately collapsed. That's why I think it's important to be a citizen of the kingdom of God, and not spend your life trying to preserve the United States or Great Britain or any other earthly kingdom. To be obedient to God and to live each day serving God, trying to create the kind of world that God wants. And then leave the rest up to him.

Second Opinion: You've observed that in Norway and other socialist countries people have reached a certain sufficient level of affluence, and now the next generation is maturing and asking, “What's all this for?” And that

sense of meaninglessness is bringing them back into the churches. But that doesn't seem to be happening here in the U.S.

Hilton: People can see the hypocrisy and the shallowness in the churches, and they're looking elsewhere. I think that's the reason for the phenomenal success of AA and the other 12-step groups. I think that's the reason for the rapid spread of the New Age movement: people have a spiritual hunger, and our churches are not helping people deal with spirituality. Our churches are peddling religion.

Second Opinion: Could you explain the distinction you're making between religion and spirituality?

Hilton: I haven't had any formal training in spirituality, but my own understanding of spirituality is that as human beings we have the ability to know. We know that we were born, that we're alive, that we're going to die. And that leaves us with inevitable questions: Why were we born? Why are we going to die? What's going to happen to us when we die? What is the meaning of life? Those are the basic spiritual questions that every human being deals with, and they unite people around the world.

Religion is the way that we express our spirituality, the way we institutionalize and concretize it. Unfortunately, religion divides, because as we institution-

alize and concretize, we begin to say ours is the right way and theirs is the wrong way. We close ourselves off from spiritual growth. That's what I see as the difference between religion and spirituality.

What do I think is wrong with the churches today? They're not helping people find answers to the spiritual questions in their lives; they're dispensing religion. What may have been very meaningful for my father or my grandfather in working out his spirituality may be totally irrelevant to me.

Second Opinion: Do you think any of the New Age beliefs have core values that could transform people?

Hilton: There are many truths in New Age and Eastern religions, the same truths we find in Christian gospel if we search carefully. None of us has all the answers to all the spiritual questions in life. We need to be walking beside each other and sharing our spiritual questions and helping each other find the answers rather than condemning those who have different answers. We Americans or we Christians don't have a corner on truth.

Second Opinion: You've worked in cultures where Christianity isn't the dominant religion. How do you reconcile the language that you use for yourself—“Christ is the answer, we must serve God”—with your statement that there are multiple truths? How do you

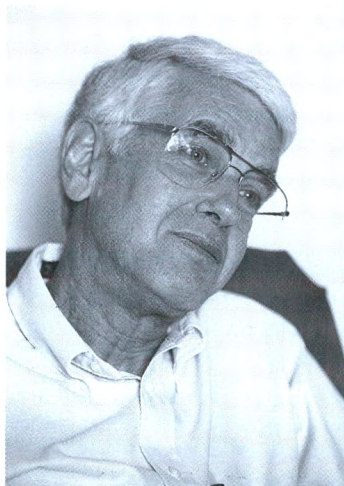
work out your own faith while simultaneously believing that other people can be justified in holding to other faiths?

Hilton: For me, the gospel story is the story that embodies the truths of life. I keep referring back to that story to keep me on track; I need it to keep me looking for answers in the right places. There are other stories, many stories, that embody the same truths. If I share my story with somebody else and listen to his story, we may both learn something from each other. I don't think it's true that "it doesn't make any difference what you believe as long as you believe something." I'm picturing instead being able to have a dialogue with, say, a Muslim and ask him, "What are the questions in your life, and what are the resources you're finding to help you deal with those questions?" When I treat that Muslim as a fellow human being, treat him with respect, he begins to see me in the same light and to respect me and ask me questions. Then together we can share things that have been helpful and meaningful to us in finding answers to our spiritual questions.

Because we're all different people, we have different questions and different perspectives. The Bible gives a good example: we have the four Gospels, all written by people who knew Jesus either directly or indirectly, and yet they give four very different accounts of what Jesus was about. Now is one of them "right" and

"This age desperately needs prophets to be calling attention to what kind of society we've created and what we're doing to ourselves.

At the same time, we should not feel that we're responsible, as individuals, to change the world; we're responsible simply to be obedient to God's call, allowing God to use whatever means to change the world that God sees fit."



the other three "wrong"? Or does it mean that people had different concerns in their lives and saw something different in Jesus? I think it's the latter.

Second Opinion: Earlier you said that change will come when Christians become healing communities and speak up for human values. Obviously everybody can't have the work experiences you've had, but what can one person do? What would you recommend to people who wish to increase their own awareness and effectiveness?

Hilton: I think *mission* is what a Christian does with his or her life, wherever that person is. We're all called to mission. But first we have to be transformed by the gospel. Then we have to be re-transformed and re-transformed—every day we have to be transformed by the gospel as we grow and experience and learn. Out of that transformation comes a heartfelt desire to be in mission, to share this powerful transforming experience with others. It's not about getting everybody on your side. It's about sharing this wonderful transforming love of God with others, whether you're a letter carrier or a grocery store clerk or a pastor. That's what life is about—sharing God's love with others.

Second Opinion: But even if you believe and are aware and treat your everyday life as a mission, what does that mean? How can a

person possibly express that sense of mission?

Hilton: First, by acting. By recycling, by not polluting your body, and by doing all that you can to respect creation and other human beings. What we do, of course, speaks much louder than what we say. Second, by speaking out. Those who have gifts of speaking and writing need to be prophets. Every age has had its prophets, and this age desperately needs prophets to be calling attention to what kind of society we've created and what we're doing to ourselves. At the same time, we should not feel that we're responsible, as individuals, to change the world; we're responsible simply to be obedient to God's call, allowing God to use whatever means to change the world that God sees fit.

Second Opinion: Do you think that churches have the obligation to take on economic and political issues?

Hilton: I think the church has a responsibility to be sensitive to those issues. There very often are not easy answers to those questions. For example, while visiting Christian health institutions in Korea I saw the terrible conditions under which the Korean workers were living and working, so when I came back to Geneva, I raised questions with the communications department at the World Council of Churches. "Why are you sending your books

to Korea to be printed, where it's much cheaper than it is in Europe? You're only supporting slave labor." Their answer was that if we didn't send our books there to be printed, the Korean workers would have less work. At least they were getting some money from this. Economics is very complicated, but we have to do the best we can to have a conscience. We have to do what we think is right and speak out against what we think is wrong. The old comment that the church ought to stay out of politics—I can't buy that at all. If we're going to pray "thy kingdom come, thy will be done on earth as it is in heaven," we clearly have an obligation to be involved and to work for it as well.

Second Opinion: What's next for you? How are you going to use all your energies and knowledge?

Hilton: I've acquired a peace that allows me just to wait and see what happens rather than try to orchestrate everything. At this point it seems to me that everything I've done before is preparing me for now. And what I'm doing now is preparing me for later. So I don't really have any aspirations now for achieving something or getting somewhere; I simply want to serve God with what God has given me, and see what that turns out to be.

I do feel a need to put people in touch with each other. Everywhere I go I find people working in isolation. For ex-

ample, the Lutherans and the Methodists and the Presbyterians are all sending medical missionaries to Zaire, but none of them has any idea what the others are doing or even where they are. I've been trying to get people together, especially ecumenically, because I've seen in action what Jesus was talking about in John 17—when he prayed five times that his followers might be one so that the world would believe. I've been many places in the world where non-Christians say, "You know, those Christians don't even get along with each other! Why in the world would I want to be a part of something like that?" The fragmentation and competition and animosity that we have among each other as Christians are tremendous impediments to having people see the truths of the gospel. There's a desperate need for us not to form one huge church but to work together and love each other and share information with each other.

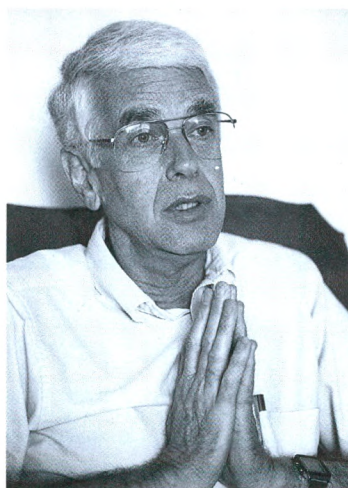
Another task I can work at is somehow to help Americans realize that we have something to learn. I've had many Third World people tell me that they characterize Americans in general and missionaries in particular as being arrogant. Americans don't realize the rich treasure that people in other cultures and other countries have to share with us and how desperately we need that in this country. For example, American doctors are going to Russia and returning with horrible tales about how bad the health care

system is there. They visit the hospitals, which are unquestionably in terrible shape—they're still using rubber tubing for intravenous drips, for example, as we were doing 40 or 50 years ago. In many places they don't even have equipment, much less drugs.

But in a small village in Russia 400 or 500 miles from Moscow, if you ask people what they do when they get sick, they say, "Well, we go to the poly-clinic." They took me to see a poly-clinic, and I found out that those people are getting *excellent* primary health care. The nurse practitioners knew every single woman in their district—which ones were on the pill, which ones were pregnant, when the pregnant women were due to deliver, when the kids had their immunizations, all that. They were responsible for the health of the people in their communities. I asked them, "What do you do if somebody doesn't come in for an immunization?" And they said, "Oh, we go out to the house to see what's wrong." If they learn, for example, that the husband has lost his job, they help him find a job. If they find that the mother's arthritis prevents her from taking care of the kids, they find someone to take care of the kids. That's comprehensive primary health care.

We have nothing like that in this country, and we desperately need it. But instead we're going over there and saying, "Oh, this is terrible. We need to rush

"That's heaviest on my heart—how to tell Americans how much we have to learn. Yes, we have some things that other people need, but let's not make everybody in the world our subjects."



American teams over here to fix this for you" instead of saying, "Hey, we've got something to learn from these people." There's a similar story with evangelism. Thousands of Americans are going out to evangelize the former Soviet Union. Yet many Soviet citizens survived terrible persecution for 70 years. What a profound spirituality those people have, and what a tremendous story they have to tell us about what spirituality is. They need to be coming over here and evangelizing us! Saying, hey, wake up! That's heaviest on my heart—how to tell Americans how much we have to learn. Yes, we have some things that other people need, but let's not make everybody in the world our subjects. Let's see how they can help us, and together we can grow. ☸

Giving and Caring in the 1990s

Robert Wuthnow

IN STUDYING CARING AND COMPASSION, I have found over and over again that stories are the most valuable means of communication we have. Stories provide us with models of good behavior, they tell us why we should be caring people, and they allow us to explain our behavior to others and to ourselves. So let me begin with a story.¹

Ellen Montgomery, a black woman in her seventies, lives in a neat but badly run-down duplex in Philadelphia. She has lived here all her life. Her grandmother, freed at age six after the Civil War, purchased the house in 1920. After her grandmother's death, Ellen and two sisters kept the house, eventually raising six children in its tiny rooms. The neighborhood surrounds the house about five blocks in each direction. A large woman whose very presence is commanding, Ellen has always been active in the community. Despite long hours working as a maid in the suburbs and time devoted to her children and grandchildren, helping others has been her way of life. "It's normal; just natural," she says.

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"If I know you're sick over there, I'll go over and see if there's anything I can do for you. If I saw you coming down the pike or waiting on a bus or something, I'd pick you up. Or we'd call each other if we needed to go to the doctor." Stressing what a beautiful community it is, she emphasizes again that caring is just "the normal thing."²

Because of people like Ellen Montgomery, it seems reasonable to be cautiously optimistic about our society. Despite all the greed and selfishness we see enacted daily, an ethic of caring is still very much a part of America in the 1990s. Consider briefly what we know about the extent of voluntarism, philanthropy, and altruistic values in our society:

- Seventy-five percent of all American households donate money to charity. The average amount donated has risen in recent years, both in absolute terms and as a percentage of household income. The typical American household donates approximately 2 percent of its disposable income to charity (Hodgkinson and Weitzman 1990:1).
- Fifty-four percent of adults in our society do volunteer work. The average amount of time each volunteer puts in is 4 hours a week. Collec-

tively, volunteers contribute more than 20 billion hours of time each year. This time has been valued at approximately \$170 billion (Hodgkinson and Weitzman 1990:2).

- Membership in religious organizations is one of the strongest predictors of giving and volunteering in American society (Wuthnow and Hodgkinson 1990). Recent figures indicate that both membership and attendance at religious services remain at high levels in our society (Gallup 1992).
- An overwhelming majority of the American public (81 percent) say that charities are needed more today than five years ago (Hodgkinson and Weitzman 1990:9).
- Apart from organized charities, individual acts of kindness are widespread in our society: within the previous 12 months, for example, 30 percent of the public in a recent survey said they had stopped to help someone who was having car trouble, 24 percent had cared for someone who was very sick, 23 percent had given money to a beggar, 10 percent had taken care of an elderly relative in their home, and 62 percent had visited someone in the hospital (Wuthnow 1991a:8).
- Commitment to the *value* of caring also remains very high in our society: in one survey, 73 percent said “helping people in need” was absolutely essential or very important to them personally (Wuthnow 1991a:13).
- We also know that many people manifest caring in their everyday lives, including within their families and in their work. In fact, 39 percent of the public say that the best way to contribute to making our society a better place is “by doing the best I can in my job,” while 57 percent say “contributing through activities outside of my job.”³

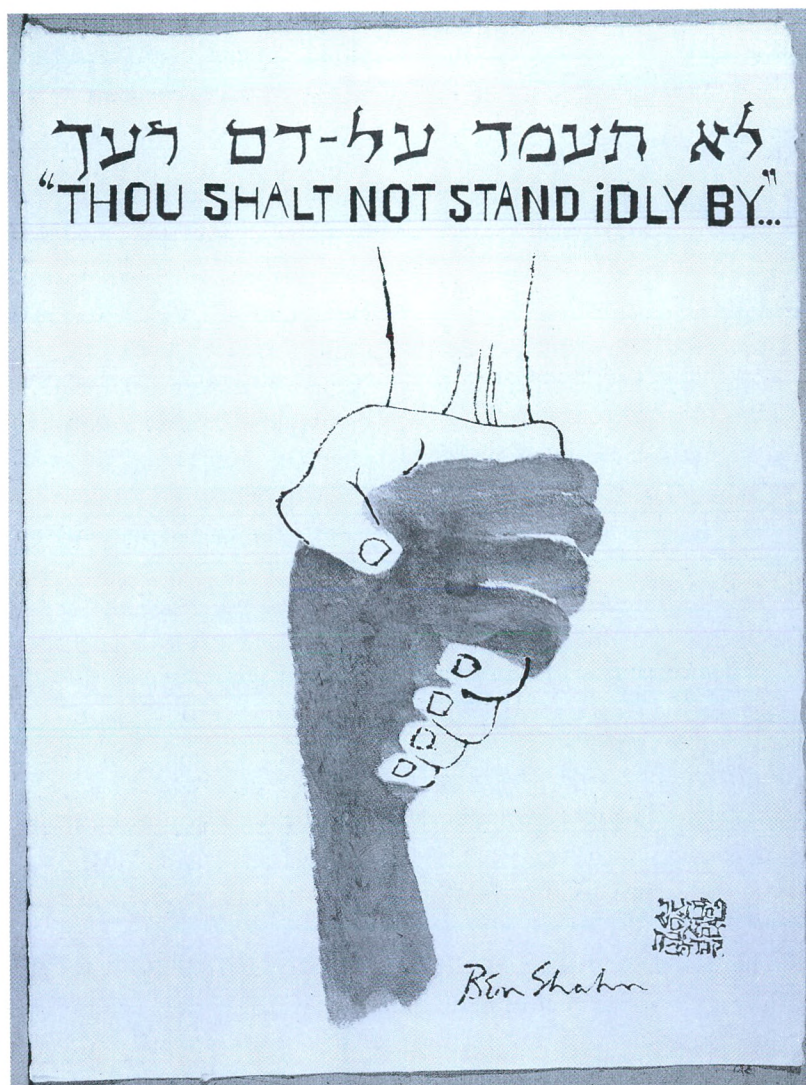
Figures like these give ample basis for optimism. Giving and caring remain vibrant in the lives of

many Americans. As a people, we believe deeply in the importance of helping others.⁴ We have been conditioned to give money to charitable causes, to devote free time to volunteer efforts, and to regard our work as a means of caring for others. Indeed, although some observers disagree, the most rapidly growing sector of our economy over the past century appears to have been the professions and semiprofessions, many of which are specifically concerned with providing care—medical care, education, legal services, therapeutic advice, vocational counseling. Questions of what it means to be genuinely concerned about human need, about ethics, about service, and about the common good are very much a part of these occupations. Yet if we are to maintain the commitment to caring and compassion that has been so vital to American culture in the past, we face several challenges in the years ahead.

