

Advocate Health - Midwest

SHARE @ Advocate Health - Midwest

Historical Documents - Combined

Advocate Health - Midwest History

Second opinion: Health, Faith, and Ethics, 1994, V19 N3, January

Advocate Aurora Health

Follow this and additional works at: <https://institutionalrepository.aah.org/alldocuments>

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

HEALTH • FAITH • ETHICS



Mandatory HIV Testing • Schizophrenia • New Age Healing • Jehovah's Witnesses and Blood Transfusions

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

COVER

Self-Awareness. Acrylic and gouache on canvas by Shirley Woodson, 1975.

Private collection. Photo: Bill Sanders.

HEALTH SCIENCES LIBRARY
LUTHERAN GENERAL HOSPITAL
177 DENVER STREET
PARK RIDGE, IL 60068

JAN 17 1994

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

HEALTH • FAITH • ETHICS



© 1994 by the Park Ridge Center

All rights reserved.

ISSN #0890-1570

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 19, number 3* • January 1994

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

Publisher

Laurence J. O'Connell

Editor

Martin E. Marty

Associate Editor

Barbara Hofmaier

Managing Editor

Sandy Pittman

Contributing Editors

Edwin R. DuBose, Ron Hamel, M. Therese Lysaught

Art Editor

Donna Ray

Editorial Assistant

Stephen Hudson

Membership

Tricia Stephens

Designer

Micah Marty

BOARD OF EDITORIAL ADVISORS

Robert N. Bellah
Daniel J. Callahan
Jimmy Carter
James F. Childress
Robert Coles
Arthur J. Dyck
H. Tristram Engelhardt, Jr.

E. Duane Engstrom
William H. Foege
Jeffrey K. Hadden
Stanley S. Harakas
Jay Katz
F. Dean Lueking
Richard A. McCormick

William F. May
Ronald L. Numbers
Edmund D. Pellegrino
Ruth B. Purtilo
Sidney A. Rand
Dietrich Ritschl
Judith A. Ryan

Donald W. Shriver
Lewis Thomas
Edwin R. Wallace IV
William J. Winslade
Gerald Winslow
Philip Woollcott, Jr.
Ernst L. Wynder

THE PARK RIDGE CENTER BOARD OF DIRECTORS

Christine K. Cassel
Michael D. Caver
Shirley Fredricks, *Vice Chair*
Candida Lund
Martin E. Marty
Laurence J. O'Connell (*ex officio*)
Daniel S. Schechter, *Chair*
Robert A. Stein
Stephen L. Ummel (*ex officio*)
George B. Caldwell, *Director Emeritus*

COUNCIL OF ACADEMIC ADVISORS

Don S. Browning, *Chair*
Karen A. Lebacqz
William F. May
Richard A. McCormick
Ruth B. Purtilo
Daniel Rudman

Second Opinion is published quarterly—every January, April, July, and October—by the Park Ridge Center for the Study of Health, Faith, and Ethics. The membership/subscription fee is \$45.00 for one year, \$80.00 for two years, and \$115.00 for three years. The student rate is \$25.00 for one year. (A portion of each fee [\$40, \$75, \$110, and \$20, respectively] is for a subscription to *Second Opinion*.) Subscribers also receive discounts on selected Center books and back issues. *Second Opinion* welcomes manuscripts for consideration; authors' guidelines are printed in the back of the journal. Views expressed in *Second Opinion* are not necessarily those of the Park Ridge Center or any organization with which it is affiliated.

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.*

CONTENTS

8 Initial Comment: Hearing Voices

Martin E. Marty

11 A Calling

Frederick J. Frese III

In a moving account of his personal experience with schizophrenia and his professional experience as the director of psychology at a state psychiatric hospital, Frese attempts to bridge the gap between the mentally ill and the “chronically normal.”

27 Mandatory HIV Testing and the Character of Medicine

Keith Berndtson

Proponents of mandatory HIV testing for patients and providers may not be giving adequate attention to the problems associated with such tests: violations of confidentiality, false negatives, reduced compliance with universal precautions, and misuse of resources.

35 Does “No” Mean “Yes”? The Continuing Problem of Jehovah’s Witnesses and Refusal of Blood Products

Dena S. Davis

The law maintains that the choice of competent adult Witnesses not to receive blood products must be respected. Yet many care providers believe that Witnesses, when actually faced with a life-threatening emergency, want their stated choice to be overridden—which permits them to evade the spiritual consequences of their unstated preference.

CASE STORIES

44 Editor’s Introduction: Case Stories and the Ethics of Voice

Arthur W. Frank

Doing narrative ethics involves recognizing that *who* tells a story has fundamental ethical implications.

49 The Case: An Eloquent Region

James Fitchette

A man who makes his living by using language learns that a brain tumor—and the surgical treatment of the tumor—impairs his language-producing capacity.

57 Commentary: When Music Is Last to Be Lost— A Neurologist’s Perspective

Harold L. Klawans

For patients with brain tumors and their physicians, treatment decisions are complicated by the uncertainties in predicting outcome and the difficulty of imagining loss of language.

61 Overview: Hearing and Editing Good Stories

Arthur W. Frank

People who live with serious illness, and the people who try to heal them, may have stories to tell that others do not wish to hear. Attentive listening to such stories is an ethical act.

(continued)

65 Holistic Healing in the New Age

Mary Farrell Bednarowski

The myriad alternative healing methods embraced by the term *New Age* are alike in two ways: they look critically at the state of the world (and often at established science and religion) and offer suggestions for improving it.

87 A Voice from the Roadside

Beth C. Junker

People who are assaulted suffer emotional as well as physical wounds. The story of the Good Samaritan may offer some guidance to health care providers who wish to foster complete healing for the victims of violence they encounter in their work.

DEPARTMENTS

93 ISSUES & CURRENTS

Ron Hamel

In the Name of God and Truth: The Catholic Ban on Sterilization

97 NOTEBOOK

102 BOOKS

Ethics: Three Views from the Shop Floor

Arthur W. Frank

Book Notes

110 LITERATURE DIGEST

CONTRIBUTORS

Mary Farrell Bednarowski is professor of religious studies, United Theological Seminary of the Twin Cities, New Brighton, Minnesota. Her major professional interests are women in American religious history and new religions in America.