Restoring Public Trust in Charities

AMBIVALENCE TOWARD THE CHARITABLE SECTOR in our society abounds, as we know. The recent troubles of the United Way, resulting from allegations that director William Aramony had misused funds and received an extravagantly high salary, are but one example. Indeed, one reason for the outcry over this particular case is that public skepticism toward charities is already very high. In the national survey I conducted for my book *Acts of Compassion* (1991a), 75 percent of the respondents agreed with the statement “Many charities fatten the pockets of their administrators instead of really helping the needy.”

Public confidence in nonprofit organizations is higher than it is in many other institutions. For example, 46 percent of the public say they have a great deal of confidence in “charities providing health or social services,” compared with only 28 percent who have this much confidence in the Congress or 21 percent who say the same about business.



Thou Shalt Not Stand Idly By. Photo-offset on Iyo glazed paper by Ben Shahn, 1965.

Collection of the New Jersey State Museum. Purchase FA1970.354.1. © Estate of Ben Shahn/VAGA, New York 1992.

In direct comparisons, the voluntary sector usually comes out looking much better than government. For example, 72 percent of the public I surveyed agreed with the statement "Private charities are generally more effective than government programs."

But it is difficult to derive very much solace from such figures. They often tell us more about the public's *dislike* of government than about its *liking* of charities. Indeed, the public is considerably cynical about charities and charitable giving. For example, 70 percent of the public agrees that "a lot of the money given to charity is really given for tax reasons." Sixty-two percent agree that "giving to charities is a way of making yourself feel good without really getting involved." And 57 percent agree that "charities provide 'Band-Aids' instead of really solving our problems."

It is easy, of course, for people who are uninvolved to sit back and take potshots at those who are involved. But frontline volunteers themselves are often the most cynical of all. Debbie Carson, a woman in her late thirties who is now doing volunteer work in Africa, remembers becoming jaded the year she spent after college as a volunteer in Newark: "When I worked in the inner city, the people on our board of directors were mostly wealthy people who lived out in the suburbs, and they felt they were doing something good by being on the board. But they would never actually come and even have a meeting where we lived. They were afraid to death their car might get smashed. People like that have a guilt complex. They want to do something. What they do may be helpful, but they aren't willing to really get involved."⁵

The reason for this ambivalence is that nonprofit organizations do more than just provide services. They also play an important *symbolic* role in our society. We want them to be good, not just get the job done. We want them to make our society better, not just keep it from getting worse. They symbolize hope, love, caring, a willingness to get involved.

In the survey, people who were involved in caring activities actually were more hopeful about

the future of our society. They were also more concerned about the threat of materialism, the breakdown of families, and corruption in public life. They saw voluntarism as a way not only of helping the needy but of maintaining high standards—basic values—in American society.

"Even the small things provide something for people to look at," one volunteer remarked. "Something to raise people's values. Volunteering is a reminder that life is more than just self-seeking endeavors."

Keeping the image of charitable activity from being tarnished is thus a significant challenge ahead. Yet image itself is often misunderstood: the word suggests something Madison Avenue might try to manipulate. Charities have been particularly concerned with demonstrating that they are run efficiently, that they "deliver," and that they are effective in meeting the needs of our society. What their leaders often do not seem to recognize is that charity has deeper meanings as well. Mother Teresa's work among the poor of Calcutta has often been criticized for being ineffective. But the public admires her far more deeply than they do large-scale nonprofit organizations because she provides a more genuine, tangible symbol of love.

Motivating Volunteers: Distinguishing between Feeling Good and Doing Good

A SECOND CHALLENGE IS THE NEED TO MOTIVATE both new and continuing volunteers. But here, the "feel good" appeals that have been so widely used in recent years need to be examined closely. "Send in your check; it'll make you feel good." Or "Spend an evening helping the homeless; you'll feel good if you do."

At one level, such appeals make sense. Asked about their motives, most of the volunteers I studied said it made them feel good to help others. They

enjoyed what they were doing. As one of my students put it this past semester: "Am I supposed to go out and do something I *hate*?" In my survey, 63 percent of those who were currently involved in charitable or social service activities said "doing things for people" gave them a great deal of personal fulfillment.

So what's wrong with the "feel good" approach? For one thing, it actually doesn't work very well. Using data from my survey, we did some statistical analysis to see how much the fulfillment people got from helping the needy contributed to their overall sense of happiness in life. We figured it would make a great deal of difference. Wrong. Of the various sources of personal happiness, it was one of the weakest. Most of us can find easier ways of making ourselves feel good than doing volunteer work.

But even if "feel good" appeals worked, a problem would remain. We may expect to get something from our giving and volunteering, but we worry if good feelings play too big a role. Our society has not yet succumbed entirely to the logic of self-interest: we want there to be genuine caring, a true commitment to the needy. And we would feel safe in assuming that such caring was strongly linked with an individual's overall sense of meaning in life.

In fact, much of the research done on the topic of fulfillment as a motive for caring *does* consider the deeper kind of reward that is better expressed as meaning in life. One study, for example, asked respondents how much various activities contributed to their "basic sense of worth as a person." A majority said that doing things for other people contributed a lot. But when respondents were compared with each other to see who actually had a stronger sense of self-worth, this particular activity proved not to be much of a factor.⁶

If the point is that the activity itself must be meaningful for people to keep doing it, no one is likely to disagree. But this raises the more fundamental question of what meaning is and what makes things meaningful. Much has been written about the meaning of meaning. The most helpful idea, though, is a simple one: the meaning of anything depends on its context.⁷ Acts of kindness may serve the recipient just as well, no matter how they are understood, but it is the framework in which they are understood that gives them meaning.

Another observation follows from this point. If the self—the individual caregiver—is the only (or main) context in which caring is understood, then the meaning of both is diminished. Caring will cease to be an end in itself and become instead a means of realizing the individual's

goals in life. Caring will be sustained only when it fits into a utilitarian calculation of what is beneficial for the caregiver. The self, deprived of a wider context, will be diminished as well. A self that is integrated into some larger community, some larger sense of what life is about, is surely a richer self than one on the lookout only for its own happiness.

Sometimes empathy is nothing more than an ability to share a small piece of another's pain. Often it has less to do with feelings than with a sense of common human destiny, shared fate, or basic humanity.

Addressing Unmet Social Needs

THE FACT THAT THE NEEDS OF VAST SEGMENTS of our society are not being addressed by the voluntary sector presents a third challenge. Even a short list of the social ills facing America in the 1990s is daunting. Many writers have expressed concern about the substandard education offered by many of our nation's schools. During the past 15 years, the con-

dition of the poor has steadily deteriorated. Homelessness and joblessness have added to the seriousness of these problems, as has the AIDS epidemic. Economists point out that the standard of living of the average American—middle-class and working-class alike—has not improved significantly in the last decade and a half, causing more families to face retirement without adequate resources, to be without reliable health insurance, and to overwork and run up huge credit-card debts.

Surveys again give evidence of the extent of these social needs. When asked in my survey about the help available to them if someone in their family became ill, for example, *half* of the American public said they could *not* count on volunteers. As government programs for the needy have been cut, the public has turned increasingly to churches and synagogues to fill the gap. And though people who attend religious services regularly are more likely to visit the sick and give money to certain kinds of charities, they are *no more likely* than anyone else to lend a helping hand to beggars on the street, to people suffering from addictions, or even to people experiencing emotional crises, apparently because many churches have not defined these as legitimate needs or as legitimate ways of helping.

Volunteers *can* make a difference. In the Trenton area, local newspapers recently carried the story of an unemployed, homeless woman with two small children. She was a Phi Beta Kappa. Her life had gone bad because she had made a principled decision not to have an abortion and had devoted her energies to caring for her children. Within days, volunteers offered her free housing and help in finding a job. A local dentist offered to clean her teeth. Readers felt good about it. But, of course, the problems for others in similar plights remain.

Volunteers, my research shows, are often painfully aware of the larger picture. Their efforts have exposed them to injustices in our society. They recognize the need for government action or legal intervention. One young man—a humble person who lives simply, gives away most of his money, and spends nearly all his spare time doing volunteer

work—observed: “It’s the role of government to be the conscience of society. The government should lead as well as just be a caretaker of day-to-day activities. It has to lead in social areas. It has to have more foresight than the average individual citizen.”

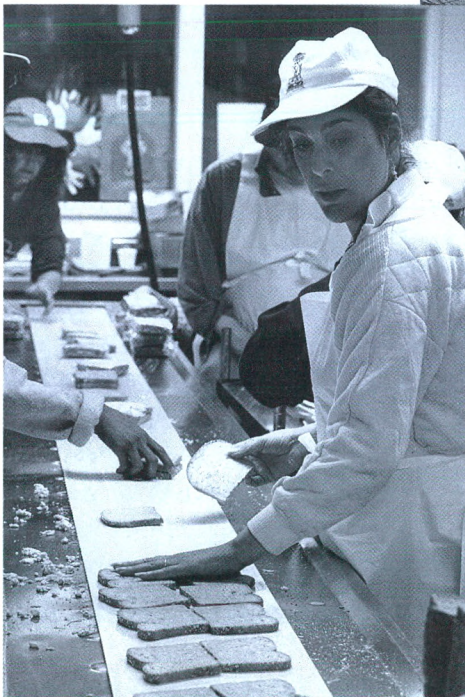
But most of the volunteers I talked to are members of a “postwelfare” generation. At one time, they may have been hopeful about reforming our society. They no longer are. They still feel it needs reforming, but they doubt whether it can be. Most people, they believe, are too self-interested to give up anything. Politicians are too corrupt. Businesspeople are too greedy. And large institutions are too inefficient.

These volunteers do not throw up their hands and do nothing. They stay involved, doing what they can as individuals. They recognize that doing a little is better than giving up, that at least one individual may be helped. They themselves feel better for what they have done. But they need guidance in seeing the larger picture.

Ted Garvey, a former Peace Corps volunteer who now works with the mentally handicapped homeless, is one of the few who senses clearly this need for the larger picture: “I think there has to be more awareness across the different levels of society of how the others live, of how bad it is, and what makes it that way.” He adds: “You need to speed up the changing awareness that bums aren’t just bums because it was their choice or because they’re deviants; they are people who worked for 30 years and then lost their jobs making cars in Flint, Michigan, and are unemployed now.”

But how does one help with immediate problems while also retaining an interest in the larger issues? The tension between the two in the voluntary sector is almost endemic. Become too activist, and the support of government and business dries up; avoid activism entirely, and the structural problems remain unaddressed.

In addition to finding the right balance between individual action and structural reform, we must balance the needs of recipient groups and the needs of caregivers themselves. On the one hand, long



Volunteers (from top): The Detroit Summer Project; clean-up efforts after the 1992 rioting in South Central Los Angeles; preparing sandwiches for Project Open Hand, San Francisco, which delivers meals to people with AIDS.

Photos courtesy Impact Visuals.

Photographers (from top):

Jim West, Ted Soqui, Rick Gerharter.

traditions of heroism have associated caregiving with self-sacrifice; on the other hand, much contemporary thinking places the caregiver squarely ahead of the recipient. Writers on the phenomenon of co-dependency, for example, worry that virtually any kind of caregiving can be a self-demeaning obsession. They worry that people must care for themselves first before caring for others (Beattie 1989).

I was brought up short on this subject not long ago in conducting a panel discussion on altruism for a group of students. After listening to a moving presentation by a man who worked with the homeless in New York City and an equally moving presentation by a woman who directed a tutoring program for inner-city children, most of the students in the room were eager to learn more. They plied the panelists with questions about how to become involved, what motivations might be most laudable, and how to think of such commitments in relation to other career options. But one young woman remained quiet. I knew she had done a great deal of volunteer work herself and was puzzled by her silence. Finally, she blurted out, "My best friend was raped and killed last night." Valuable as it was to be thinking about the needs of the poor, at that moment our first responsibility was clearly to care for the needs of this caregiver in our midst. Not to do so would have proven we didn't know the first thing about compassion.

In my own research, and in much of the published literature on the subject, *empathy* surfaces as the factor that motivates people most effectively to reach out to others in need.⁸ Sometimes empathy is nothing more than an ability to share a small piece of another's pain. Often it has less to do with feelings than with a sense of common human destiny, shared fate, or basic humanity. In either case, it is greatly encouraged by having experienced needs in one's personal life—and by having had those needs met in some way.

This, then, is the vital connection between taking care of ourselves (or other caregivers) and being concerned about other people who may be in need. Though it may sound crass, volunteers must

help each other if they are going to be of any service to the wider community. Members of religious organizations must do the same. The large variety of self-help and support groups that have emerged in local communities and among the helping professions themselves suggests that the need for a network of mutual support is widespread.

Avoiding the Excesses of Individualism

THE FOURTH CHALLENGE TO ALTRUISM is presented by the individualistic spirit of our culture. Jack Casey, a man I profiled in *Acts of Compassion*, is a rugged individualist. His heroes are Davy Crockett and the Lone Ranger, and like them, he tries to be of service to his community. He is a member of the rescue squad and a volunteer firefighter. He has literally risked his life to save the lives of others. Yet Casey describes himself as "the ice man." He doesn't want to be dependent on anyone else; he has trouble maintaining relationships. And when the suffering he sometimes witnesses firsthand becomes too great, he finds it easier to get drunk than to seek support.

Many of my students at Princeton are like Jack Casey. They sincerely want to do something beneficial for society. But they argue strenuously that their own careers and their own interests must come first. They see nothing wrong with self-interest. Indeed, they believe self-interest is truly the only basis on which to be a caring person. They would say of someone like Mother Teresa that she is really self-interested, that she helps others only because it makes her happy or because it fulfills some curious need she has to please God.

But is this really the attitude we wish to cultivate? Perhaps the nonprofit sector can recruit volunteers by appealing to young people's self-interest. Perhaps the nation's education system can encourage "community service" by requiring it of all high school students. But in the process the meaning of compassion is fundamentally corrupted.

Political scientist Kristen Monroe and her colleagues have been studying rescuers of Jews in Europe during World War II (Monroe et al. 1990). They describe these rescuers as “John Donne’s people” because they acted out of a common sense of humanity, believing intuitively that “no man is an island.” Self-interest was not enough to motivate these people; indeed, they *endangered* their own interests. Nor may it be enough for us, especially when serious sacrifices are required.

Aristotle argued that a mixture of egoism and altruism was the most laudable motivation for human behavior (see Kekes 1988). The more thoughtful volunteers I have studied make a similar argument. If an act of kindness helps a stranger, it can scarcely be faulted; if it also benefits the caregiver, so much the better. What they worry about is the tendency for everything to be reduced to self-interest. Caring behavior, they point out, must be genuinely concerned with the recipient’s needs—and with the recipient as a person.

Two points about individualism thus emerge with stark clarity. First, the benefits that an individual receives from helping others should be considered as a means of growing and becoming better able to serve in the future. What I learn today benefits me so that I am a stronger and more compassionate person tomorrow. Second, individuals must not be allowed to forget the importance of social institutions. Although the deep skepticism in our society toward large-scale institutions is probably healthy insofar as it makes us reluctant to trust blindly in the authority of abstract social entities, we know intuitively that life cannot exist without institutions. Helping one person in need may be better than doing nothing, but such help is even more effective if it leads to the cultivation of leadership skills and the formation of organizations that bring together the resources necessary to tackle large-scale problems.⁹

Rebuilding a Sense of Community

A FINAL CHALLENGE IS PRESENTED by the breakdown of community in our society. Ellen Montgomery, we recall, said that helping her neighbors in Philadelphia was “natural, just the normal thing to do.” And throughout most of our nation’s history, that was the way things were. Doing things for the community shaved the sharp edges off the questions about volunteer work that have arisen so abruptly in recent years: Am I doing it for someone else or for me? How can I find time to be a volunteer when my work and my family take all my energy? Questions of this kind made no sense when the recipient was one’s community: sure, someone other than yourself benefited, but so did you, because you were a part of this larger entity. Caring for others was neither altruistic nor egoistic; it was mutually beneficial. Favors done for others became an implicit bond; you could count on them (or their family) to return the favor when you were in need.

But now, for increasing numbers of us, helping our neighbors has been replaced by doing volunteer work for strangers in some other part of the city. That’s where the need is. But caring ceases to be “natural.” It takes more effort, more soul-searching, and it can more easily lead to cynicism and burnout, or at least to a decision that the effort is not worth it.

Consider the experience of Tom Larson, a Minneapolis businessman. Having been raised in a small town, Tom always thought fostering community spirit was a good thing to do. When he first moved to suburban Minneapolis, he joined Kiwanis and Rotary; he even served a stint as president of the League of Women Voters. But after a few years he dropped out. Nobody in the community knew him personally. They didn’t understand why he was so interested in volunteer organizations. Instead of assuming he was interested in the good of the community, they told each other he must be power-hungry, doing these things to make himself

feel stronger. Tom eventually decided he didn't need this kind of suspicion. He still believes he is a good, other-regarding person. But he has more questions about his values, his commitments, and balancing his own interests with those of his community than he did before.

It is doubtful that many of us can reconstruct the close-knit community life that once existed in small towns and in rural villages—and doubtful that many of us would want to do so. But there is perhaps a greater sense of community left in our society than naysayers are willing to recognize. Most people still have close friends. Most people feel they have coworkers who care genuinely for them as persons. The vast majority of Americans are still involved in churches and synagogues that provide some sense of community. We even gain some feeling of community—of being in it together—when we watch the evening news or when we participate in national rituals like elections and holidays.

The challenge is to think creatively about these meanings of community, to rediscover the links with our ways of caring and showing compassion. Volunteer work that takes place in one's own community—activities performed at the local school or fire department or church—strengthen those links. Many volunteers report experiencing a deep sense of community among fellow volunteers. But there must also be new thinking about the common bonds that are needed to unite us in spite of economic, racial, and national differences.

Meeting the Challenges

THE VOLUNTARY SECTOR REMAINS ONE of the mainstays of American democracy; it is well organized and has the capacity to mobilize vast resources. It must utilize these resources wisely, not only to provide goods and services but also to maintain the ideals on which democracy itself is based. Caring is part of the Judeo-Christian tradition. It is fundamental to any notion of humanitarianism.

Charities and volunteer efforts, however, are only one way in which values of giving and caring are transmitted in our society. Churches and synagogues, of course, play an important role in keeping these ideals alive. Families are perhaps even more fundamental, for if children do not learn to help others at home, they may find it unthinkable to help anyone else. Schools, and even businesses, must also shoulder the burden of exemplifying what it means to be caring and compassionate.

It is well within the purview of churches and synagogues to encourage helping behavior. But religious organizations are themselves undergoing a time of radical reshaping. Despite the fact that most Americans still claim some affinity with traditional religious beliefs and organizations, a pervasive decline in the authority of these traditions is also well under way in our society. Rather than accepting the teachings of these traditions, vast numbers of people seem more inclined to question them, treating them as curiosities to be debated and debunked. Ask students to write about their religious beliefs, one colleague of mine reported, and they are likely to list some standard ideas about God, Christ, and the Bible—and then

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proceed to show how their own ideas represent *improvements* on these various tenets.

Such demonstrations may be the fruit of our efforts to cultivate critical thinking in our students and children, but they may not be conducive to the disciplined commitment that has led people of faith in the past to devote themselves sacrificially to caring for the needy. Indeed, my research showed that people had to be active members of a religious community for their beliefs to generate actual helping behavior. Those who were less involved were often deeply spiritual, but their spirituality did not translate into action (Wuthnow 1991a:154–56). Religious organizations, then, must encourage participation in communities of faith rather than simply hope that their ideals will somehow find roots in the lives of individual believers.

Families can help meet the challenges we face by providing role models for children. Many of the caregivers I talked to had learned compassion by seeing it in the lives of their mothers and fathers. With the stresses that modern life places on many families, the likelihood of young people learning compassion from their parents may be seriously diminished. It is thus even more important for role models to be available in other settings. Teachers, pastors, Scout leaders, neighbors—all these may be instruments through which values of caring and compassion are transmitted.

Schools have become increasingly active in this arena in recent years, often requiring “voluntary” service as part of junior high or high school curricula. Such programs can encourage otherwise reluctant students to engage in community service. But coerced voluntarism is not voluntarism. The meaning of service is fundamentally changed from altruism into something one does for self-interest. It can be argued in defense of these activities that they at least benefit the community. But caring is more than service. Throughout the centuries it has always

involved notions of honor, virtue, sacrifice, and personal relationships as well.

Businesses are perhaps in the most curious position of all. On the one hand, they exist for no other reason than to turn a profit. On the other hand, many businesses have found that service enhances profits. They cultivate an image of caring, of community involvement, and of social responsibility. Still, the public remains skeptical; most people believe that being a good businessperson requires a thick skin and a willingness to put self-interest first. They see caring as the antithesis of bureaucracy, commerce, and materialism. The challenge for business is to recognize that caring has these cultural meanings, including traditional connotations suggested in words like *compassion* and *love*. Efforts to promote caring for strictly instrumental purposes are likely to lead only to deeper cynicism. But caring activities clearly cannot succeed without the support of business. Its leaders must become involved, perhaps even at a sacrifice to their personal advancement and material success.

The American public fundamentally admires the shining examples of compassion that occasionally appear in our world—a Mother Teresa, people who risk their lives in combat, Peace Corps volunteers. They do not believe it is possible for everyone to be like this, but they do want small ways in which they themselves can be good, decent, caring individuals. Opportunities must remain available for all of us to act out these desires—for our own good and for the good of our society. As we face the challenges ahead, we have good reasons to be optimistic but also to be cautious.

Caring is a part of our cultural heritage, and it is needed badly to help alleviate the pain and suffering in our world. Fortunately, many Americans still give generously of their time. But we must also face squarely the challenges that are working against this spirit. ☸

NOTES

1. The results of my research on giving and caring in the United States are presented in Wuthnow 1991a; further discussion of the role of stories is provided in Wuthnow 1993.
2. Ellen Montgomery (a fictitious name) is one of 150 people interviewed by my research team as part of a new study concerned with the relationships among faith, work, money, and caring.
3. These figures are from a national survey of the U.S. that I conducted in 1989; details of the survey are presented in Wuthnow 1991a.
4. Comparative statistics are not exact because of different wordings of questions and different definitions of voluntarism, but studies generally show higher rates of voluntarism in the U.S. than in other advanced industrial societies (see Wuthnow 1991b).
5. Debbie Carson was one of the 100 volunteers interviewed for the compassion study; she is profiled in greater detail in Wuthnow 1991a:121–56.
6. This example is based on results from a Gallup survey examining the correlates of self-esteem; the data analysis is my own and is reported in Wuthnow 1991a, chapter 4.
7. Among those who have stressed this argument, see Langer 1951 and Berger and Luckmann 1966.
8. Much of this literature is reviewed in Batson 1987 and in Batson et al. 1986.
9. On institutions, see Bellah et al. 1991; and for background on individualism, see Bellah et al. 1985.

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REFLECTION

Righteous Anger, Health, and Well-Being

Bernie S. Siegel

THE ONCOLOGY NURSE CALLED MY OFFICE ONE DAY and said, "We have a man up here threatening to kill the intern. Can you come up and help us? You'll love him." I did go, and I did grow to love him. I listened to his life story. I learned about his stored-up rage, which had led him to carry a gun. He used it to threaten people if they didn't "behave" as he felt they should. I explained to him that killing the intern wouldn't improve his chances of being cured of leukemia but that I felt he could use the energy to help fight his disease. Ultimately, he did change his view of life and found spiritual peace. This man was more than angry. He could have become a murderer. He hated and resented the world and how life had treated him.

It is important to make a distinction between anger, resentment, and hatred—to understand that anger can be healthy. It contains an energy that can be used to heal, protect, or defend one's self. To define this healthy anger, let me share some personal experiences. Several years ago, I was upset because numerous changes in the operating room schedule were creating a difficult situation for me, my office, and my patients. I expressed my anger to the O.R. secretary when she called my office. A few hours later when I went to the O.R. to operate, she saw me coming and crouched behind the desk. I said, "Why are you hiding?" She asked, "Aren't you going to yell at me?"

I said, "I did yell. If you want a hug right now, I'll be happy to give you one." She came out and we embraced and she said, "The others yell for days." In a similar manner, a friend of our daughter who accompanied us on vacation said to me, "Your family doesn't know how to be angry. You get angry and then talk to each other a half hour later. In my family we don't talk for weeks." I laughed and accepted it as a compliment.

When we can express our anger in a healthy way and have someone listen, healing can occur. It is the stored-up anger, never expressed, that leads to destructive conflict. This is no longer anger but a resentment and hatred that leads to violence and sickness. On a larger scale I see the Los Angeles riots as a manifestation of this same pent-up rage.

I have attended workshops and worked on my anger. I used to feel, as many do, that anger was always unhealthy, that I should be in control of my feelings. I have learned that I have needs too and that the anger protected me when people wanted more from me than I could provide or when they were not treating me with respect.

The word *patient* means a submissive sufferer. A patient who is a fighter is often seen as difficult, uncooperative, a character. Yet when I see these words in a medical record, I know that the person is more likely to be a survivor. This person is saying, "I am an individual, not a disease or statistic." She speaks up and asserts herself. She has a feeling of self-worth.

Dr. George Solomon, a psychiatrist at Stanford who has worked in the field of psychoneuroimmunology, detects an immune-competent personality by asking several questions. Two of the most significant are these: "Am I able to express anger in defense of

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myself?" and "Am I able to say no to someone when I do not want to do what is asked?" What I ask people to do is to decide how they want to love the world, so that each day in our work and relationships we are serving out of love. More people have heart attacks at 9 A.M. Monday than at any other time. This is no coincidence. When our work has meaning and is an opportunity to express love, this changes. Barbers work an average of 28 years, physicians 10. So become a barber, elevator operator, bus driver, school custodian, or driving education instructor. Why? In order to have a trapped audience for your love. A bus driver in Denver bought muffins and donuts for all the people on his bus at 6 A.M. Monday. Why? He said, "I never saw so many miserable people before. I had to do something." In Santa Monica, a bus driver said, "I love you," and sang "You Are My Sunshine" to two men on his bus pointing guns at each other. They put their guns away and now ride his bus as monitors, to be sure everyone is loving.

This gives your life meaning. You no longer just play a role, earn a living, make this marriage work if it kills you, or pay the bills—you are contributing love to the world in your unique way. Your love heals both you and the people who receive it.

When we are pressured to deviate from our choice of how to live, we can get angry and say no. I am not saying "be selfish" but rather "act out of love." The immune system is enhanced by this activity; you may get tired, but you'll never burn out. It is also crucial to define your way of loving so that you know what to surrender to, what it is not worth being angry about. The serenity prayer conveys this message. We are to decide what we have the courage to fight and what to accept or leave to God.

Say you are a patient in the hospital. You learn that at 8 A.M. you will have a CAT scan and be

discharged. By 11 A.M. no scan. I enter your room on rounds, and you tell me what has happened—no scan and no discharge. You are angry and I say, "Thank God."

"What do you mean, thank God?"

"Well, the cable broke on the hospital elevator, and it crashed to the ground at 8:00 this morning."

"Wow, really?"

"No, I was just trying to make a point. You may get to X ray at 11:30 and sit next to someone who gives you great advice and you'll say, 'Thank God I was here at 11:30 and met you.' Or you can get up and go to the nurses' station and sign out and tell them to call you when the CAT scanner is repaired."

These are the decisions we must make in our lives. What is worth getting angry about and fighting for? Our dignity, our value as human beings, certainly. Our desire to be cared for, absolutely. As a surgeon I get angry at the American College of Surgeons pledge, which states, "I will deal with my patients as I would wish to be dealt with."

If I am a patient I don't want to be dealt with, I want to be cared for and cared about.

I have also learned that the universe has a schedule and that if I get on it there are fewer things to be angry about. I think I am improving. Recently I was working outdoors with our son Jeff, and he asked, "Dad, are you happy?" I said, "Yes." That night I began to wonder why he had asked. What was he concerned about? I called him and asked why he had questioned me. He said, "Well, I haven't seen you angry at Mom or Grandma lately, and I wondered if you were okay." I laughed, because our family is used to having things be expressed. I told him I was learning to love more and leave more to God. But there are still many days I reassure him by being my old self and expressing healthy anger and righteous indignation.

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ISSUES & CURRENTS

Speaking of God: Must Theology Remain Silent in Bioethics and Public Debate?

Ron Hamel

BIOETHICS AND ITS PRACTITIONERS HAVE NOT BEEN terribly hospitable to religion and theology over the past 20 or so years. This is ironic since bioethics had its beginnings in theological ethics (especially Roman Catholic and Jewish), and theologians were prominent among the first scholars in the field as it emerged and began to take shape in the mid-1960s and early 1970s. Before long, however, the voice of theology was not only drowned out by the voices of philosophy and law but was, in fact, muted. Theology was essentially barred from the playing field.

Newcomers to bioethics, especially some philosophers, argued that religion and theology had no place in the public forum, which is characterized by secularity and pluralism. Both were legitimate in the private domain, in the private lives of individual citizens, but not in the sphere of public discourse and in the formation of public policy. How could society achieve any consensus on the pressing and complex issues in bioethics if arguments were made on the basis of convictions held by diverse religious communities? Allowing religion and theology a voice in public debate would only lead to a modern-day "tower of Babel." And even if this didn't occur, religion and theology were still inappropriate in public discourse because of the secularity of American society and the separation of church and state. Within such a context, religious arguments for social policy or religious justifications for state activity had no legitimacy. What was needed instead was a common language, a language that transcended the particularity of various groups and that was based on commonly accepted values and beliefs. The language of public discourse and public policy had to be accessible to all.

Theologians, unfortunately, demurred. Wanting to maintain some role in the field of bioethics and to participate in public discourse on the issues, they left their religious language and convictions at the door and adopted the common tongue. They began to speak the language of *autonomy*, *beneficence*, *nonmaleficence*, and *justice* as these terms (particularly the first and last) had come to be defined by the tradition of liberalism. With this development, religion and theology were effectively shut out from bioethics, particularly in the public domain.

This situation may be changing, however. We may be witnessing a shift in current. Over the past two or three years, there has been more and more talk about the legitimate, and even significant, role of religion and theology in bioethics. This is evidenced by conversations among scholars and practitioners in the field; papers at conferences; the start-up of a book series in theology and medicine edited by Earl Shelp of the Houston-based Foundation for Interfaith Resources and Ministry; a biannual collection of essays titled *Theological Developments in Bioethics*, published by the Center for Ethics, Medicine, and Public Policy Issues in Houston; and by special focuses on the subject in two of the leading journals in the field. The *Hastings Center Report* published a special supplement in its July/August 1990 issue ("Theology, Religious Traditions, and Bioethics"), and the *Journal of Medicine and Philosophy* devoted its entire June 1992 issue to "theology and bioethics." An article titled "Religious Ethics and Active Euthanasia in a Pluralistic Society" appeared in the September 1992 issue of the *Kennedy Institute of Ethics Journal*. Whether these developments merely reflect the personal interests of a few individuals or the beginnings of a new current in bioethics is yet to be seen. Whatever the case, it is

worth considering what is being said about the role of religion and theology in bioethics. The special issues and article referred to above are wide-ranging, but the discussion that follows will focus exclusively on the relation of theology to bioethics in the public arena, and, specifically, on three questions: Why has theology been silenced? How is the problem being addressed? and What could theology contribute to bioethics and to the formation of public policy?

Why the attempt to silence religion and theology in public discourse about bioethics issues (or any other issues for that matter)? There are several reasons, some of which have already been mentioned, and most of which are acknowledged in one way or another by the contributors to the discussions mentioned above. Some of the concerns about the public role of religion and theology come from within religious communities themselves, while others arise from the secular, pluralistic context in which they exist. First, we live in a society that is pluralistic in its beliefs and in which freedom of religion is highly cherished. Many fear that if religion were allowed into public policy debates, a particular religious vision would be imposed upon the larger society. Second, we live in a society in which there is a constitutional separation of church and state. As a result, all public policy and legislation must be justified on a secular, rational basis. Religious rationales are seen as infringing on this constitutional requirement. Third, religious communities that seek to shape the culture as well as themselves will be involved in compromise. This means that "the church will be left with the continual problem of being a party to, and perhaps an exponent of, policies, laws and programs which do not conform to the fullness of its moral principles" (Hehir 1992:355). For some within the churches, this is unacceptable. Fourth, when religious bodies speak to the whole society, they are likely to "lose the edge" of their convictions. They forfeit "the opportunity to use the richer, sharper, more demanding language and ideas of the prophets, the Sermon on the Mount and the haunting societal judgments found in Matthew 25. The church loses the edge of biblical imagery and inspiration, and it loses the moral appeal which the revealed word holds for the human heart and mind" (Hehir 1992:355). In "translating" theological language into the neutral language of public discourse, there is the danger that theologians and others betray

the integrity of their religious convictions and cease speaking theologically. Hence, as Louis Newman observes, "by bringing theology into our common discussion of moral problems, we threaten either the religious neutrality of our society or the theological commitments of the religious ethicist, or both" (1992:321).

Of course, the public role of religion and theology is a problem only for those religious bodies that believe they have a public mission. Some religious thinkers maintain that the responsibility of the church is to itself and not to society. The responsibility of the church is to be the church. That is, the church should be concerned with its own religious and moral formation, and with faithfulness to its own religious convictions. When this occurs, there is no need for religious communities to "translate" their distinctive convictions into terms accessible to those outside their communities. It is not the responsibility of the church to change society or to affect social policy. If this occurs at all, it will occur because the church is faithful to what it is meant to be. What is operative here is "an ethic of an exemplary community that witnesses to the integrity of its religious convictions primarily in practice rather than discourse" (Campbell 1990:6).