Keith Berndtson is medical director, Rush Corporate Health Center, Rush-Presbyterian-St. Luke's Medical Center, Chicago, Illinois. He also teaches medical ethics and health policy to medical and nursing students at Rush College.

Dena S. Davis is assistant professor of law, Cleveland-Marshall College of Law, Cleveland State University, Cleveland, Ohio. She is the recipient of an Indo-American Fellowship that will send her to Pune, India, in January 1994 to observe allopathic and Ayurvedic physicians make end-of-life decisions with patients and families.

James Fitchette is a self-employed writer who lives and works in North York, Ontario, Canada. He is the author of two short stories and more than a hundred articles on golf.

Arthur W. Frank is professor of sociology, University of Calgary, Calgary, Alberta, Canada. He is author of *At the Will of the Body: Reflections on Illness*. He now serves as editor of *Second Opinion's* "Case Stories" series.

Frederick J. Frese III is director of psychology, Western Reserve Psychiatric Hospital, Northfield, Ohio, and clinical assistant professor, Case Western Reserve University, Cleveland, Ohio. He was president of the National Mental Health Consumers' Association in 1992 and 1993.

Beth C. Junker is a free-lance writer who lives and works in Marietta, Georgia. Her main areas of interest are law and public policy and religion.

Harold L. Klawans is a neurologist at Rush-Presbyterian-St. Luke's Medical Center, Chicago, Illinois, and the founder of their Section of Movement Disorders.

INITIAL COMMENT

Hearing Voices

YOU DO NOT ORDINARILY HEAR A PERIODICAL. Unless a pile of *National Geographic* tumbles in the attic or someone tears a clipping out of a magazine, the world of journals and their readers is silent. So it may seem strange and perhaps counterproductive to stress sound and voice as much as do writers in this issue of *Second Opinion*. With so many other media bidding for attention, some of them designed for the aural, we print-media folk ought to be holding our ground, touting the exclusive benefits of a quiet reading experience.

As one reads on in this issue, however, it becomes clear that important things can be said about the acts of speaking and hearing, especially as these relate to illness and health. It is possible that the speech of patients, the verbal bids of counselees, and the healing stories of the seriously ill will be unattended to or misunderstood unless potential hearers reflect on the act of hearing. So it is that reading and hearing, stressing the eye and stressing the ear, can be complementary activities.

Our library shelves hold numerous works with the word *voice* in the title. I remember in my own first writing for the Park Ridge Center calling attention to a marvelous but neglected book by Finnish theologian Aarne Siirala, *The Voice of Illness*. At a Center devoted to “health, faith, and

ethics,” we have had good reason to be responsive to humanities scholar Walter Ong’s thesis in *Voice as Summons for Belief*. The book of pastoral letters by the martyred Roman Catholic archbishop Oscar Romero, speaking for the people he served, was called *Voice of the Voiceless*. The most recent *Books in Print* includes well over a dozen long small-type columns of books whose titles begin *Voice* or *Voices*. Writing about voice is as familiar and necessary as giving voice to what has been written.

The focus of our thinking about voice is the introduction to a new series of “Case Stories,” not “Case Studies,” the series editor insists. Arthur W. Frank, beginning his round as editor after important pioneering work by Kathryn Montgomery Hunter and Steven H. Miles in these pages, tells why he is happy they chose *stories*, narratives, instead of *cases*, with the implied concept of people being objects of inquiry. He connects case stories and the ethics of voice in ways that come close to defining a central focus of our Center and this journal. James Fitchette then tells a story of brain surgery and the loss of some ability to generate speech; neurologist Harold L. Klawans points to the difficulty patients have in making informed decisions about treatment when a possible outcome—loss of speech—is so hard to imagine.

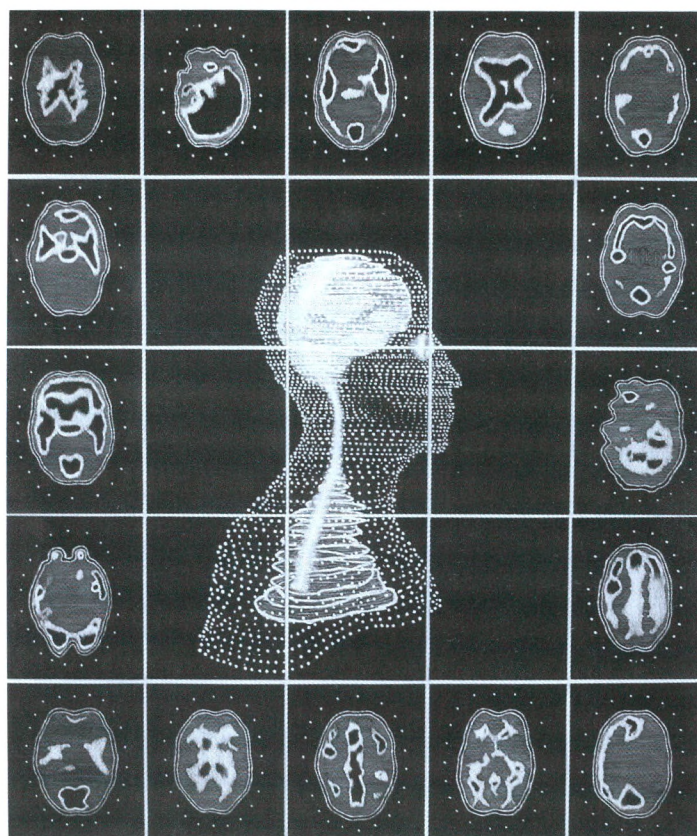
The accent on stories, voice, hearing-and-healing can also be located in other articles. Beth C. Junker's essay, for instance, came to us with the title "A Voice from the Roadside." Junker speaks as a victim of violent assault, asking health care givers to listen so that they can become more merciful "neighbors." In a rare and remarkable offering, Frederick J. Frese III, a psychologist whose own life is marked by schizophrenia, gives voice to the world of people who, in a crude colloquialism, "hear voices." We who do most of our inquiries in the corridors where mainstream medicine is practiced get to hear "other voices" from "other rooms" in Mary Farrell Bednarowski's "Holistic Healing in the New Age." We asked her to do a fair-minded, phenomenological overview, neither pro nor con, of the

very popular alternative medical approaches of the day.

Dena S. Davis takes on a controversial theme, dealing with the clash of voices when Jehovah's Witnesses encounter clinics and the law over the issue of blood transfusions. And Keith Berndtson finds our culture "spellbound" by the AIDS epidemic and wants to help break the spell. This means giving voice to the fears of caregivers and possible victims and hearing the voices of those who have AIDS as well as the voices of the physicians, nurses, and others who speak up for them or model courage—a virtue that has a voice of its own.

A handwritten signature in dark ink, appearing to read "M. E. Marty". The script is fluid and cursive, with the first letter of each name being capitalized and prominent.

Martin E. Marty



16 States. Scratchboard by Joshua Simons, 1987.

Photo courtesy of the artist.

A Calling

Frederick J. Frese III

“When his family heard of this, they set out to take charge of him;
for people were saying that he was out of his mind.”

—Mark 3:21 (*New English Bible*)

“I HAD TO DO IT, DR. FRESE. The computers were going to blow up and hurt people. They really were. I had to disable the computers. There were going to be big explosions. It was going to be awful. . . . I want my little girl. I am so lonely.” Robert then began to sob.

Robert (a pseudonym) told me this shortly after it was reported that he had unplugged the word-processing units in one of the hospital’s administration buildings. Robert is a person with schizophrenia. He is one of more than 300 patients with serious mental illness for whose care I am responsible at a large state public psychiatric hospital near Cleveland. For the past 12 years I have served as the director of psychology at this hospital.

Robert is a person with schizophrenia . . . and so am I. Although I am not as severely disabled with

this disorder as Robert is, I still carry the diagnosis I was given 27 years ago, and my cognitive processes are still at least periodically influenced to some degree by the disorder.

Since the introduction of psychotropic medicine in the mid-1950s, 80 to 90 percent of those of us who were, or would have been, in public psychiatric facilities have been released. Many of my “brothers and sisters” have been abandoned and are living in the streets and in shelters. Many others are in prisons and jails or are somehow being cared for by their families. But some of us are doing much better. Some of us have jobs, families of our own, and in general can function reasonably well living in the community. It is unusual, however, for one of us to openly identify him- or herself as being a person with schizophrenia.

Although many of us are out in the general population now, most members of the greater society tend to know very little about us, in great part because of our own silence about our condition. Often what is known is shaped by headline news

Frederick J. Frese III is director of psychology, Western Reserve Psychiatric Hospital, Northfield, Ohio.

For citation: Frese, Frederick J., III. 1994. “A Calling.” *Second Opinion* 19, no. 3 (January): 11–25.

releases declaring that a former or escaped mental patient has killed someone in a bizarre manner or committed some other terrible crime. Those of us who have never been dangerous generally have thought it best not to bring attention to ourselves and our conditions.

This article is an attempt to make one little step toward breaking through the walls of silence that have been standing between us and the world of those of you I have come to call “chronically normal people.” As a way to accomplish this, I give a biographical sketch of the schizophrenic person that I know best, namely, myself. I tell a little about my family and my personal background in the preschizophrenic years. I then focus on my years of living with periodic attacks of schizophrenia. Finally, I say a little about how I currently function, incorporating my experiences with schizophrenia, both past and present, into my roles as psychologist, husband, and father of four.

Family History

BOTH MY MOTHER’S and my paternal grandmother’s families came from the Catholic Irish-American communities of Georgia. Relatives on my mother’s side, being witty and musical, were much involved in the performing arts. My great-uncle, Oscar, went north to spend his life on a showboat cruising the Ohio River. Prior to marrying, my mother, who had performed briefly with her uncle on the showboat, worked as a dancing instructor in Montezuma, a small town in southwestern Georgia. This proclivity is evidenced in my generation in one sister who works full time as a dancing instructor.

I had always been told the Irish were brought to Georgia as indentured servants because blacks had

difficulty working in the swampland around Savannah. I now suspect my ancestors may have left their homeland to avoid some stigma attached to mental illness. Schizophrenia occurs at a relatively high rate in Ireland, and although most of my many maternal kinfolk appear to have been relatively well adjusted and accomplished, I understand that at least two relatives on my mother’s side suffered from

schizophrenia or other “serious mental difficulty.”

Because there is now substantial evidence that mental illness is largely genetic, this knowledge about my mother’s family tree has important implications for our children, who are now in or around adolescence, as well as for Frese generations to come.

On my father’s side I know of no mental illness, but then I have fewer relatives on that side. The only kin I have known on my father’s side are his brother and my grandparents, but I do know more about them than I do about relatives on my mother’s side. Also I feel somewhat freer to write about my paternal relatives because none has been mentally ill.

My paternal grandparents had two sons, 13 months apart. When my father, the elder son, was about to enter high school, the family left Georgia for the Bronx in New York. After the first few months of culture shock and concerted efforts to lose their southern accents, the Frese brothers went on to become fairly successful. My uncle became a Jesuit priest and later completed his Ph.D. in American history at Harvard. He spent his professional life as a professor and administrator at Fordham University.

My father graduated from Fordham University and then went on to medical school in St. Louis. He often repeats the story of how he met my mother when he was finishing medical school. One day at church he dropped his prayer book, and a picture of

**Most members of the
greater society tend to know
very little about us,
in great part because
of our own silence
about our condition.**

an old girlfriend from grade school in Savannah fell out. Her name was Katheryn Sullivan. He had neither seen nor heard from her in years. But, inspired by the dropping of the picture in church, he contacted her and invited her to come from Georgia to his graduation ceremony in Missouri. She accepted the invitation, and shortly thereafter my parents were married. The year was 1939.

America was still in the Great Depression, and employment, even for physicians, was not readily obtained. My father had always been attracted to the military, so he signed up with the U.S. Army Medical Corps. When the war started, opportunities for promotion came quickly. By the time he was 31, he was a full colonel, one of the youngest officers with that rank in the entire medical corps. After the war, he transferred to the newly created U.S. Air Force and spent most of the next 25 years as an administrator and physician in the Air Force's emerging space program.