Other religious communities, however (and probably the majority), believe that they do have a mission not only to members of their own community but also to society. Their "pastoral responsibility extends beyond the ecclesial community to the civil society" (Hehir 1992:354). The degree of responsibility and involvement varies, depending on the particular religious community's self-understanding (its ecclesiology) and other fundamental theological tenets.

In the articles cited above, all of the authors, Jewish and Christian alike, maintain to a greater or lesser degree the appropriateness of religious communities' having a voice in the public forum. None suggests that religious bodies abandon the struggle to affect social policy, nor does any condone the abandonment of theological convictions and language, pure and simple, for the language of public discourse. Most, however, do see the need for some form of "translation."

What are the proposals for doing this? How might religion and theology speak publicly? Two approaches emerge, each different, yet trying to forge

a middle way between a withdrawing from social involvement on the one hand, and abandoning religious convictions on the other. Lisa Cahill, in her essay, gives the most sustained attention to the issue. She views public discourse as a meeting ground of the diverse moral traditions that make up American society, some of which are religiously grounded. The contributions of religiously based moral traditions to public discourse, she believes, "will be appropriate and effective to the extent that they can be articulated in terms with a broad if not universal appeal."

In other words, faith language that offers a particular tradition's beliefs about God as the sole warrant for moral conclusions will convince only members of that tradition. But faith commitments can legitimately motivate participants in public discussion to seek a moral consensus consistent with their faith while at the same time be congenial to members of other moral traditions, the persuasion of whom may be the object of religious groups and theologians who argue and act for social change. (1990:11)

Therefore, religious ethicists trying to influence the development of public policy need to speak *out* of their traditions but also *beyond* them. In order to speak beyond, they will need to employ language that is "appropriate and communicative" to people from a variety of traditions who are trying to achieve consensus on some issue. The aim would be to achieve consensus around a common course of action consistent with one's religious convictions—in spite of disagreement about the underlying beliefs that might ground those convictions. In order to be able to engage in this discourse, Cahill believes it is necessary to "construct a language of 'principles'" (1990:11).

Louis Newman shares a similar position. He contends that certain "principles, values or rules" that have a religious grounding can appeal to nonreligious persons, or religious persons from other traditions, independent of their theological source. They are principles, rules, or values that "people find compelling," that resonate with people's basic moral intuitions, and that are "intelligible outside of a strictly theological context" (1992:323). Some of these would be the sacredness of human life, the obligation to preserve life, and the equality of all human beings.

In taking this position, are Cahill and Newman actually advocating adoption of some universal lan-

guage that is tradition free? Does Cahill, in fact, believe that religious ethicists should leave their theological convictions behind and instead speak the dominant language of bioethics, namely, the language of autonomy, beneficence, nonmaleficence, and justice? She claims that this is not the case:

To speak of distinctly secular language and arguments also implies that to be intelligible, religious or theological language must undergo some sort of "translation" into the lingua franca—into some different vocabulary universally understood. *But this is a distorted understanding both of religious traditions and their theologies, and of what happens in "public" discourse about bioethics.* (1990:11, emphasis added)

Cahill believes it is a mistake to expect theologians to adopt some sort of "pidgin," some neutral, objective, dominant language that rises above particular traditions, commitments, and points of view. Theologians do not participate in the process of forging social existence "via an objective, traditionless, secular version of philosophical reasoning."

Rather, she maintains that

it is best to construe "public discourse" not as a separate *realm* into which we can and ought to enter tradition free, but as embodying a *commitment* to civil exchanges among traditions. . . . The language of "secular" and "publicly accessible" serves exactly to exhort persons from traditions to adopt a stance of dialogue and openness, of mutual critique, of commitment to consensus and to hammering out institutions and policies that will affect the common life "for the better," as defined on the broadest consensus we can achieve. It is a commitment to the dialogic and consensual mode of discourse, or perspective, or attitude, or stance, that is indicated by the expectation that religious and other traditions will make public rather than particularistic appeals in addressing civil society or the body politic. (1990:12)

What does all this entail? Cahill believes that religious ethicists, if they hope to be influential in shaping a public consensus that can support public policy, must speak in a manner that is "intelligible and persuasive" (and not necessarily universal), that "strikes a responsive chord" in people from a plurality of moral and religious traditions. Theologians will need to speak "on the basis of moral quandaries, moral

sensibilities, moral images, and moral vocabulary shared among other religious and moral traditions" (1990:13). This for Cahill does not mean sacrificing the moral truth of religious convictions but rather communicating that truth in nonreligious language.

But as Courtney Campbell points out, the compromises in language required to gain broader hearing may well exact a price in substance "since the common discourse of bioethics may not be sufficiently rich to convey the full meaning of relevant religious language" (e.g., *imago Dei* is not adequately conveyed by *autonomy*, nor *covenant* by *contract*, nor *neighbor love* by *beneficence* [1990:5]). Addressing a public audience on generally accessible grounds "may compromise not only a vocational responsibility to speak *out of* a particular religious tradition, but also responsibility to speak *to* the tradition embodied in an identifiable community of believers" (1990:6). In other words, a community's theologians may in effect become its philosophers. "The costs of conformity to public discourse requirements may be the loss of meaning and content about ultimate concerns embedded in a particular tradition" (1990:5).

Cahill seems to want to avoid this. She endorses James Gustafson's claim that theology has a critical function in public discourse "if the edge of religious commitment can be sharpened so as to cut through cultural assumptions" (1990:11). The civil community can be introduced to the insights of various religious traditions provided that there is some possibility of communication and intelligibility. In fact, according to Cahill, "recognizing and retaining the countercultural edge of such [religious] commitments is the first task of the theologian" and one of the major contributions of theology to the development of public policy (1990:12). "Theology can influence policy through a prophetic function that challenges the civil community to consider more seriously values and alternatives which other traditions and established forms of life may have neglected" (1990:14). This prophetic function is also at the heart of the relevance of theology to bioethics. That relevance lies not in a distinct contribution to the process of argumentation nor to identifying particular behaviors justifiable only on the basis of revelation, faith, or church authority, but rather in the formation of radical communities "that challenge dominant values and patterns of social relationship . . . by participating in

. . . [society] in challenging and even subversive ways" (1990:12). Hence, there is in Cahill's understanding some notion of theology forming the identity and way of life of the faith community.

This is precisely the emphasis in the second approach. Of the religious thinkers who contributed to the discussions cited above, it is Allen Verhey who is most emphatic that theologians may and must talk about God, and do so theologically. First and foremost they speak to the community of faith where talk of God is viewed as central and not marginal.

In communities of faith, by some grace there is an effort to attend to God and to respond appropriately to God, to attend to all things as related to God and to respond to all things in ways appropriate to their relations to God. There the tradition exists . . . as that which continues to evoke and to shape the loyalties and the identities of the community and its members, even as they make use of science and reason. There faithful people orient themselves in their worship—and in their living and their dying and their suffering and their caring for the suffering—to God and to the cause of God. There people transfigure questions of conduct and character into questions of the deeds and dispositions worthy of the story they love to tell and long to live. There people ask how religious convictions can guide and limit new medical powers. There in the middle of the struggles with infertility and in the middle of the technological apparatus that surrounds the dying, people ask about the resources and requirements of their religious convictions and commitments. (1990:22)

For Verhey, the community of believers is a true public, a place for moral discourse, deliberation, and discernment to occur in the context of the community's religious traditions and loyalties. The theologian's task is to nurture and sustain such activities and to help congregations renew their loyalty to God, their commitment to the cause of God, and to form their identities accordingly. Within communities of faith, theologians are able to speak of God and medical ethics at the same time.

But Verhey also acknowledges other publics. A second consists of those who do not belong to a community of faith or do not identify with any religious tradition but who will listen to talk about God nonetheless. Among these are physicians, nurses, and patients who are keenly attuned to aspects of their

experience that open up to an "inscrutable power" or perhaps even have a sense of an unnamed transcendent other.

Finally, "moral theologians may talk of God, and sometimes must, in the presence of those who would rather not and in the presence of those who may not" (1990:23). Verhey acknowledges that at times it may be necessary to employ arguments not tied to one's religious convictions or to be silent about one's religious convictions (e.g., in speaking with public-policy makers). "In such settings arguments based candidly on Christian convictions may be regarded as at least insufficient, and perhaps as irrelevant" (1990:23). But in these contexts, Verhey calls for theological candor.

This seems to mean several things for him. When society has a minimalist understanding of the moral life and employs a minimalist ethic, then what theology has to say about the broader and more fundamental dimensions of human life takes on increased importance. Religious persons and communities "can speak more eloquently in their own moral languages about medicine and morals, and more candidly theological talk about medical ethics may at least remind a pluralistic culture of the *minimal* character of the standards it presumes are universal and rational" (1990:24). Furthermore, there are situations when moral theologians will not be able to work toward consensus. Rather they will need to make it clear that their assumptions are different; they will need to take on the "ineliminable conflict." It could happen that raising a theologically articulate voice in protest might make a difference.

Regardless of how they speak, do theologians have anything to contribute to public moral discourse? There is some agreement in this regard among the various contributors. Newman, for example, maintains that there is a very constructive role for religious ethicists and thinkers to play with regard to public policy, and it is a role that does not entail abandoning their theological convictions. That role is "doing what theologians have always done—directing our attention to dimensions of the human situation that may have escaped our notice. By expanding our vision of who we are and what kind of world we live in, they can deepen our appreciation of the moral dilemmas we face and of the options available to us for responding to them" (1992:325). In doing this, however,

theologians must realize that what they have to say will have varying degrees of relevance to different audiences, "depending upon the degree to which those audiences share their theological premises" (1992:325). He concludes:

Religious ethicists (no matter what their denominational affiliation) should not feel they have compromised their integrity just because their message to outsiders is more limited than to members of their own religious communities. In the broader "marketplace of ideas" their view will be only one among many, and frequently in the minority. But this does not diminish the importance of the distinctive contribution they make, nor the possibility that others who hear them might just be led to see their moral lives differently. (1992:325)

David Novak, another Jewish thinker, recommends that Christians and Jews first speak to one another before speaking in the public domain to develop a "common ethical stance" toward many issues. This in turn might "demonstrate to the larger world that their common approach offers a more coherent means for dealing with specific ethical questions than secular methods" (e.g., the notion of *imago Dei* offers a more comprehensive understanding of the person than individual autonomy).

Campbell contends that beneath the answers to the questions that bioethics usually asks (e.g., what should be done or who should decide) are "fundamental issues that require a substantive account of the purpose of human life and destiny. These are common questions of meaning that religious communities have devoted considerable attention to in their theologies, rituals, and practical ethics" (1990:6). Hence, a major contribution of theology to bioethics may be to raise basic human questions that are generally left unaddressed by bioethics, thereby broadening our moral vision. These questions are about "the nature and purpose of life, and the place of health, medicine, suffering, and death within a vision of human nature and destiny" (1990:8).

In a recent article in the *Kennedy Institute of Ethics Journal*, Campbell asks: "What, if any, significance does such religious discourse have for public policy about active euthanasia?" He answers this way:

At stake . . . in the legalization of active euthanasia are the profound issues of human meaning and purpose, of identity and destiny. Such questions strike to the very core of our being and integrity as persons and as a moral community. . . .

. . . The most visible locus of engagement with such issues has historically been within religious traditions and their embodiment most identifiable in the caring practices of religious communities. The prophetic witness of these communities to the society involves bringing to public consciousness the ultimate dimensions of the euthanasia question and [functioning] as social critic if a society is reticent about accommodating such concerns in public moral discourse. (1992:275)

In addition to providing interpretations of fundamental human questions and serving a prophetic function, religious traditions and their theologies have at least two other roles. Religious discourse about virtues and dispositions can assist bioethics in placing particular decisions "within the context of a fuller account of purpose and meaning in life" and move our moral vision beyond the narrow preoccupation with decision making to a concern for the kinds of moral agents and communities we become. Furthermore, religious traditions may be helpful in reminding people of the limitations of an ethic of principles. While affirming what is true in a principle, they can also challenge its adequacy (e.g., though beneficence does convey a sense of moral obligation to and responsibility for the welfare of others, it appears minimalistic in comparison to the norm of neighbor love).

As Martin E. Marty observes from a historian's perspective

the overall trend has been toward at least some modest recovery of religion in the "bio-realm"; some reassertion of theology in bioethics; some resolution that churches have a part to play in providing health care; and, more, in interpreting illness and wellness or advocating and embodying measures of justice in delivery of care. (1992:288)

These recent forays into the relationship of theology and bioethics and the role of theology in public discourse about bioethics issues are heartening. The current formulation and language of bioethics—crafted largely by philosophers and lawyers intent on making them acceptable to a pluralistic, secular society—has been costly to both bioethics and theology (and, per-

haps, even to public policy). Bioethics as we know it today is seriously impoverished. Though it may do well what it does—provide principles for analysis and resolution of complex dilemmas—there is much that it does not do. It tends to lack both breadth and depth. Its vision of the moral life is constricted, and, in focusing so much on principles and actions, it fails to account for the interpretive frameworks people bring to their experience of illness, their search for health, and their struggle with death. Theology as it relates to bioethics is also impoverished. It has not adequately addressed how it is that people of faith might deal with the issues of bioethics out of the context of their religious convictions. Nor has it sufficiently developed interpretations of those human (and religious) experiences that are at the core of bioethics. Theology may yet regain its voice in the field, and it may yet be recognized as a legitimate voice in public discourse. It must first, however, find its voice. And here there is much work yet to be done.

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NOTEBOOK

An unusual new course at Chilton Memorial Hospital in Pompton Plains, New Jersey, is aimed at sensitizing nurses to the feelings, needs, and fears of elderly patients. Reporter Andrew H. Malcolm describes one exercise:

There they were, a roomful of nurses feeding each other crackers that crumbled on their chest, juice that dribbled down their chin, and spoons laden with orange Jell-O that tasted like grandma's punishment for sassing.

The women giggled at the awkward experience of being a dependent adult. It's silly at first, then strange, frighteningly confining and, well, downright demeaning after decades of independence.

You try it tonight too. Get in some pajamas with no back. Turn the heat down. Remove your glasses. And have someone feed you on their schedule, not yours. See if you pull back as unfamiliar fingers near your face. See if they place proper portions in your mouth when you want, in the order you want, without you feeling like an infant. Try to capture the moving straw with your mouth before it catches on your nose.

For atmosphere, line the room with linoleum and spritz blasts of bleach. Turn on two or three loud TV's nearby, each to a different program (but one must be "Jeopardy"). Have the children ring the doorbell and run around with paper megaphones paging people. Experience the need to request everything, even a bedpan. Sip tepid tea. See how good the institutional life is. See how long you're interested in eating. Oh, don't forget your pills in that dinky paper cup.

And imagine your reply to the cheery query, "Well, how are we today?"

(*New York Times*, 20 October 1992)

A combination of effective lobbying and growing congressional interest in issues of special concern to women has resulted in the most generous federal financing yet for research into breast cancer.

Before Congress adjourned in early October, it approved a budget of more than \$400 million for breast cancer research for the fiscal year that began in October. This is an almost threefold increase from the \$158 million budgeted last year for the disease, which strikes one in every eight American women and kills 46,000 a year.

Breast cancer research will receive more federal funds than research into any other kind of cancer; in second place is prostate cancer research, at \$39 million. By comparison, the federal budget for AIDS research is about \$1.2 billion in 1993.

(*New York Times*, 19 October 1992)

U.S. life expectancy at birth has risen steadily this century, to 75.4 in 1990 from 73.7 in 1980 and 47.3 in 1900. But life expectancy has been increasing in other countries, too, and the U.S. still ranks 11th out of 15 countries with traditionally low mortality rates,



according to Metropolitan Life Insurance analyst Stanley Kranczer. That's just about where the U.S. ranked a decade ago.

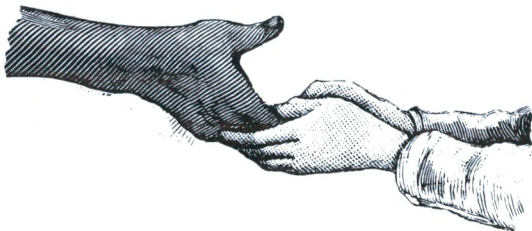
Japan has the highest life expectancy at birth in 1990 (78.9 years), followed by Iceland (78), Sweden (77.6), and Switzerland (77.4). Also ahead of the U.S. were the Netherlands, Australia, Norway, Canada, France, and the former West Germany. Trailing the U.S. slightly were Finland, Denmark, the United Kingdom, and New Zealand.

(*Wall Street Journal*, 19 August 1992)

Stephen Turner believes he has discovered the latest advance in eye surgery: 83-year-old Margaret Pickford.

Each Monday morning, Mrs. Pickford chats with patients on whom Dr. Turner will be performing cataract surgery. Then she dons her operating room clothes, slips off her rings, and holds each patient's hand during the operation. Two other hand-holders work on different days.

Patients, who are under local anesthesia, can't see during the operation and aren't supposed to move or talk. Having a hand to hold helps them to relax and



lowers their blood pressure and heart rate, the ophthalmologist says.