Personal History, Preschizophrenia

I SPENT MY FIRST SEVEN YEARS moving from one military facility to another. By the time I arrived in Texas to enter the third grade, I had lived in seven different states. Thereafter, however, our family tended to be stationary compared to other military families. Except for three years in the Montgomery, Alabama, area, the rest of my childhood and youth were spent at Randolph Air Force Base near San Antonio, Texas.

Growing up, I knew almost nothing about mental illness. But I recall an experience I had in Alabama that seems related to the themes of some of my later schizophrenic breakdowns. I was 12 years old when the family moved to Maxwell Air Force Base in Alabama. As we were settling in, there was considerable hoopla over the arrival of another colonel, Paul Tibbets, who had piloted the B-29 that dropped the atomic bomb on Hiroshima. Holly-

wood had even made a movie about Tibbets—*Above and Beyond*, starring Robert Taylor. There was a special showing of the film at the base theater. Colonel Tibbets was quite celebrated at that time. It happened that Colonel Tibbets also had a 12-year-old son named after him. Paul the Third attended the school I did, and we became close friends. We were both "Thirds." Another close friend, Charlie, was also a "Third." Naturally enough, our other friends often made jokes about our "needing three Thirds to make a whole."

During my three years in Alabama, Colonel Tibbets continued to be the focus of considerable attention. I got a glimpse of what it was like to be the son of the man who had ushered in the atomic age, the debut of which had brought such devastation to the people of Hiroshima.

During the fifties the threat posed by atomic weapons was constantly on the minds of Americans, but particularly for those of us in Air Force families. The planes were all around us every day. Looking back, I can see that I must have been particularly impressed by the importance of the Hiroshima bomb. But the full impact of that impression on me was to come later.

For the most part, growing up seems to have been fairly normal for me. Nothing seemed to portend the development of serious mental illness. I thought of myself as a fairly well-rounded adolescent. In high school I participated in football, track, and basketball. I had a number of close friends. Beginning in my teenage years, I usually had a steady girlfriend. As I remember, these relationships generally ended when the girls' fathers were transferred to some distant state. I also seemed to be popular with my classmates, having been elected twice as class president. I also performed fairly well academically, particularly in mathematics.

During my senior year, after I had been back in Texas for about 12 months, the Soviets surprised the U.S. by putting up a space satellite. The entire country seemed to go into panic. It appeared as though our Cold War enemies were jumping ahead of us in applied science. Youngsters with aptitudes

for mathematics or science were suddenly strongly encouraged to study such subjects in college. I had won a scholarship from the U.S. Navy and was being sent to Tulane University. Nuclear physics was a subject I knew little about, but I understood that it was important and serious and I chose it as my major. However, physics failed to keep my interest kindled. My mind reasoned that I would learn much more about man's destruction of himself by studying about man than by studying about nuclear energy. I decided to major in psychology with a strong minor in mathematics.

During college, we reserve midshipmen were required to spend six weeks each summer on a cruise with the Navy. During the first cruise, after my freshman year, we were rated every two weeks by upperclassmen on our potential as naval officers. I had never seen myself as particularly good officer material, and during the school year I had been given rather mediocre ratings in military aptitude. But about a week after my first cruise began, something strange happened. It was as though a spell came over me. For no apparent reason, I suddenly became unrealistically happy. I started having a feeling of joy about such tasks as chipping paint and obeying orders to do just about anything. I did not understand why this was happening or what the source of my joy was. But I wound up being rated the highest of all the midshipmen for the last two of the three rating periods. The "spell" lasted for some time after the cruise. Upon leaving the ship to which I had been assigned, I visited my Jesuit uncle in New York. He remarked that I seemed quite changed and that he was "edified" by spending time with me. Gradually the spell went away. I never thought much about it again until later in my life.

During my second year, I applied and was accepted to be trained as a Marine. This option was available to about 17 percent of the midshipmen nationally. Although I certainly did not have a natural Marine officer's posture, and I was not particularly interested in leadership or warfare, I was in good physical shape from pole vaulting for the Tulane track team. I could do a considerable number

of chin-ups, push-ups, and (my specialty) one-legged, deep knee-bends. I felt my physical abilities would be more valuable to me in the Marines than in the Navy. In any event I was able to survive the rigors of Marine Corps indoctrination. Upon completing my degree and having met the Marines' requirements, I was commissioned a second lieutenant.

During six additional months of training at Quantico, Virginia, I decided to request assignment to Okinawa. Since this was not a popular request, I was readily given my first choice.

I had always wanted to learn a foreign language firsthand. As soon as I received my travel orders, I bought a "Living Japanese" language course and began to spend my spare time studying. When I arrived in Okinawa several months later, I was surprised to find that my very broken Japanese was better than that of any American I encountered. Thus encouraged, I spent most of my free time taking Japanese language courses and practicing conversation with the local citizenry. Near the end of my 13-month Okinawa tour, I requested a transfer to the Marine air base at Iwa Kuni, Japan, in order to further develop my nascent language skills.

Iwa Kuni is located on the coast of the Inland Sea near Hiroshima. At the time I was there I thought very little about my friendship with Colonel Tibbets's son. My assignment was to work as the camp maintenance officer, with about 120 men under my authority. Fortunately, many of them were very experienced sergeants, and my duties were not too taxing. In truth, I was more interested in increasing my skills in the Japanese language than I was in developing myself as a regular Marine Corps officer.

I obtained an after-hours position teaching English to executives from the Mitsui Polychemical Corporation, located in nearby Hiroshima Prefecture. I taught at the company two nights each week, and I was frequently invited to socialize with my students after the classes and on weekends. I met many individuals who had lost family members in the 1945 bombing.

I was surprised by their outward reaction to the American devastation of their city. Virtually all the people I met had lost a close family member in the bombing, but with rare exception, I never was able to discern any animosity toward me or other Americans. I think that if I had lost my family members in such an attack, I would find it very hard to forgive those responsible. To this day I am exceedingly impressed by the relative stoicism I observed in the people of Hiroshima.

Generally, I very much liked Japan. During the two years that I was there, I found the people to be thoughtful, very polite, and surprisingly cultured. I felt very lucky that I had been sent to Japan, and I was very glad that I had begun to learn the country's language. I decided that after I finished my four-year obligation with the Marine Corps I would return to school to study international business and prepare for a career doing business in the Orient. I felt my efforts to learn Japanese could pay off if I could secure a position with a corporation doing business in the Far East.

In 1965, as my tour of duty came to a close, the war in Vietnam intensified. President Johnson was greatly increasing U.S. troop strength in Southeast Asia. Two close friends, fellow officers who had been sharing a house in Iwa Kuni with me, received orders to the war zone.

I felt very lucky because I knew it was unlikely that I would be considered for a third Far Eastern duty station before I was due to be discharged. I was being transferred to duty at the Marine Corps barracks at the naval air station in Jacksonville, Florida. It was to be an experience that would substantially change the course of my life.

Schizophrenia: The Beginning

AT THE TIME, I WAS EXPECTING TO SPEND a fairly comfortable year as a Marine guard officer in sunny Florida, after which I planned to resign my commission quietly and begin graduate school. Things were not going to work out so smoothly.

After two years among the Japanese, I had a little difficulty adjusting to things back in the States. I began to long to return to Japan but felt confident that I would be doing that in just a few years.

The purpose of the Marine barracks operation at Jacksonville was fourfold. The Marines were to man the main gate, guard the station brig (jail), provide security for the Fleet Intelligence Center, Europe, and most important, guard the many nuclear weapons stored at the base. In all these positions the Marines were to present the appearance of neatness, confidence, and efficiency. There were about 140 Marines and four officers at the facility. I was the junior officer.

The commanding officer was a small, hyperactive Brooklynite. When I told him that I planned to leave the Marine Corps at the end of my tour in Jacksonville, he indicated he was not pleased. As time went by, he became increasingly exacting. Since the Marine Corps has very precise ways of doing things, he was usually able to find fault with any task I performed and took pleasure in doing so. He continually made references to my various shortcomings as an officer. I began to find working to be very difficult emotionally, but I felt I could put up with anything for a year or so. My perception was that I was constantly belittled and berated. It should have been clear to me that no matter what I did I was going to be castigated. I was obviously seen as disloyal because of my intention to resign my commission. As months passed, I began to feel increasing psychological pressure.

To take my mind away from the stress and to bolster my self-esteem, I started taking advanced mathematics at the local university. I also applied for membership in Mensa, an organization for persons with high intelligence, and began studying diligently for the graduate record exams, in preparation for applying to graduate school.

Nevertheless, for the first nine months I was at Jacksonville, the psychological pressure continued to build. But then things began to break my way: I was accepted into Mensa, I scored well on the graduate record examinations (especially in math),

and, much to my surprise, I was promoted to the rank of captain. Things were going well, and I had only a few more months in the Corps.

Just then, a genuine tragedy occurred at the worksite. We always had two Marines on guard duty at the atomic weapons area. Suddenly one was killed. His weapon discharged, and he was shot through the heart and died immediately. It appeared to be an accident, but no one knew for certain. The surviving guard was immediately sent home.

Shortly thereafter, my mind-set was to be altered considerably. One of my major duties about this time had been to write the policies for the guards at the various work locations. I had rewritten the orders for the guards at the Fleet Intelligence Center several times, and they had finally been approved by the commanding officer. I remember being pleased with myself, for I had finally accomplished something important at work. I was also basking in the successes of my other recent accomplishments; I began to feel that I was, after all, an intellectually capable person of some value. But the situation with the commanding officer still bothered me. If I were so intelligent, why had I been unable to please him?

One day near the end of March 1965, not long after the death at the atomic weapons site, I was sitting at my office desk. Suddenly, as though I were struck by lightning, I had an astounding insight. It was so clear to me. Everything that had been troubling me became resolved. Everything came together and made sense. It was so obvious. Why had I not seen it before? The commanding officer, the major in charge of our operation, had often talked about serving in the Korean War and how much he had loved being in combat. Obviously, if he had enjoyed the war to that degree, something

must have happened to his mind while he was there. He must have undergone some kind of brainwashing experience. Maybe he had been captured when he was in Korea, and maybe the enemy had brainwashed or hypnotized him. That was it. Somehow he was under the control of the Chinese Communists. It was just like in the movie I had seen a few years before, *The Manchurian Candidate*, starring Frank Sinatra. The movie showed how the Chinese

Communists could plant post-hypnotic suggestions in the minds of captured Americans and have control over them after they returned home. The author of the book from which the movie was taken must have known something.

Now it all made sense to me. The major (and obviously many other officers and sergeants who had been in the Korean War) were under the hypnotic control of our Chinese enemies. This explained why the major had been so hostile toward me. I had uncovered the secret tactics of my country's enemies. Now, no matter what the major did, I would understand his motivation. He could not get through to me, because I knew he was only acting as an agent of the Chinese. I felt very confident of my purpose for the first time since arriving in Jacksonville. I had become very confident indeed.

It happened that the season was just turning from winter to spring. The orders that I had written for the guards at the Fleet Intelligence Center had already been delivered—about a week early. They stated that all personnel were to be in the proper uniform for the season, spring. According to those orders, all the personnel at the center, who were still in winter dress, were in the wrong uniform. Technically, they should all be prohibited from entering or leaving the facility. Ordinarily the guards would

Each time I was released from treatment, I thought that I just might be the only unhospitalized recovering schizophrenic person in the country. There must have been others, but I did not know of any.

have seen that their orders had been delivered early, and they would have disregarded them. But that particular day I was the duty officer, and with my newly found confidence I became most insistent that the guards follow their orders exactly. Initially the guards resisted, but when I, as their superior, insisted, they hesitantly complied. In the state of mind I was in at the time, I could only see that they were not obeying their orders. I had no appreciation for the difficulty that was about to ensue.

After leaving the guards at the Intelligence Center, I returned to headquarters. Presently I found myself engaged in conversation with the major. Soon the phone rang, and the major was clearly upset by the call from a high-ranking naval officer. Something serious was wrong. The major took me with him to the Intelligence Center. There, numerous naval officers were lined up on either side of the facility gate, being prohibited from entering or leaving by the Marine guards. The senior naval officer was quite upset. He called the major over to him and began speaking in a firm and somewhat threatening tone. The major, in response, began pointing in my direction. I felt quite certain I was on firm ground, because it was my duty to ensure that all orders were carried out as written. The major was beginning to show strain. This was not going to help his career.