"Some people, particularly men, don't want the support at first," says Mrs. Pickford. "But they usually end up squeezing so tightly I think my hand is going to come off at the wrist." Since taking on the job in 1987, she has held the hands of about 1,400 patients. She recalls only three refusals, including "a very pompous tax collector" who later apologized.

Hand-holding "is nurturing and a distraction," says Eileen Moore, administrative nurse at the University of California's Pain Management Center in San Francisco, where staffers sometimes hold the hands of

patients. She adds: "I know I'd want someone to hold my hand during surgery . . . maybe we should give out teddy bears, too."

Though Dr. Turner says he "wouldn't want to perform the surgery" without hand-holders, he doesn't pay them. Jokes Mrs. Pickford, "I'm just doing my part to keep medical costs down."

(*Wall Street Journal*, 6 August 1992)

In a recent survey of physicians regarding health care reform, 14 percent of respondents favored implementing a federally financed national health insurance program, 81 percent favored reform through a combination of government and private programs, while 3 percent of physicians would resist any significant change in the U.S. health care system.

(*AMA News*, 27 July 1992)

According to a new study, women who smoke two or more packs of cigarettes a day during pregnancy are



twice as likely as nonsmoking moms to have children with behavioral problems.

"No one has clearly explained the link between maternal smoking and behavioral problems, but I can tell you there are more than 2,000 chemicals in cigarette smoke," says Michael Weitzman, M.D., of Rochester University, who conducted the survey of 2,577 mothers and their 4- to 15-year-old children. "We know that nicotine contracts blood vessels in the placenta, it increases the amount of carbon monoxide in the mother's milk, and it reduces the oxygen supply."

(*Chicago Life Magazine*, July 1992)

In an effort to test the importance of good looks, scientists at Philadelphia's Temple University painted a large purple birthmark on the face of a woman and sent her to ride the subway. She was instructed to fake an epileptic seizure, throwing herself down on the subway car floor.

"We wanted to see how long it would take before a Good Samaritan helped her," said Albert Klingman, professor of dermatology at the University of Pennsylvania. "Instead, the car emptied out right over her. We tried it three different times and no one even helped her." But when the same act was performed minus the "birthmark," help was readily offered. Adds Klingman, "Appearance is so important to our opinions of other people, it's almost disgusting."

The bias starts early. In an equally disturbing study, conducted by Judith Langlois, a psychologist at the University of Texas, mothers were shown to interact more with their newborns if the babies were cute. The good news, according to Langlois, is that "no



mother treated her baby unkindly. The bad news is the more attractive ones got a lot more attention." Langlois also videotaped three- and six-month-old infants looking at pictures of pretty and plain women. The infants consistently turned away from the plain faces and stared longer at the pretty ones.

(*San Francisco Chronicle*, July 1992)

The National Medical Association (NMA), the nation's principal black physicians' group, advocates a play-or-pay model for health care reform. In its August national meeting, the NMA House of Delegates adopted the proposal that would change Medicaid into a source of funds for all individuals whose jobs do not provide health care coverage. Hoping to get their idea out into

the public debate, the NMA plans to arrange a discussion among groups such as the Urban League and the NAACP to refine the proposal further.

(*American Medical News*, 24 August 1992)

A survey conducted by the National Association of People with AIDS (NAPWA) reports that more than one-fourth of their 800 respondents cited difficulty in obtaining health care services even when payment was available. The NAPWA's executive director, William J. Freeman, noted that education of physicians, particularly in their residency year, would reduce the problem.

(*American Medical News*, 24 August 1992)

A recent Harvard study has shown that

- every \$1 spent by the federal government on the Women, Infants, and Children prenatal program saves up to \$3 in hospital costs for low-birth-weight babies.
- every \$1 spent on childhood immunizations saves \$10 in later medical costs
- every \$1 spent on comprehensive prenatal care through Medicaid saves \$3.38 in later health care costs
- every \$1 spent on early childhood education saves \$6 in later special education, crime, and welfare costs.

(*Voices for Illinois Children*, Fall 1992)

Efforts to prosecute pregnant women who expose their fetuses to narcotics have recently been rejected. Two state supreme courts have ruled that criminal penalties are inappropriate in such cases.

In Florida, the state's highest court ruled unanimously that a law aimed at drug dealers could not be applied to pregnant women. A mother had been convicted in a lower court of drug trafficking by delivering narcotics to the fetus through the umbilical cord. Her defense had been supported by the AMA and by other medical and civil rights groups, which contended that treatment, not prosecution, was the most

effective way to deal with drug-addicted mothers and to protect their children. Connecticut's supreme court, in a similar case, held that authorities had acted improperly in taking a baby away from its mother because the mother had used cocaine shortly before going into labor.

Both cases cut across complex legal, emotional, and ethical issues, but it has become clear that criminal prosecution is inappropriate. The decisions are part of a growing number reflecting this view. The Center for Reproductive Law and Policy reports that at least 165 women across the country have been criminally charged for exposing their fetuses or infants to controlled substances. Many of the charges were dismissed, and some mothers pleaded guilty, but in all of the 19 cases that have gone to appellate courts the convictions were overturned.

Evidence continues to accumulate indicating that threatening a pregnant, drug-abusing woman with prosecution will not protect the health of the fetus. Fear of prosecution is unlikely to influence a woman to discontinue drug use early enough to reduce significantly the hazards to the fetus. Moreover, withdrawal has the potential to complicate pregnancy and threaten fetal health. Also, a state-mandated policy of prosecution would discourage women from contacting health care professionals. Finally, many physicians have noted that if no risk of prosecution is involved, pregnant women are one of the most receptive groups for drug abuse therapy, primarily because of their concern for their unborn children.

(*AMA News*, 17 September 1992)

War has a clearly detrimental effect on health, but it has seldom been a topic addressed by health care givers, especially nurses. But Joanne M. Hall and Patricia E. Stevens believe that the nursing profession



has an obligation to "encourage nurses' visible involvement in public policy about war and its health consequences." Looking back at the Gulf War a year later, they note the United Nations and World Health Organization's prediction that "deaths from infectious diseases in Iraq will outnumber the civilian and military deaths from allied bombing." They continue:

The infrastructure of Iraq was totally decimated. Immobility, isolation, inadequate treatment of sewage, and shortages of water, food, shelter, electricity, heat, drugs, and medical supplies made epidemics, malnutrition, exposure-related trauma, and mental decompensation inevitable for Iraqi civilians. Cholera, typhoid, and meningitis thrive in such conditions. . . . the deadliest effects appear after global attention has moved elsewhere; thus moral responsibility can be denied and popular revulsion avoided.

And there are consequences both for American combatants and their families and for the larger society: "The aftermath of this war is likely to have an impact on psychosocial health in the United States into the next century. Nurses must not settle only for military and media explanation that obscures the human costs of war."

(*Nursing Outlook*, May/June 1992)

Experts are predicting that by the year 2000 managing the AIDS epidemic will have become one of the world's largest economic and social concerns. By that time, the pandemic will have moved out of the cities, where it is largely concentrated now, and into more rural and remote areas. Rates of transmission in places like Southeast Asia will have grown to match those seen in Africa. The vast majority of cases (probably over 97 percent) will involve transmission via heterosexual intercourse. Younger and younger people will be exposed to the virus. Women will constitute 50 percent of the infected population. In total, WHO expects 30-40 million adults will be infected with HIV by the end of this decade. The Harvard-based Global AIDS Policy Coalition is even more pessimistic, anticipating at least 38 million adult cases and perhaps as many as 100 million. Both agencies estimate the number of children infected with HIV will have swelled to over 10 million.

A recent study by leading economist Nariman Behravesh published in *U.S. News and World Report* predicted that if the higher estimate is correct, the worldwide cost of the pandemic could reach \$356–\$514 billion by 2000. The worst-case scenario projects that by the end of the decade the annual cost of the HIV pandemic could equal 14 percent of the world's total gross domestic product. This would be the financial equivalent of removing both Australia and India from the world economy. In the United States alone, the pandemic could drain \$81–\$107 billion from the economy.

(News Journal of the Physicians Association for AIDS Care, July/August 1992)



The effects on a woman's mental health of having an abortion have long been disputed. According to Dr. Nada Stotland, a University of Chicago psychiatrist, claims that women who undergo legal abortions suffer severe and lasting psychological damage are not supported by scientific evidence.

After an extensive search of the psychiatric and psychological literature, Dr. Stotland concludes that the so-called abortion trauma syndrome—unexplained depression, “hardening of the spirit,” thwarted maternal instincts, intense feelings of guilt, and thoughts of suicide—may be fictional.

Stotland found in her research that although there is evidence that some women suffer temporary feelings of stress, guilt, and sadness after abortions, such emotions normally diminish over time. The bulk of the research, however, overwhelmingly contradicted the existence of a postabortion syndrome, she said.

In one study of 360 women interviewed just before they had abortions and 18 months afterward, researchers found that the majority expressed feelings of relief and demonstrated significant improvement in personal relationships and psychiatric symptoms. In a similar study of 207 women, 94 percent reported that their mental health improved or remained the same after they terminated their unwanted pregnancies.

A British study found the incidence of diagnosed psychiatric illness and hospitalization is considerably lower after abortion than after childbirth. The British researchers found that psychosis occurred in an average

of 1.7 cases per 1,000 after delivery and in 0.3 cases out of 1,000 after abortion.

A similar investigation was undertaken by Dr. C. Everett Koop in the late 1980s when he was surgeon general under Ronald Reagan. “What he discovered,” Stotland said, “is that the available scientific evidence does not demonstrate significant mental health effects, negative or positive, of abortion.”

Dr. Wanda Franz, a developmental psychologist and president of the National Right to Life Committee in Washington, challenged studies that she said “reflected a pro-choice bias,” adding, “We need more studies that are long-term and grief-sensitive.”

(Chicago Tribune, 23 October 1992)



If you treat a patient like a person rather than an illness, will they get better faster? That is the question behind a \$2 million experiment being conducted on the sixth floor of Beth Israel Medical Center in New York City.

An entire hospital floor has been completely renovated so it looks warm and welcoming to patients, and a staff of 54 is being retrained to make hospital stays more comfortable and less stressful. Across the U.S., four other hospitals, one small, one rural, one mid-sized, and one exclusive, are trying out the same so-called Planetree units in a study that, its sponsors hope, will scientifically determine whether there is a benefit to being nice to people.

“In a way, it's unfortunate that we have to call something that's so intuitively correct an experiment,” said Dr. Steven F. Horowitz, chief of the cardiology division of Beth Israel and medical director of the Planetree unit there. “What we are really asking here is, ‘When do patients heal?’ I'm not sure. But I can tell you when they don't heal. When they're sleep deprived. When they're agitated, trying to get another blanket. When they're afraid, because no one explains things to them.”

Studies of patients at the original Planetree unit, created seven years ago at what is now Pacific Medical Center, showed that they were more satisfied with their hospital stay than patients on other wards, understood their illnesses and medical needs better, and were less likely to require rehospitalization. Similar studies of staff members have found higher

levels of satisfaction and lower turnover rates among those working in the Planetree unit.

In addition to using questionnaires to measure levels of satisfaction among patients and staff members, Beth Israel is developing ways of comparing such things as depression levels, immune-system strength, rates of rehospitalization, and the need for pain medication in Planetree patients with those elsewhere in the hospital.

Added touches to the Planetree unit include fresh muffins, baked daily by the floor nutritionist, piano music coming over the hallway speakers, and overhead light fixtures designed to be easy on the eyes of the patients lying on their backs on stretchers. Medical equipment such as resuscitation carts and spare wheelchairs is stored out of sight. Doctors, nurses, and therapists who work in these wards are taught to include patients as much as possible in daily care—providing and explaining medical books, for instance, so that patients can make informed decisions.

“This is where I want to be from now on,” said Howard Wheeler, a 31-year-old patient with kidney

disease who has been hospitalized 10 times this year.

Several doors away, 80-year-old Maggie Mattox, hospitalized for shortness of breath, also raved about the new floor—particularly the food. “The food on this floor is wonderful,” she said. “So much better. On the other floor I couldn’t eat anything, I just sent it all back. Here I eat everything.”

Mattox’s appetite, Dr. Horowitz said, is perhaps the best evidence of the power of ambience to heal. The food on the Planetree unit, he said, is exactly the same as elsewhere in the hospital.

Dr. Horowitz is aware that some in the hospital believe that nearly \$2 million is a lot to spend to coax an elderly patient to eat her dinner, but he believes the cost is an investment. If Planetree units can be proven to work, he said, then the lessons learned can be applied to all new hospitals as they are built.

“The whole hospital should work this way,” he said. “If this works I can see administrators all over the country with cartoon light bulbs over their heads saying ‘Caring. What a concept!’”

(New York Times, 26 September 1992)

BOOKS

Feminist Ethics

Karen Lebacqz

Susan Sherwin. *No Longer Patient: Feminist Ethics and Health Care*. Philadelphia: Temple University Press, 1992.

FEMINIST CRITICISMS OF MEDICAL PRACTICE ABOUND. So do feminist texts in philosophy. But to date there has been no single, sustained effort to connect feminist analysis with the mainstream of bioethics. Into this hiatus Susan Sherwin steps, with happy results. Sherwin offers a feminist approach to health care that provides an introduction to feminist methodology in ethics, applies that methodology to several traditional bioethics issues such as abortion, medical research, and paternalism, and then suggests new agendas for bioethical investigation. Here at last is the book we have been waiting for: one that will move feminism into the vanguard of bioethical discourse. As a feminist working in the field of bioethics, I welcome Sherwin's contribution as a possible classic in the field and as the beginning for an ongoing dialogue.

Although feminism does not provide a single, comprehensive theory, Sherwin nonetheless argues that its strands contain a common core: the perception that women are systematically oppressed, that the personal is therefore political, and that the political is

also personal. What happens to a woman cannot be separated from larger social, economic, and political structures, and particularly from the arrangements of power in society. Our reality is socially constructed, and it is the task of feminist analysis to unmask that construction and to suggest new constructions.

In a world permeated by sexism, argues Sherwin, it is necessary to illuminate the oppressions inherent in the arrangements of women's diverse lives. "In a world where women are oppressed, an adequate ethics must address that oppression" (p. 57). Thus any true ethical analysis, in bioethics as elsewhere, must begin with the concrete realities of oppression for women. Since feminism is "the recognition of the pattern that runs across these diverse social arrangements and connects the various manifestations of sexism" (p. 19), Sherwin operates from a feminist perspective.

Sherwin's approach to feminism is eclectic. She draws from liberal, Marxist, and radical feminism and attempts as well to incorporate criticisms of "womanists" (feminists of color) and of other schools of thought. For those not familiar with the developing schools of feminist thought, her review of these positions is cursory but illuminating.

Sherwin distinguishes feminist ethics from both traditional and "feminine" ethics. Traditional ethical theories—deontological, consequentialist, and contractarian—all put autonomy in a central role. Historically, they all also denigrate women. For example, they identify male patterns of thinking as constituting rationality and deny rationality to women's ways of knowing. "Feminine" ethics (such as Noddings's early book *Caring* and Gilligan's *In a Different Voice*) therefore attempt to lift up the particular gifts and experiences of

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women as new ways of knowing and propose that women bring a moral point of view different from that brought by men but equally valid.

Feminist ethics is yet again different. "It derives from the explicitly political perspective of feminism, wherein the oppression of women is seen to be morally and politically unacceptable" (p. 49). Hence, feminist ethics rests not simply in recognition of women's distinctive practices and experiences but precisely in a political critique of oppressive practices. While both feminine and feminist ethics reject the paradigm of moral subjects as autonomous, stressing instead our embeddedness in social context, feminist ethics always asks how the particular issue under consideration relates to patterns of oppression of women.

Feminist ethics is contextual. "To speak meaningfully about justice," proposes Sherwin, "it is necessary to examine the actual forces that undermine it, as well as those that support it" (p. 55). There can be no abstract principles apart from consideration of actual circumstances.

To argue for such a contextual approach, however, is to run the risk of moral relativism. Sherwin's attempt (in chapter 3) to draw on epistemological theory in order to find an alternative to either ethical relativism or ethical absolutism is one of the most helpful aspects of her book. Since feminists want to criticize social arrangements, including the arrangements of medical practice, it will not do for them to assume that everything is merely contextual. To do so would be to forgo the right to criticize another context or culture and its practices. For example, feminists would not be in a position to criticize clitoridectomy or foot binding in spite of their appalling impact on women's health. How are we to get around this problem without adopting the ethical absolutism that has characterized so much of Western ethics?

Sherwin proposes that simply adopting community standards will not do. We must ask not only what community standards are in place but how they were reached, whose interests they serve, and what procedures are in place that allow for discussion and change. Not all moral standards are acceptable. If we look at how they developed, we often find a history of oppression. The standards cannot be judged apart from the history of the community, but from a feminist perspective, that history is often not reliable. Such a historical approach allows not only for tolerance

of differing community values but also for criticism of a community's practices.