From my perspective, my discovery that he was a Chinese agent increased the confidence I needed to withstand his belittling and berating behavior.

When we returned to headquarters, it was still early in the afternoon. I was feeling good about my newly found confidence. But suddenly it occurred to me that the Chinese would probably soon find out that I had uncovered their secret. I realized that I had best inform the U.S. authorities about the situation. I decided that the best person to tell would be the base psychiatrist, who should, after all, have a good understanding of matters psychological, including hypnosis.

I phoned the base hospital and requested an appointment to see the psychiatrist. He agreed to see me right away. When I arrived, he was most

interested in hearing what I had to say and listened attentively for about 20 minutes. But when I finished speaking, he made it clear that I was not going to be allowed to leave the hospital. Two men in white coats came and escorted me back to an empty room with no furniture. It had thick padding on the walls.

It was obvious to me that I was now in a psychiatric ward. It was also obvious that I had miscalculated badly. Clearly the psychiatrist had been in Korea and was one of those under the control of the Chinese. There was no telling how many other agents knew that I had discovered their secret. Obviously they were going to have to kill me. I became terrified.

Being a Catholic, I demanded to receive the last rites. Initially the priest was not willing to administer extreme unction, but he must have seen my terror, for he finally gave me "the last sacrament." I remember he also left me some printed material about becoming a priest.

After a few days isolated in that hospital room, I was sent to Bethesda Naval Hospital near Washington, D.C. En route I saw my records with the diagnosis "paranoid schizophrenia." I was shocked by the label. I realized how very clever the enemies were being. By giving me a psychiatric diagnosis, they could impugn my credibility completely.

I was kept in the psychiatric ward at Bethesda for about five months. They gave me what were then called major tranquilizers. The side effects were terrible. They caused me considerable psychological trauma and did not really help me to understand that I had become psychotic and needed help. Somehow, after a few months, I gradually came to the conclusion that my "discovery" probably was not as important as I had at first thought it to be. I had uncovered something important and had done my duty in apprising the authorities of my finding. Maybe they just did not want everyone to know about the threat from those who had been hypnotized—panic might spread. An effective and humane solution was to declare me schizophrenic. I was no longer an immediate threat to them.

Slowly I became less afraid that I was going to be killed. I was now going to be discharged from the hospital and from the Marine Corps. Perhaps I could go on with my life as though nothing of lasting consequence had happened to me. Indeed, some of the higher ranking patients at Bethesda were kind enough to sign letters of recommendation to graduate schools for me.

I was medically retired with the rank of captain. I had not yet reached my twenty-sixth birthday. I entered the American Graduate School of International Management in Phoenix, Arizona, immediately. I told no one, of course, about my psychiatric hospitalization. Incredibly, the school had not asked about my health history as part of the application process.

I majored in Asian business studies and did well. Many large corporations recruited at the school. I had numerous job interviews and received eight tentative offers of employment. One firm did not require information about my health, and I accepted employment with them. Koehring Corporation, a large Fortune 500 manufacturer of capital goods headquartered in Milwaukee, first sent me to work in one of its plants in Ohio that specialized in the manufacture of hydraulic presses and similar capital equipment.

After working in various parts of the Ohio factory as a management trainee for about three months, I and about seven other trainees from various parts of the country were summoned to spend a week in classes at the firm's headquarters. There, my superiors seemed interested in my claim that I was conversant in Japanese. They tested my skills and asked me to stay on in Milwaukee for further assignments. To start, I was to be the escort and interpreter for some Japanese customers who were to be flying to Nashville the following Monday.

The weekend after the training, and before the Monday I was to leave with the Japanese, I began to become very confident in my abilities again. This time my increased confidence was coming from my realization of relationships that "tied things

together." I began to believe that there was some kind of code that could be used to weave together important concepts and items of information. I also began to feel I was developing the ability to break the code. Part of breaking the code was realizing that people reacted in different ways to different numbers. I knew that the Japanese were suspicious about the number four. The Japanese word for "four," *shi*, also means "death." The Japanese tend to avoid this sound whenever they can.

Of course, Americans, too, give special meanings to numbers. We are conditioned all our lives to respond to the number three. Our traffic lights are green, yellow, and red. For all our lives red has meant "stop" or "fire" or "blood." Yellow has meant "caution," and green has meant "go" or, perhaps, "money." And, of course, for Christians the Trinity is sacred. Truly by tuning into the deeper meanings of the numbers that so subtly control our lives, especially the number three, one could gain greater understanding of people's deeper motivations. For me all this was becoming a profound mystical journey of discovery.

On Sunday morning prior to my scheduled trip to Nashville, I planned to go to church, as was usual for me. By this time I was confident that I was beginning to be tuned into a special force or system. Before leaving my hotel, I began making phone calls. I dialed numbers based on how they fit together in my mind. All combinations had a generous proportion of threes, and I avoided fours. I had no idea who I would be calling. I just knew I had broken the code and that I must use these numbers to communicate with others. I greeted those who answered my calls as though I knew them or had important messages for them, but my messages were not generally received in a friendly manner. However, those icy receptions that Sunday morning did nothing to dampen my confidence.

As I remember, it was ten blocks to the cathedral where I was planning to attend the service. As I started walking, I became very much under the influence of the traffic lights. No matter where I was in a block, I would stop if the light became red and



L'Ascension. Mixed media on paper by Louis Soutter, ca. 1937–42.

Courtesy of Galerie Karsten Greve, Cologne.

go if it became green. Frequently I would be in the middle of the block when the light turned red. Despite my unusual stopping and starting, I eventually arrived at the cathedral. I climbed the steps, entered, and sat in a pew on the aisle near the back of the congregation. The service had already begun. After about ten minutes, I suddenly became inspired with the idea that I was on a sacred mission. I was to proceed forward to assist the priest in celebrating the mass. I left my pew and walked directly to the altar. I knelt down next to the priest and remained solidly there in prayer position throughout the rest of the ceremony, perhaps a 20-minute period.

When the service was over, the priest spoke to me sternly. He told me to leave or he would get the police. I remained kneeling with my hands folded at the altar. I said nothing. The priest seemed not to understand about my mission. Other priests appeared and began to gather around me. A couple of them were Orientals, and I began speaking to them in Japanese. I do not think any of them understood me.