With this introduction to feminism in mind, Sherwin turns to the question of bioethics. Here, she notes that on the surface traditional bioethics and feminism appear to have much in common: both have and use principles such as not harming or nonoppression, and both focus on concrete cases, lifting up certain aspects of the context and rejecting any simple focus on principles alone. Nonetheless, Sherwin argues that traditional bioethics has not been feminist. "Political analyses of the unequal power of women and men, of white people and people of color, of First World and Third World people, of the rich and poor, of the healthy and the disabled, and so forth are central to feminist ethics. To date, that sort of analysis has been almost entirely absent from the literature of mainstream medical ethics" (p. 84). Concern about the political role of medicine—its part in unjust power arrangements in society—is central to feminist bioethics and almost entirely lacking in other approaches to bioethics.

While both feminist bioethics and mainstream bioethics urge a focus on context, then, they differ in how they define the important context. For feminists, the context that matters is the interlocking system of oppressive practices. It is these, above all, that must be lifted up if we are to have an adequate biomedical ethics.

This is the task Sherwin takes on in the second and third parts of her book. She turns first to some troubling questions that have received considerable ethical analysis in the bioethics literature—abortion, in vitro fertilization, paternalism, scientific research. In each case she attempts to show how a feminist perspective brings new insights and prompts new questions. "From a feminist perspective," for example, "the central moral feature of pregnancy is that it takes place in women's bodies and has profound effects on women's lives" (p. 104). Thus a feminist looking at abortion can never settle the matter by asking whether the fetus is "human." Rather, a feminist asks about the social and political conditions under which women become pregnant and under which women will live following abortion or live birth.

Feminists also note that anti-abortion campaigns tend historically to arise in direct correlation with movements toward women's increased freedom, thus

suggesting a hidden agenda of keeping control over women by denying access to abortion. These larger political and social patterns must be taken into account when assessing the morality of abortion. From a feminist perspective, the appeal to reproductive freedom for women is not simply a reiteration of traditional values of autonomy. It is rather "the freedom for women to choose their status as childbearers, which is especially important in the face of the social, economic, and political significance that is associated with reproduction for women" (p. 133).

Finally, Sherwin suggests that if we take this political agenda seriously, there will be new questions to be asked that have not been addressed well in the bioethics literature. The "medicalization" of reality (the social construction of reality as medical phenomena) has already received considerable attention from feminists, who decry the tendency for the medical profession to control women by declaring normal bodily functions to be diseases. Feminists are also skeptical about how the medical profession contributes to power arrangements in the sexual arena by declaring sexual orientations or habits to be medically "normal" or "healthy" or otherwise. And finally, feminists, especially feminists of color, have pointed out the serious connections between ill health and oppression. This calls for a new paradigm for medical ethics: "once we recognize the need to include oppression as a factor in health, we can no longer maintain the authoritarian medical model, in which physicians are the experts" (p. 239). To spell out this paradigm in detail will require, says Sherwin, the democratizing of the entire enterprise of bioethics. It is to that agenda that she invites her readers.

NO LONGER PATIENT DESERVES TO BE "MUST" READING for everyone in the field of bioethics—ethicists, health care providers, and policymakers. Those not familiar with feminist approaches to ethical issues will find here a clear and cogent introduction to feminist thought. Disputes within feminism are noted (for example, Marxist feminists make economic agendas central, while radical feminists believe that differentiation along gender lines is central to oppression), but the common core of feminist affirmation is given voice. Most important, Sherwin makes clear what *difference* it makes to be a feminist by showing how a feminist approach to several traditional questions in

bioethics differs from the standard approaches in bioethics.

One of the genuine strengths of the book is Sherwin's discussion of ethical relativism. Here not only does she challenge feminists to do significant work in ethical theory, but she goes beyond the traditional literature in ethics as well. In a day of cultural pluralism and cross-cultural dialogue, Sherwin's discussion of ethical relativism is salutary.

Sherwin is also to be commended for holding justice and caring together as important norms in feminist thought. Like Noddings (1984) and Gilligan (1982), most feminists have lifted up values of caring and relationality as central to feminist thought. But such a focus runs the risk of becoming a double bind, in which women are seen as more "caring" than men and therefore continue to be confined to socially constructed caregiving roles. Sherwin's emphasis on social justice provides an important corrective. She keeps feminism from becoming care oriented by always pushing for the criticism of patterns of oppression. And yet, as Sherwin indicates, an important agenda lies ahead if bioethics is to be permeated with feminist thought and practice.

First, there are the internal debates within feminism. Does eclectic feminism work? Can one avoid the weaknesses of particular schools of feminism by choosing selectively the strength of each? Or does the eclectic approach simply leave one without a clear theoretical foundation? While my own approach to feminism is also largely eclectic, there are unresolved questions here about the feminist base from which bioethics is to be done. For instance, whether we take economics or gender to be central to women's oppression may have serious implications for feminist approaches to health care.

Second, Sherwin argues for historical and political analysis of patterns of oppression. In her review of traditional problems and her proposal for new foci within the field of bioethics, she attempts to provide such analysis. But her reviews are often rather general, not punctuated with the statistics and evidence needed to convince some. Those not familiar with the feminist literature may not know that such evidence does in fact exist. There is a need in the feminist literature to bring together social analysis and ethical theorizing. Sherwin's eminently sensible approach to the issues may, ironically, blunt some of the force of

her arguments. The reader is lulled into saying "yes" but fails to realize how radical a response that "yes" is.

Third, there are unresolved ethical issues that must be confronted within feminism in order for feminists to contribute to debates in bioethics. If "reproductive freedom" for women is not to be taken as synonymous with autonomy, traditionally defined, then what does it mean? Is reproductive freedom always compatible with justice, or are there places where freedom might have to be curtailed in the interest of justice? If everything is distorted by social constructions of reality, then do we even know what it would mean to be "caring" or how to fit caring into a feminist ethic?

Fourth, Sherwin works from a primarily philosophical base. Does feminist *theology* have something to contribute here that might again open up the discussion? Philosophical ethics itself needs to be "deconstructed" and "reconstructed" from a feminist perspective. Theological feminism might have something to contribute to this task.

Fifth, and a related concern: if feminist ethics is truly to combine a concern with context and a focus on principles, then attention will be needed to the principles that might emerge from a feminist standpoint. Sherwin proposes a principle of non-exploitation or nonoppression. She also notes that most feminists argue strongly for women's control over their own reproductive capacities. But other principles might be important as well. For example, if relationality and caring are central to feminist ethics, then some principles drawn from covenant traditions might be applicable. There is much work to do to elaborate what a feminist bioethic would truly be.

It is to such future agendas that Sherwin invites us all. If we do not answer the invitation, the field of bioethics promises to stagnate. If we do answer it, we have the hope of a new approach to bioethics that genuinely addresses patterns of oppression in our world.

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Caplan Essays

Dennis Brodeur

Arthur Caplan. *If I Were a Rich Man Could I Buy a Pancreas? and Other Essays on the Ethics of Health Care*. Bloomington: Indiana University Press, 1992.

ARTHUR CAPLAN HAS COMPILED A NUMBER of previously published articles and two new additions into a book. The reprinted articles reflect his work through the 1980s. As he states in his introduction, no overarching ethical methodology ties together this disparate group of articles, but there is continued interest in the topics covered and the original articles are scattered and not readily accessible.

The elusive search for a "foundational ethic" of health care in this century is not Caplan's concern. Rather, he states that the articles collected should be evaluated on the basis of the degree to which they contribute to a pragmatic endeavor. Do the articles help determine the nature of a problem, pinpoint the source of issues, and determine whether it is possible to do anything about them? The essays provide philosophical analyses of particular ethical questions. Readers interested in exploring theological and religious aspects of the topics will not find much to whet the appetite.

The collection of essays is divided into six sections. Not surprisingly, given Caplan's practical concerns, there is no explicit discussion of moral methodology, although certain normative themes are apparent—particularly in his discussions of organ transplants, animal and human experimentation, and money, medicine, and morality.

The strength of the collection lies in part 4, "Transplants and Other Unnatural Acts." Readers familiar with Caplan's ground-breaking work on transplants, required-request laws, and xenografts (tissue grafts between members of different species) will find familiar ethical analyses. Issues include obtaining the consent of family members to retrieve organs from the recently deceased, family conflicts,

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the role of professionals, cost concerns, and a benefit-burden analysis of transplantation. The ethics of organ procurement are reviewed, and the essay that lends its title to the book addresses the practical realities of transplant decisions for hospital personnel and donors or their families. The recent case in Pittsburgh in which a baboon's liver was transplanted into a person confirms the continuing relevance of Caplan's excellent summary of the ethical issues involved in xenografts. The issues outlined in that 1985 article are no more resolved today than when the article first appeared.

Other ethical dilemmas involved in organ procurement that Caplan outlines also remain unresolved. How does society establish a protocol for requesting organs from a dead person's family or from the family of a person expected to die soon? Should laws be changed to presume consent to organ donation? How should these issues be addressed in the health care community and society at large? The ethical questions surrounding organ donations surface throughout the book—in sections on consent, the cost of new technology, rationing health care, and cost containment.

The second section of the book addresses ethical concerns in human and animal experimentation. Chapters 5 and 6, on social science research and the "duty" to serve as a subject of biomedical research, review ethical principles that are not new but that are still on the front burner of research ethics. Chapters 3 and 4 are better organized and provide an introduction to the issues, examining when animal experimentation is ethically justified and then exploring procedural concerns when animal experimentation is warranted. Militant antivivisectionists will not be satisfied with his arguments, but this is a well-argued conservative approach to respect for animal rights and human needs.

The chapters on transplants, human experimentation, and animal experimentation give the reader the clearest peek at Caplan's ethical methodological bias. One sees there his balanced commitment to human needs, societal concern, and the protection of rights. The chapters do not explore the philosophical foundation for his moral claims, but readers can sense Caplan's commitment to medically beneficial progress in transplants and experimentation and the need for society to think carefully about an ethic of obligation to care for, cure, and treat those in need. His essay

"Hard Data Is the Only Answer to Hard Choices" reiterates his arguments for a societal obligation to the sick and needy.

However, chapters that deal with choice and autonomy do not explore any social issues or concerns. The principle of autonomy and choice is addressed in the context of care for the aged, the chronically ill, and those in need of rehabilitative services. Caplan tackles the problems of consent for those who are not always competent to make medical decisions, for those who require long-term treatment and care due to trauma or disease, and for the institutionalized "long-term-care" population. He rightly points out that issues of consent for those in need of chronic care or rehabilitative services differ from those of acute-care patients. The number of caregivers, the duration and process of treatment, and other factors affect the consent form.

In "Can Autonomy Be Saved?" Caplan analyzes the mandatory requirements of the Patient Self-Determination Act and the proposals for values histories and values baselines—especially for the aged. The analysis of procedures to identify value choices through various advance directive forms is interesting, but it does not get to the heart of the matter of limits to the principle of autonomy.

Recent writings in biomedical ethics question the limits of autonomy. Can patients or their surrogates demand certain "useless," "futile," or "minimal outcome" treatments? How should one balance allocation and rationing choices with patient and family wishes? Is there no moral common ground for discussing limits to decisions about the acceptance, withdrawal, or refusal of medical treatments? The chapters on autonomy and informed consent do not address these critical concerns.

Caplan seems to suggest that patient choice, based on legally or medically appropriate advance directives, should be followed. However, this begs the question of the limits of patient autonomy, personal choice, and medical resources. Here the lack of any ethical methodology becomes problematic, for there is no basis for proscribing interventions on grounds of medical futility or of rationing principles. Perhaps he believes that no rationing is necessary. However, this is precisely the question being raised by many today. In the final section of the book on money, medicine, and morality, he discusses rationing and makes reference to the fact that this is the fodder of ethicists' work

today. It is one of the major issues of the current debate. Should society allocate certain health care resources? If so, what does this mean for personal autonomy—even in a value-based context? If autonomy is to be limited, should it not be for some publicly debated and consensual ideal? If so, does a value-based previous directive trump other medical and societal decisions? Caplan offers no clear argument about whether there is a limit to autonomy or whether autonomy needs to be saved. The autonomy question raises issues of professional judgment, allocation of resources, the rationing of allocated resources, and personal and social decision making that are not addressed. An examination of choice by the aged in the present legal and moral context does not advance this important debate.

There are many years of research and development ahead for the Human Genome Project, which will stimulate moral arguments for many years to come. Newcomers, particularly, will benefit from the analysis Caplan provides in his excellent chapter "Mapping Morality: Ethics and the Human Genome Project." This chapter addresses fundamental concerns about the relationship of science (supposedly morally

neutral) and the applications of science to the concept of human life and life in society. No startling new ethical principles appear in the chapter, but it does bring together a variety of ethical and scientific concerns about this project and its possible implications for what it means to be "human," to be "sick," or to be in need of "care."

Readers familiar with Caplan's insightful work over the last 15 years will find a confirmation of his basic insight and philosophy in this volume. Those not familiar with his work will be introduced to both sides of ethical arguments about many topics of current debate. Readers who are looking for a consistent and thorough philosophical grounding and approach to health care ethics debates will not find one. But he promised it would not be there! Nonetheless, most of the chapters offer practical solutions to difficult ethical dilemmas. Some who disagree with Caplan will do so for methodological reasons. Others will do so because they do not share his assumptions, reasoning, or values. Whether one agrees or disagrees with Caplan, the book merits careful reading. It captures the insight and wisdom he has brought to these ethical dilemmas over the last two decades.

LITERATURE DIGEST

On nurses and caring

Hilde L. Nelson, "Against Caring," *Journal of Clinical Ethics* 3, no. 1 (Spring 1992): 8–15.

Nel Noddings, "In Defense of Caring," *Journal of Clinical Ethics* 3, no. 1 (Spring 1992): 15–18.

Toni M. Vezeau, "Caring: From Philosophical Concerns to Practice," *Journal of Clinical Ethics* 3, no. 1 (Spring 1992): 18–20.

RECENT MEDICAL ETHICS LITERATURE, particularly that written by and for nurses, has shown interest in the feminist-generated "ethic of caring." This trio of articles examines an ethic of caring from three perspectives. Hilde L. Nelson offers a scathing critique of an ethic of caring as a model for the nursing profession. Nel Noddings, the most articulate proponent of an ethic of caring, responds to what she considers Nelson's complete misunderstanding and misrepresentation of the ethic of caring. Toni M. Vezeau, a practicing nurse, concurs with Noddings and likewise raises serious questions about Nelson's portrayal of both the nursing profession and responsible ethical reflection.

Because the ethic of caring has been embraced as an appropriate ethic for nurses, Nelson addresses her remarks to nurses and uses examples involving nurses to illustrate her points. Nelson draws on Noddings's work for a definition of the ethic of caring: "a local ethics in which we maintain our relationships by a daily round of care for family, friends, and the 'proximate stranger.'" She finds an ethic of caring, compared to an ethic of justice, not only inadequate

but dangerous; because an ethic of justice has been sufficiently critiqued, however, she offers a third alternative, an "ethic of attention."

Nelson criticizes an ethic of caring from what she calls procedural and methodological angles. Under procedural points, she finds that the term *caring* has not been well-defined. Moreover, literature on the concept is theoretically inconsistent or irrelevant. For Nelson, vaunted notions of women's subjectivity and intuition praised by the "feminine nurse-caring movement" often become incoherent.

Nelson finds an ethic of caring, in addition to being conceptually confused, "dangerously narrow in scope." It does not require us to test our values against universal reason, as does the impartial ethic of justice; it can obtain only local, parochial agreement. Clinically, it leaves nurses in the limited setting of the "lived experience" of day-to-day care and gives them no conceptual tools for examining broader concerns like societal health care or effecting systemic change in the social order.

Furthermore, an ethic of caring, according to Nelson, is "ultimately exploitative." This exploitation arises on two fronts. First, although she understands Noddings's rejection of justice as an abstract principle used to justify many evils, including the subjection of women, Nelson charges that caring is "blind and indiscriminate," not subject to any regulation or direction (that is, it can be directed toward worthy or unworthy objects). Nelson believes that without principles we will be unable to resist doing evil to strangers and intimates. Without principles, the parochial ethic of caring tends dangerously toward racism, xenophobia, and care only for the present generation.

But an ethic of caring tends to exploit a second group: women, and in particular, nurses. For Nelson, Noddings's characterizations of care suggest unidirectionality and selflessness. This selflessness, says Nelson, encourages the ideal of womanly sacrifice and reinforces oppression. For the nurse following patient advocacy theories rooted in an ethic of caring, it means that patients decide their care and the nurse simply carries out their wishes; it is "slave-caring . . . the slave master's fantasy of the loving mammy who, acting out of others' motives rather than her own, lavishes care on the master's son so that he may grow up to become a master (perhaps her master) himself." Nelson also criticizes Noddings's notion of "self care" as being *selfless* because it focuses on helping the caregiver care for others. In summary, "the ethics of care . . . cannot keep the nurse from harming herself in her interactions with patients."

Should such a flawed ethic be retained and corrected? Nelson does not think so. Attempts to "stir" justice into the ethic of caring will not work. Nor will replacing the ethic of caring with the old, absolute, impartial ethic of justice. Nelson proposes that the nursing profession consider what she calls a particularist ethic—an ethic of attention.

To describe this particularist ethic, Nelson draws on the writings of Simone Weil, Iris Murdoch, and Martha Nussbaum. She likens it to the loving attention found in the gaze of an artist toward a human reality. Such deliberate attention involves seeing justly, lovingly, clearly, and realistically.

What links such careful scrutiny to ethics? Nelson cites Socrates' dictum "the unexamined life is not worth living," which she calls his "knowledge." Nelson finds the guide to virtuous action in the ability and habit of seeing clearly the details and nuances of a situation. Such careful attention becomes habitual, and, according to Nelson, provides moral direction. But by itself a careful gaze will not promote moral behavior; it must be accompanied by a commitment to right action and a sense of obligation.

Nelson believes that the ethic of attention corrects the inadequacies of an ethic of caring. She suggests that, although like caring, attention seems overly other-directed, as it matures, the attentive gaze will return from its focus on others to the self. This will result in less self-denial, more self-knowledge, and fewer illusions about the objectivity of decisions. This

mature gaze has the goal of principled and loving knowledge of all the particulars of a situation. Fineness of perception, in conjunction with principles of rights and utility, says Nelson, will keep us from treating strangers carelessly.

This ethic of attention, according to Nelson, improves upon the abstract principles that have served the purposes of those who have the most power. It also has the capacity to address broader social questions because it begins with nursing care directed toward strangers, which has a "social intimacy" different from care for family. Nelson maintains that her ethic of attention still allows for the uniqueness of each of those personal relationships found in nurse-patient interactions. Moreover, the ethic of attention, Nelson asserts, can resist a tendency toward the subjugation of women, foster personal integrity, and promote awareness of larger social issues.

Nelson admits two weaknesses in her ethic but does not consider them fatal. First, perceptions of situations clearly will differ from person to person; she does not resolve this difficulty. And second, though this ethic of careful, just, and loving scrutiny seems idealistic, morality, says Nelson, should provide a goal to strive toward; she closes with the story of Sir Galahad, advocating his heroism rather than the caring of a suburban mother as an appropriate model for nurses. Nurses, and all of us, should become people who miss nothing, who pay attention with sensitivity and intelligence to all that occurs around them.

Noddings maintains that Nelson has misunderstood her work. Using quotations from her text, *Caring*, Noddings shows that she does not advocate selflessness and pathological caring. Nor does her concept of "motivational displacement" enjoin a warped sense of living solely for others: "Caring, as I have described it, is mainly a relational—not an individual—attribute or virtue. From this perspective, a person is a relational entity. When I maintain my capacity to care, I maintain my *self* in the deepest sense; I maintain my capacity to participate in caring relations." Caring, says Noddings, is not self-abnegation, as Nelson charges. Such a conclusion may be drawn when we mistakenly think of persons as permanent carers. For Noddings, however, if the self is maintained in the best sense of that term, the person preserves her capacity to engage in caring relations in which she is sometimes cared for and sometimes carer.

Neither should we assume that Noddings's ethic of caring would let the patient do whatever he or she wants (in fact, Nelson's description of this situation is structured less by an ethic of caring than by an ethic of autonomy). In any decision, the entire network of care should be considered. Noddings further admits that care does not correct the undervaluing of females, but she maintains that justice may not necessarily do so either, even though it pronounces all people equal. While noting that "neither caring nor justice necessarily affects behavior," Noddings suggests that care may better educate interpersonal actions because of its use of "small narratives."

Noddings is puzzled by Nelson's attacks, as she finds points of contact between an ethic of caring and an ethic of attention. She maintains that she and Nelson fundamentally agree on the importance of attention. Noddings, however, prefers the term *engrossment* to attention, even though it is vulnerable to a mistaken, sentimental interpretation. Noddings uses the term *engrossment*, which she likewise develops using Weil and Murdoch, because she considers two capacities significantly different—intellectual attention and interpersonal attention; Noddings holds that these are not always contained within the same person.

The real point of contention Noddings sees between her ethic and the particularist ethic of attention is Nelson's need for a grounding principle of right and wrong, a master narrative of morals. If one has the habit of attention and sensitivity—Nelson's ethic—and a mature sense of responsibility—the companion Nelson gives to her ethic—why does one need a grounding theory? Noddings holds that the well-developed sense of obligation comes from the habit of *motivational displacement* (her term for seeing others' concerns as our own): If I truly feel the pain of the oppressed and allow this feeling to lead me, I will aid them without needing to consult other principles. Finally, Noddings notes that while an ethic of caring may not provide a theory for developing more just social procedures, it can give direction. An ethic of caring is capable of addressing social problems, but further work must be done to demonstrate this.

Caring is what Vezeau does as a nurse; it is her "lived experience." Consequently, she sides with Noddings and pointedly criticizes Nelson's views. For Vezeau, Nelson misunderstands nursing and devalues

nurses' capacities for intellectual and moral reflection. Vezeau maintains that, in addition to making moral decisions that are contextual and local, nurses can relate one context to another and thus imagine alternatives not seen in the present situation.

Moreover, Vezeau claims, Nelson misunderstands not only nurses but "caring as it is lived in nursing practice." For Vezeau, caring is not a theoretical norm for interaction but a reality, existing only in a valued relationship. Caring does not involve rules and flow charts, but *verstehen*, understanding, of the people cared for. *Verstehen* is different from Nelson's *attention*: attention is objective, unrelated, reductionistic observation while *verstehen* is local knowledge of patients, developed by nurses working toward whole-self relationships (involving senses, feeling, and spirit) with particular patients.

Vezeau counters Nelson's portrayal of caring nurses as "altruistic drones." Nurses are in the field of care because they value "the relationship," which provides the opportunity to learn what it is to be human. This is possible because caring is not unidirectional but part of a mutual and reciprocal relational context. Moreover, Vezeau's description of caring communicates its inherently moral, because teleological, character: "Caring in nursing practice is not limited to 'caring about,' as Nelson asserts. We care *for* and *toward*." Vezeau's more lived and nuanced discussion of caring illustrates how nurses are able to care and still maintain their identities: "To assert otherwise is to perpetuate the sexist view that women cannot be intimate without losing themselves in the process."

After challenging Nelson's portrayal of nursing and caring, Vezeau turns to what she believes underlies Nelson's charge: a strong discomfort with the ambiguity of actual ethical decision making. Vezeau finds in Nelson a contradictory desire for an ethical framework that is at once specific, broad in scope, and open to variability in decision making. But ambiguity, Nelson's enemy, is the stuff of the moral life; for Vezeau, "The purpose of an ethical framework is not to provide formulas to solve the predicament, but to carve out a place for the discussion of ambiguity." Caring, comfortable in the shadings of ethical deliberations, helps create this space. The uncertainty embraced by an ethic of caring keeps it from becoming, as feared by Nelson, too narrow in scope, because it will recognize the variability of perception and

perspective and therefore be reluctant to close off options. Vezeau believes, along with Noddings, that although caring will not lead to principles or laws, it will create a context for "improved thinking and enhanced compassion based on sustained presence in difficult human complexities."

Vezeau finally rejects Nelson's model of hero as "unworkable and undesirable" for nursing practice. The image she suggests resembles more a companion than a savior: one who attends to patients' humanity and in the process retains her own.

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Planned Parenthood v. Casey: **The current state of abortion law**

ON JUNE 29, 1992, THE SUPREME COURT delivered its latest abortion opinion. In *Planned Parenthood of Southeastern Pennsylvania, et al. v. Robert P. Casey, et al.*¹ the Court upheld four of the five disputed state restrictions on abortion in the Pennsylvania Abortion Control Act (the "Act").² The "joint opinion" in *Casey*, authored by Justice O'Connor, who was joined by Justices Kennedy and Souter (in this holding, Justices Blackmun and Stevens also concurred), explicitly "reaffirmed" constitutional protection of a woman's decision to terminate her pregnancy. In the process, the Court "reaffirmed" and put forth its own interpretation of the "central" holdings of *Roe v. Wade*, the 1973 abortion decision.³ The facts in *Casey* forced the Court to find the proper balance between a woman's right to terminate her pregnancy and the state's interest in protecting the life of the fetus and the health of the woman, which, the Court argues, it accomplishes through restricting abortions. The resulting opinion in *Casey* provides only general guidance and will likely necessitate more litigation regarding the precise balance between individual and state rights. This article discusses the joint opinion and the various concurring and dissenting opinions and sets out the "law on abortion" as it stands, according to the Supreme Court.

The plaintiffs in the original case were five abortion clinics and one physician representing himself

and a class of abortion-performing physicians. They filed a lawsuit in the United States District Court in Pennsylvania, asking the court to declare five provisions of the Act unconstitutional and to prevent the Commonwealth of Pennsylvania from enforcing them. Three of the provisions concerned requirements that had (with certain exceptions) to be met before an abortion could be performed: informed consent of the woman seeking an abortion, parental consent in the case of a minor, and notification of a spouse. A fourth provision defined a "medical emergency" that would necessitate an immediate abortion; this definition was central because in cases where a "medical emergency" existed, the Act exempted compliance with the above three restrictions. A fifth provision imposed certain reporting requirements on abortion facilities.

These five provisions can be summarized briefly:

§3205, on informed consent with 24-hour waiting period: Except in cases of "medical emergency," no abortion can be performed on a woman unless she has given her "informed consent": at least 24 hours before the procedure is performed, she is to be provided by the physician information on the nature of the procedure, the health risks of both abortion and childbirth, and the likely age of the fetus.

§3206, on parental consent: Except in cases of "medical emergency," no unemancipated young woman under 18 may obtain an abortion unless she and one of her parents or her guardian provides informed consent. If neither a parent nor her guardian consents, a court may authorize an abortion upon determining that the woman is mature and capable of giving informed consent and has in fact done so, or that an abortion would be in her best interests.

§3209, on spousal notification: Except in cases of "medical emergency," a physician may not perform an abortion on a married woman without receiving a signed statement from the woman that she has notified her spouse that she is about to undergo an abortion. The woman may provide an alternative signed statement certifying (1) that her hus-

band is not the man who impregnated her; (2) that her husband could not be located; (3) that the pregnancy resulted from a spousal sexual assault that she has previously reported; or (4) that she believes that notifying her husband will cause him or someone else to injure her bodily. The state may revoke the license of any physician violating this section, and hold the physician liable in damages to the husband.

§3203, on a definition of “medical emergency”: A “medical emergency” is defined as a condition which, in a physician’s “good faith” judgment, necessitates an immediate abortion to avert the mother’s death, or for which a delay creates “serious risk of substantial and irreversible impairment of a major bodily function.”

§§3207(b), 3214(a) and (f), on reporting requirements: For each abortion, a report must be filed containing public health information, including the number of prior pregnancies and abortions and the gestational age of the fetus. The woman’s anonymity is explicitly preserved.

After a three-day trial, the District Court ruled in the plaintiffs’ favor, preventing Pennsylvania from enforcing these provisions. The defendants, including the Governor of Pennsylvania, appealed. The Third Circuit Court of Appeals reversed the District Court, concluding that four of the five provisions were constitutional and that only the spousal consent provision violated women’s constitutional rights. The original plaintiffs (the “petitioners” in front of the Supreme Court) then appealed to the Supreme Court, which heard oral argument in April 1992 and released its decision two months later.

Much of the publicity surrounding the case, and indeed much of its legal importance, involves the Court’s interpretation and the continuing validity of *Roe v. Wade*. The petitioners argued that none of the contested provisions of the Act could be upheld unless the Court explicitly overruled *Roe*. The “respondents” in the case, including the Governor and Commonwealth of Pennsylvania and the United States, acting

through the Solicitor General (“responding” to the petition), urged the Court to overturn *Roe* and uphold the Act in its entirety. The Court was thus asked either to overrule *Roe* or to reinterpret it in a way consistent with its holdings in the 1992 case.⁴

This it did: the first three sections of the joint opinion are devoted to reaffirming and reinterpreting *Roe*’s continuing precedential and legal value. Because a majority of five justices agreed with the holding of these three sections (both Justice Blackmun, the author of *Roe*, and Justice Stevens filed separate concurrences with them), these sections represent “the law.” These five justices differed, however, on whether particular provisions of the Act are inconsistent with *Roe* and with the Constitution. But, at a minimum, Justices O’Connor, Kennedy, and Souter clearly articulated a view of “*Roe*’s essential holding.” In their view, *Roe* had three central holdings: (1) before the fetus’s viability, a woman has the right to an abortion without “undue interference” from the state; (2) after viability, the state may restrict abortions, so long as the restrictions contain exceptions allowing abortion in pregnancies that threaten the mother’s life or health; and (3) from the outset of the pregnancy, the state has a legitimate interest in protecting both the health of the woman and the life of the fetus. It appears that these holdings contradict one another. The Court recognized this. The five justices in the majority that affirmed *Roe* struggled to sort out the parameters of just how far the state may restrict a woman’s right to a previability abortion in order to foster its policy of protecting her health and life and the life of the fetus.

As did the majority opinion in *Roe*, the majority in *Casey* explicitly “reaffirmed” constitutional protection of a woman’s right to decide to terminate her pregnancy. However, the language of *Roe* differs from that of *Casey* in describing this right. In *Roe*, the Court held that a woman’s right to a previability (or first-two-trimester) abortion is based upon the “fundamental” right of “privacy,” which encompasses a woman’s decision to terminate her pregnancy. The authors of the joint opinion in *Casey* recast this right as an example of a citizen’s “liberty” interest and declared that this is really what *Roe* stood for all along. In this way, they sidestepped the controversial issue of whether “privacy” is a “fundamental” right found explicitly or implicitly in the Constitution. Instead, they based a woman’s right on the individual’s liberty

interest, which unquestionably protects fundamental rights, including, the joint opinion states, the right "to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." This is important because it determines the state's power to restrict the right; a state has more power to restrict a "nonfundamental" right, such as education.

In Supreme Court jurisprudence, any state restriction of such a "fundamental" right as liberty is reviewed under the "strict scrutiny" standard. This has meant that the right could not be restricted except to serve a "compelling" state interest. In the view of the joint opinion's authors, the right to abortion derives from the "due process" clause of Section 1 of the 14th Amendment (ratified in 1868), which reads, in pertinent part: "[no state shall] deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." The issue surrounding a woman's "right to choose" involves her "liberty." Read literally, this important constitutional provision seems to refer only to "procedural due process" and to imply that a state may make any deprivation so long as it affords citizens a fair hearing. However, in a line of venerable decisions, the Court has held that "substantive due process" also exists—there are certain government actions that are barred regardless of the fairness of the procedures used to implement them. These substantive liberties, referred to in, but not exhausted by, the Bill of Rights, are incorporated into the 14th Amendment. In addition, the 14th Amendment protects against more than just those practices that were protected against in 1868, when the amendment was adopted. In the famous language of Justice John Harlan, "'liberty' is not a series of isolated points pricked out in terms of the taking of property; the freedom of speech, press, and religion . . . and so on. It is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints."⁵

As Justice O'Connor framed it, the issue in *Casey* is how far a woman's "protected liberty interest" in "personal decisions relating to marriage, procreation, contraception, pregnancy and child rearing" may go without governmental interference such that (as in the Act) the "woman [would lack] all choice in the matter, except perhaps in those rare circumstances in which

the pregnancy is itself a danger to her own life or health, or is the result of rape or incest." These matters involve a classically liberal, Enlightenment view of human freedom. The joint opinion declares: "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy . . . are central to the liberty protected by the 14th Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life."

How, then, do we balance the woman's liberty to choose whether to terminate her pregnancy against the state's interest in protecting both her and the fetus? Part 4 of the opinion, to which only Justices O'Connor, Kennedy, and Souter agreed, answers this question by relying on the concept of viability. Before viability, a woman has the right to choose to terminate her pregnancy. But the state may still enact regulations designed to ensure that the woman's choice is "thoughtful and informed" and may even allow the state to disseminate pamphlets designed to apprise the woman of "philosophic and social arguments of great weight" in favor of continuing her pregnancy to full term. After viability (as even *Roe* acknowledges), the state has an uncontroverted interest in protecting the potential life represented by the fetus. *Roe* did not establish an unconditional, absolute right to choose an abortion. And not every law making a right more difficult to exercise necessarily constitutes an infringement of that right. Thus, the joint opinion continues,

Only where state regulation imposes an *undue burden* on a woman's ability to make this decision does the power of the State reach into the heart of the liberty protected by the Due Process Clause. (emphasis added)

All regulations interfere to some extent; the issue is whether that interference constitutes an "undue burden."