After a few minutes of speaking this way, I began to feel a change coming over me, as though I were changing into an animal, like an ape, perhaps. I began to emit animal-like grunts. Gradually my grunts turned into barks, as though I had changed again, this time into some kind of dog. Then I felt as though I had become a dragon. I could feel myself breathing fire. Next I was on the ground writhing like a snake. From then it was as though I continued on a journey backward through the chain of evolutionary development. I became a fish, a one-celled animal, then just a single atom. Quickly I realized that I had become a tritium atom, the one in the construction of a hydrogen bomb.

Upon feeling myself turn into this atom, I came to know that my mission was to be split. I realized that I had become the atom that was to activate the nuclear explosion that was to begin the Third World War. This was the power of the number three, of the Trinity. I had broken the code of the universe. And now was the time for it all to end. The world was to be destroyed. The Deity had chosen me as His instrument, and I had given myself over totally to

His purpose. I had become His mechanism for initiating Armageddon and the Apocalypse. I actually felt myself being lifted and placed into what I thought to be an airplane with engines loudly running, ready for takeoff. I was quite certain of my mission. I was a little frightened, but mostly I was joyfully confident that I was with the Lord and doing His will.

I recall that throughout this Sabbath experience, I felt that I was being asked by God whether I was willing to accept the mission I was being given. In a way I felt like Abraham being asked to destroy Isaac on Mount Moriah. The experience was terrifyingly joyful. Early into the process, I knew there would be no turning back. In my mind, I kept responding to God that I was with Him as I made this sacred journey. I was totally submissive to His will, no matter what the cost. I had become an instrument of the Trinity. I offered no resistance. I had total confidence. It was almost as though I was greeting God, face-to-face.

Shortly after being loaded into the "plane" (later I realized that it must have been an ambulance), I blanked out. When I came to, I was in a completely white room. My arms and legs were strapped down to the sides of the table that I was lying on. My first thought was that I must be in heaven or in a kind of limbo. I had no memory of the world actually having been destroyed, but I was sure that it had been. Then I realized that I was very thirsty. I was dismayed to find I would be so thirsty in heaven. Eventually someone entered the room. When I made a comment about heaven, and about the earth having been destroyed, I was told I was in a psychiatric ward and that in the world outside life was going on pretty much as usual.

I was kept strapped down for some time. When I was eventually released, I remained quite confused. Even after I was allowed to go out into the dayroom, I remember thinking that the other patients were close friends of mine, and I greeted them accordingly. They all pulled back from my advances and treated me as a stranger who was being too forward with them. At one point I remember noticing that

the floor was quite dirty. I had no rag or mop to clean it, so I began licking the floor with my tongue. Whenever I was approached by professionals I would bow down before their feet as though they were royalty. I was behaving in a very bizarre fashion. Somehow I never completely got over the idea that I was on a mission of some kind. It was just that my mission was becoming complicated, with many curious twists and surprises.

After a few weeks in the public psychiatric hospital, I was called into the office of a social worker who asked me if I wanted to leave. Of course I said yes, even though I was still quite delusional. Shortly thereafter I found myself wandering about the streets of Milwaukee. It was cold and windy outside.

Somehow I made my way to the apartment of a friend who permitted me to sleep on his floor for a few nights. Later, after I visited the corporation headquarters to explain why I had not made my appointment to accompany the Japanese to Nashville, I drove back to Ohio via a somewhat circuitous route. I was still behaving rather strangely. Everything at work confused me. About the second or third day back I went to church instead of going to work at the plant. When a fellow employee came to get me and take me home, I started into growling again. I was again coming into mystical contact with the code of numbers and colors and sounds. The company contacted my family. My brother-in-law flew up from Texas and took me back with him. My family had me placed in yet another psychiatric hospital, the Air Force's Wilford Hall in San Antonio. I stayed there for several weeks and, after being released, returned to live with my parents, who were now in Florida. I was heavily drugged and the side effects of the medication made me extremely uncomfortable.

After spending about a month with my parents, I began to become extremely concerned about how I was going to support myself. I returned to Ohio and started looking for work in earnest. I applied for dozens of jobs. With my education and military experience, I easily obtained interviews, but when-

ever I mentioned I had been in mental hospitals, my reception would suddenly turn cold. No company offered me what I considered a suitable job.

I was receiving a small pension from the government, so I could eat and pay for a bed in a boardinghouse. But my days were empty. I became discouraged and went into a period of despondency. For several months I did very little of substance. Often I did not get out of bed until late in the afternoon. I spent most of my waking hours watching television and throwing darts at a target that hung in the living room. My life seemed to have little purpose or meaning.

When summer arrived, the other young men living in the boardinghouse decided to have a Fourth of July party. As the party began, for some reason my despondency lifted, and I suddenly became inspired to deliver a message to my fellow human beings. I had a mission again. I began to tell everyone I met that they were to celebrate the fact that all people in the world were members of the family of humankind. With joy in my heart I proclaimed to everyone I saw that we were all brothers and sisters. I went out into the street and, like Mohammed, proclaimed the message to all, including those in passing cars.

Before long a police car arrived, and I was taken away to the local state psychiatric hospital. After a brief chat with a man in a white coat who spoke with a heavy accent, I was placed in the seclusion room of one of the back wards.

While in the seclusion room, I realized that I had again come into mystical contact with a kind of Cosmic Force. Late at night, while others slept, I thought I could communicate directly with the people in the Orient, who were then awake during their daytime. I was full of my purpose. I knew I had a mission and had been blessed with special powers of communication.

During the daytime, I could look out through a hole about the size of a silver dollar in the seclusion room door. I could see my fellow patients, my new "friends and family members." They were behaving very strangely. One fellow kept goose stepping back

and forth along the far wall. Many just stayed in place and stared. I remember looking out and being struck by a realization that my mission was related directly to helping these people who were locked up in this back ward. I remember thinking quite clearly that if I put my mind to it and worked very hard, I might be able to help these mentally ill persons in some fashion. Perhaps I could somehow organize them.