But what is an "undue burden?" As the joint opinion declares, it means

that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus. A statute with this purpose is invalid because the means chosen by the State to further the interest in potential life must be calculated to inform the woman's free choice, not hinder it.

The opinion wishes to preserve the woman's right to make the ultimate decision but not necessarily her right to be free from the influence of others in doing so.

While this "undue burden" standard may constitute the most important part of the decision, technically it commands the assent of only three justices. Both Stevens and Blackmun dissented from the section of the joint opinion that announced the "undue burden" standard. Both believe that the right to abortion is "fundamental," requiring protection by the "strict scrutiny" standard. Both would strike down much more of the Act than did Justices Kennedy, O'Connor, and Souter. (Stevens would leave only the definition of medical emergency and the reporting requirements of §3207(b); Blackmun would strike down all but the definition of medical emergency.) Both acknowledged, however, that the undue burden standard serves a useful purpose, and neither explicitly repudiated the standard. Thus for now it appears that the key issue in determining the constitutionality of all future abortion regulations will be whether they impose an undue burden on the availability of previability abortions. This may well be *Casey's* legacy to the public debate on abortion for years to come.

Applying this standard to the five contested provisions of the Act, the five justices first affirmed the validity of the definition of *medical emergency*. The challengers of the definition, the petitioners, had argued that it was too narrow, in effect preventing immediate abortions in three circumstances that might lead to illness with substantial and irreversible consequences. The Court interpreted the provision such that these circumstances would be considered "serious risks," thus allowing immediate abortions when these risks occur.

Regarding the "informed consent" provision of the Act, the joint opinion held that the state may, at any time during the pregnancy—even the previability stage—require a woman to give her informed consent to the abortion as a condition of receiving it. (Justices Blackmun and Stevens dissented to this part, but Rehnquist, Scalia, and Thomas agreed, thus making it "the law.") The provision requires that, at least 24 hours before performing an abortion, a physician inform the woman of the nature of the procedure, the health risks of an abortion and of carrying the pregnancy to full term, and the probable age of the fetus.

In addition, either the physician or a qualified non-physician must inform the woman of the availability of printed materials published by the state describing the fetus and containing information about medical assistance for birth, child support from the father, and agencies that provide adoption and other services as alternatives to abortion. The petitioners did not challenge the requirement of informed consent itself—many medical procedures require it as a precondition. Rather, they contested the 24-hour waiting period and the provision of specific information by the physician. The joint opinion (with the concurrence of Justices Rehnquist, Scalia, Thomas, and White) holds that a state may, consistent with *Roe* and the 14th Amendment, require the provision of "truthful and nonmisleading" information about the risks, even if not directly relevant to the particular woman's situation. Requiring that a physician provide the information also does not present an undue burden on the woman. (Both Justices Blackmun and Stevens objected to this holding as demeaning to women by implying that their initial decision to obtain the abortion is not taken seriously.)

The three justices also upheld the 24-hour waiting period (likewise, with the concurrence of Rehnquist, Scalia, Thomas, and White, and over the dissents of Blackmun and Stevens). They argued that, as a result of this waiting period, abortion decisions will be more informed and deliberate, and in the case of a medical emergency, the period may be avoided altogether. The delay otherwise causes no appreciable health risk. But, petitioners argued, in practice the delay may subject women to harassment by anti-abortion protesters and require poorer women to spend more money because they must make at least two visits to the doctor. The joint opinion rejected these arguments as well. Potentially increased costs and risks of delay, they held, do not constitute an undue burden.

Regarding parental consent, the joint opinion (with the concurrence of Rehnquist, Scalia, Thomas, and White) holds that a state may require a minor seeking an abortion to obtain the consent of a parent or guardian, provided there is an adequate judicial bypass procedure. Both Justices Blackmun and Stevens dissented from this holding on the basis that the Act goes too far—it requires not only that a parent consent but that the physician provide parents with

information in a face-to-face meeting. This might lead to long delays and thereby violate a minor's abortion rights.

The spousal notification provision was the only section of the Act that the joint opinion (and Justices Blackmun and Stevens) struck down as imposing an undue burden (over the dissents of the four remaining justices). The Act allows exceptions to the spousal notification requirement only in cases in which the woman has previously reported a sexual assault by her husband. But the evidence on the record before the Court showed that the vast majority of such assaults go unreported. Thus the five justices agreed that the notification requirement would constitute a substantial obstacle for women seeking abortion. Moreover, the five justices objected to the view of marriage reflected in this statute. In emotional language, Justice O'Connor's opinion disposed of the argument that the husband's interest in his child's life outweighs his wife's right to terminate her pregnancy. The understanding of marriage and the relationship between the sexes implicit in this provision "is consonant with the common-law status of married women but repugnant to our present understanding of marriage and of the nature of the rights secured by the Constitution." If the husband's interest in the potential life of his child outweighed his wife's liberty interest, she reasoned, the state could, logically, require a married woman to notify her husband before engaging in any conduct causing risks to the fetus, including drinking alcohol or using contraceptives.

Finally, over the dissent only of Justice Blackmun, the Court upheld the reporting requirements of the Act, all of which relate to the state's interest in promoting public health. Collecting medical information remains critical to maintaining public health, and these requirements do not appear to pose any obstacle to a woman's right to obtain an abortion.

In a dissenting opinion (with which Justices Scalia, Thomas, and White concurred) Chief Justice Rehnquist argued that the Court should have overruled *Roe* and upheld the Act in its entirety. Rehnquist contended that the joint opinion in effect gutted *Roe* of any real substance by changing the critical turning point from *Roe*'s old trimester system to viability of the fetus. Moreover, Rehnquist argued that the right to an abortion is nowhere found in the Constitution and thus cannot be a "fundamental" right, entitled to

the same protection as those enumerated in the Bill of Rights. The right to abortion can and should be restricted by a state so long as the state shows that it has a "rational" reason for doing so. He believes that the restrictions imposed by the Act are rationally related to the state's interest in potential life. Justice Scalia's dissent (also joined by Rehnquist, Thomas, and White) echoed these concerns. Scalia does not believe that the right to an abortion, at any time during pregnancy, exists anywhere in the Constitution; it must be granted directly by a state legislature. His opinion rested largely on his more literal interpretation of the Constitution and what he called "longstanding traditions of American society" that have permitted that abortion be legally proscribed.

So, the "law of the land" can be summarized as follows: states may regulate abortions at any time during a pregnancy so long as the restrictions do not place an undue burden on the woman's liberty to terminate her pregnancy. If the regulation restricts the availability of postviability abortions, except in extreme cases (medical emergencies, rape, or incest), it is likely to be upheld, because such regulations probably do not constitute undue burdens. Regarding previability abortions, where the real controversy presents itself, a spousal notification provision like the one in the Act does place such an undue burden on a woman and would thus be unconstitutional. It was also established that a state has a legitimate interest in providing information designed to encourage women to carry their pregnancies to term. Thus, without convincing evidence that the providing of information in fact poses a substantial obstacle to a woman's liberty, a state may require physicians to provide to the woman unambiguously anti-abortion information published by the state.

We are sure to see more abortion cases in the federal courts, and probably in the Supreme Court as well. The "undue burden" standard leaves open the possibility that the Pennsylvania Act, or others like it (for example, Mississippi's abortion law, which provides for a 24-hour waiting period), may in fact pose a substantial obstacle to women seeking previability abortions. This is a certain recipe for more litigation, for refinement of what constitutes an "undue burden" or a "substantial obstacle" and what does not. Neither the Pennsylvania nor the Mississippi statute has been in effect long enough to document

the consequences of the 24-hour waiting period or the psychological effects of providing women with certain state-supported or state-published anti-abortion pamphlets. *Casey* declares only that various provisions of the Act are not unconstitutional *on their face*. No court has yet had time to consider or litigate the actual ramifications of such a statute in practice.

Casey makes viability the new pivotal point in the law's judgment about when the state may restrict a woman's right to an abortion and thereby favor the potential life of the fetus over the woman's liberty interest. In so doing, the Court seems implicitly to have judged that (if an American state so decides) a viable fetus represents a being with moral standing equal to its mother's autonomy reflected in her right to control her own reproductive capacity. Equally important, by striking down the spousal notification provision of the Pennsylvania act, a majority of the Court has affirmed that a husband's interest in a marriage should not and may not allow him to veto his wife's decision to terminate her pregnancy, and that, in any event, a woman may, by herself, make a sound moral (and legal) decision to terminate her pregnancy for nontherapeutic reasons.

—Steven I. Berlin
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1. 60 U.S. Law Week 4795 (1992).
2. 18 Pa. Cons. Stat. §3200 et seq. (1990). Interestingly, *Casey* is the second decision in which the Supreme Court has considered the constitutionality of this statute, making Pennsylvania an abortion battleground in the courts. In the 1986 case of *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, the Court ruled that an earlier version of that law was unconstitutional to the extent that it required that women be given specific "informed consent" information intended to discourage abortions. The current version of the act was drafted specifically to revisit before the Court the issues ultimately decided.
3. 410 U.S. 113 (1973).
4. Indeed, in his dissent, joined by Justices Scalia, Thomas, and White, Chief Justice Rehnquist argued that *Roe* should have been overturned immediately. In answer to Rehnquist's dissent, the joint opinion holds that *Roe* should not be overturned: *Roe* is not unworkable in practice, and women have relied on the availability of abortions in organizing their intimate relationships and defining themselves and their place in society. Moreover, the law has not changed so as to make the doctrine of *Roe* obsolete; nor has the factual basis on which

Roe was premised changed. To overturn *Roe* on the basis that many may disagree with it would, in the view of five justices, undermine the Court's legitimacy.

5. Taken from his dissenting opinion in *Poe v. Ullman*, 367 U.S. 497, 543.

Do physicians make too much money?

Howard J. Curzer, "Do Physicians Make Too Much Money?" *Theoretical Medicine* 13, no. 1 (March 1992): 45–65.

David A. Hyman, "Professional Profiteering? The Ethics of Physician Entrepreneurship," *Perspectives in Biology and Medicine* 35, no. 3 (Spring 1992): 318–29.

DO PHYSICIANS MAKE TOO MUCH MONEY? This question is pertinent for those thinking about effective yet just ways to reform health care, whether they are motivated by pragmatic concerns or religious convictions regarding economic and social justice. These articles examine physician reimbursement from two angles: Howard Curzer investigates the disparity between the incomes of physicians and those of other professionals; David Hyman examines physician ownership in medical facilities.

Curzer sets the context for this discussion. He cites that "in 1988 the median annual *net* income of physicians in the USA was \$117,780" and notes that this is "four times the average income of people working in all domestic industries in the USA." Curzer examines four principles of economic justice traditionally invoked to warrant this income differential: (1) Aristotle's Income Principle; (2) the Free Market Principle; (3) the Utilitarian Income Principle; and (4) Rawls's Difference Principle. After defining each principle and describing how each is invoked, Curzer argues that none of these sufficiently defends the magnitude of the income disparity between physicians and the rest of society.

Curzer defines Aristotle's Income Principle: "People with equal amounts of characteristic C ought to receive equal incomes. People with unequal amounts of C ought to receive proportionately unequal incomes." He notes that this is a formal prin-

ciple, which must be supplemented by a material principle specifying characteristic C; traditionally, C is linked with effort, talent, or contribution to society. Aristotle's Income Principle will supply different answers depending on the material principle chosen. Curzer examines these three material principles individually, citing traditional arguments and drawbacks, and concludes that, all in all, Aristotle's Income Principle fails to justify physicians' high income. Because no one really appeals to Aristotle's Income Principle but rather to one of the other three, Curzer admits that these critiques are mostly moot.

Curzer discusses the Utilitarian Income Principle and Rawls's Difference Principle together because they appeal to similar arguments. In utilitarian thinking, says Curzer, "the just way of distributing income in a society is the way which will maximize happiness for the society." Rawls's Difference Principle adds a layer to utilitarianism, offering a mechanism for determining "just inequalities": "social and economic inequalities are to be arranged so that they are to the greatest benefit of the least advantaged' insofar as this can be done without restricting the basic liberties and fair equality of opportunity within the society." These determinations are to be made by those who are "rational, self-interested, [and] non-envious" from behind a "veil of ignorance," that is, without prior knowledge of which socioeconomic group they will belong to. Curzer identifies ten steps that the proponents of both principles use to justify physicians' incomes and offers counterarguments for many of these steps.

The final, and most popular, justification is the Free Market Principle, defined by Curzer as follows: "All acquisitions and transfers involving force, threat of force, or [coercion] are unjust. All other acquisitions and transfers are just. Distributions are just if and only if they arise from preceding just distributions through just acquisitions and transfers, or they arise from preceding unjust distributions through the appropriate rectifications." Curzer identifies "free marketeers" as either "hard core" or "soft core." Both share the above principle but differ concerning what counts as force or coercion and what constitutes a truly *free* market. Hard-core free marketeers are staunch libertarians: autonomy—defined as absence of coercion against one's life, freedom, or property—is paramount. Soft-core free marketeers, recognizing the

systemic character of the free market, extend this autonomy to include "freedom to choose without coercion, deception, or monopoly."

The Free Market Principle justifies physicians' high incomes by arguing that physicians' incomes do not involve force, threat of force, or constraint of freedom. Curzer suggests that health care is currently not a free-market industry (regulation and restriction of physician-supply do exist), that it is subsidized by huge governmental funding at all levels (medical education, research and development, hospital construction), and that it has been created out of a series of past unjust transactions. (He might have also noted that in times of illness, those who seek health care are not "autonomous," are in many ways "coerced," and are not in a position to shop for the best deal, as a free-market model would suggest.)

A PRACTICE OFTEN JUSTIFIED BY AN APPEAL to the Free Market Principle is physician entrepreneurship, which David Hyman takes to task in his article, "Professional Profiteering? The Ethics of Physician Entrepreneurship." Citing the ongoing conflict over physician compensation, Hyman identifies the tension at the core of the controversy: "Medicine is a profession, bound by ethical principles. Medicine is also a business, whereby its practitioners hope to earn a living."

Hyman defines physician entrepreneurship (which he wryly refers to as an oxymoron) as "the receipt of income in one way or another for making a 'referral' of some sort." This includes referrals for prescriptions, to hospitals to which the physician is linked, or to laboratory, technical, or outpatient facilities in which the physician has an investment interest; Hyman argues that these practices are essentially the same as the traditionally condemned practice of fee-splitting. He identifies two problems with these practices: the related issues of conflicts of interest and erosion of trust.

Hyman challenges the growing image of physicians as technicians. He recalls the traditional—and not yet abandoned—self-image of physicians as members of a profession who have "professed" to place patients' interests above their own when it comes to making decisions about patient care. The physician is not an entrepreneurial capitalist; as Hyman notes, "the

standard is not caveat emptor, the general rule of the marketplace." Rather, the physician is a *trustee*—the nature of illness and healing requires a fiduciary relationship based on confidence and trust.

Not only does entrepreneurial activity threaten to sway the decision-making process away from patients' needs toward physician self-interest, it also undermines this essential trust. For the most part, physician investment interests are not revealed to patients; patients are thus unable to make fully informed decisions and give the appropriate consent.

The final argument against physician entrepreneurship is simply financial: referral reimbursement will tend to encourage overtesting and general overuse, driving up the already uncontrollable costs of health care. History certainly backs up this argument.

Hyman suggests that both professional societies and legislation can help solve the problems associated with physician entrepreneurship. The profession

needs to set a standard for itself, and indeed, Hyman notes that a number of societies—the American College of Physicians, the American College of Surgeons, the American College of Radiology, and the Institute of Medicine's Committee on For Profit Enterprise in Health Care—have already registered strong negative reactions to these practices and have enacted or suggested stringent regulations. Interestingly, the AMA has taken a more contradictory approach: it has condemned conflict-of-interest situations but sanctions "physician ownership of facilities to which they refer patients." In conclusion, Hyman notes, it will probably be only through legislative effort and sanction that these practices will be curbed, for the ethical injunctions of professional societies will restrain only those with integrity.

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1. The manuscript should be typed on one side only, on standard white paper, with margins of at least 1 inch. All material, including extracts and references, should be double-spaced. Manuscript length should not exceed 35 double-spaced pages.
2. Style and spelling in the journal are governed by *The Chicago Manual of Style* (13th edition) and *Webster's New International Dictionary*. If you have any questions on style, please consult these sources.
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4. Figures, diagrams, tables, and charts, if appropriate, should be submitted on separate pages and keyed to their position in the text. In addition, a list of legends or captions should be typed separately.
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7. Notes, citations. Notes are to be reserved for substantive observations, and their use is discouraged. They should be numbered consecutively and placed in a separate section following the text. All notes that consist merely of supporting citations should be placed in parentheses in the text, listing (in order): last name of author, year of publication, and page numbers where appropriate, e.g., (Tillich 1967:353). Subsequent citations of the same source should also follow this model.
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Examples

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