I was in the seclusion room for three days before I was cleaned up and escorted to a courtroom setting somewhere in the hospital. The lawyers and doctors determined that I was “an insane person under the laws of the state of Ohio” and committed me to the state hospital for an indefinite period of time. It was my third breakdown, my third taste of florid psychosis. This was not my last breakdown, but from the perspective of my subsequent struggles I view this third experience as turning point, or at least the bottoming point, of my experience with psychosis.

After a few weeks in the state hospital, I was transferred to a veterans’ hospital, where I made a wooden bowl and was preoccupied with the number eight. I was released early in the fall.

In Recovery

SHORTLY AFTER MY RETURN to the boardinghouse from the Veterans’ Hospital, my luck took a turn for the better. One of the men in the house had a managerial internship in the state personnel office. He suggested I take the examination for a job as a psychologist. In 1968, only a bachelor’s degree was required to get a job as a state-employed psychologist. I took the test, passed, and was hired to work for the predecessor of what is now the Ohio Department of Mental Health.

Initially, I worked in a maximum-security facility, providing services to mentally ill offenders incarcerated in the state prison in Chillicothe. In the past these persons had been referred to as “the criminally insane.” I suffered periodic breakdowns,

but I learned to consult frequently with the Veterans’ Administration psychiatrists located just across the street. With their help I learned to adjust my psychotropic medication depending on my degree of stress and to withdraw by taking a few days off work until my thought processes began to return to normal. I became comfortable working with seriously mentally ill persons, but I also realized that if I were to be taken seriously in this type of work, I would have to earn advanced degrees in psychology.

After three years, I returned to school. It took me five years, full time, to complete the coursework for master’s and Ph.D. degrees. I was hospitalized twice and thus lost about one year. But, thanks in part to a few wise and very understanding psychology professors, I had completed enough schoolwork to leave for full-time employment in 1976.

Shortly before leaving the university, I attended a meeting of a charismatic group at the local Catholic church. I went out of curiosity, because my sister in Texas had become very involved with such a group. The group consisted mostly of graduate students as well as a number of former mental patients from the nearby state hospital. Group members were very friendly toward me, and I returned several times. I found their praying in tongues and other such behaviors a bit strange, but I also found myself making friends, particularly with one female graduate student in fine arts. She wore a wedding ring and frequently had a young child with her, who I assumed was her son. I was wrong. She explained one day that the child was her nephew, and the wedding ring signified that she was not available—she was a Franciscan nun. I was very much taken aback at the time, but probably no more than she was when I explained to her a few weeks later that I was schizophrenic.

I was in an impossible situation. I was in a developing relationship with a nun who was quite happy with her vocation and had no intention of leaving the religious life. I still do not know how it happened. Catholic boys do not grow up to marry nuns, and I am certain that no girl, nun or otherwise, dreams of a partnership-for-life with someone who

has schizophrenia. But somehow it did happen. Less than a year after we met, the beautiful lady who had entered the convent 15 years before and the man who had repeatedly been put away in mental hospitals during the previous 10 years were wed.

Shortly before the wedding, I had returned to work for the Ohio Department of Mental Health on a full-time basis at Ohio's largest public psychiatric facility, located near Cleveland. I worked on my dissertation in the evenings and on weekends. In 1978 our first child, Joe, was born, and in the fall of that year I was awarded the Ph.D. A year later I stood for the state licensing examination and shortly thereafter became a licensed psychologist. After a few additional years working with persons with serious mental illness and the arrival of our two daughters, I was promoted to the position of director of psychology, a position I have now held for more than 12 years.

It has now been almost exactly 25 years since I was put in the seclusion room in the Columbus State Hospital. From time to time I have had breakdowns, but I have been able to handle these episodes by taking off for a few days and spending my time singing, dancing, eating raw acorns, and synthesizing the world's religions or doing whatever else it takes for me to work through my difficulties. At any rate, I have not been rehospitalized since marrying and starting a family more than 16 years ago.

Lessons Learned

OF WHAT PURPOSE IS ANY OF THIS EXPERIENCE? Does it help or does it hinder my ability to serve the patients in my care? It could be suggested that a psychologist with schizophrenia is likely to be unreliable. How could one know that he was not again experiencing some sort of delusions? These are fair questions, but I feel such considerations are outweighed by three strengths.

First, since beginning to be open about this condition, I find I am becoming somewhat of a role model for others who have the disorder. Each time I

was released from treatment, I thought that I just might be the only unhospitalized recovering schizophrenic person in the country. There must have been others, but I did not know of any. If someone ever recovered, they simply did not tell anyone about it.

Having come out in the open, I now see others taking the attitude, "If he can do it, so can I." I travel around the country frequently, giving speeches about schizophrenia. Several large newspapers have written about my activities, and I display articles from the *San Francisco Examiner*, the *Houston Post*, the *Cleveland Plain Dealer*, and other papers outside my office. I have such joy whenever I see patients reading these articles. Usually their eyes begin to sparkle, and a look of knowing appreciation appears on their faces. I have also occasionally appeared on local television talk shows that my patients have seen. Their reaction afterward is almost uniformly positive and enthusiastic. It is as though they are joyous because "one of us made it." It seems to give them, and their families, such hope.

Because during group therapy sessions I am quite open about my background, the group meetings quickly become meetings of "us," those who share this disorder.

Second, I feel that having been there gives me a much better understanding of how the patients are behaving and thinking than I could have if I were just another chronically normal person. No matter how bizarre or confused a patient is, I know he is doing his best to live with his disability and to communicate with others. I can almost always connect with the patients by appreciating their metaphorical expressions and other use of poetic logic. They have such a need to be understood and such a difficult time relating to others effectively. In a way I see myself as a translator or even a kind of bridge to normality. Having lived in both worlds, not only can I empathize with those in psychosis, but I can clearly remember being there myself. Often this means my perceptions about patients may be quite different from those of other staff members. I sometimes find I must be very diplomatic with

other staff, but I have great confidence in my own approach to persons with serious mental illness.

Finally, during the past few years I have begun to see myself more as a guide or coach for others who are like me but are more disabled than I. Shortly after deciding to be public about my disorder, I began to be invited to deliver presentations to various mental health groups. Frequently I've been asked how I was able to recover when so many others have not been so fortunate. In formulating an answer to this question, I have drawn heavily on what I have observed in my patients, on the literature on serious mental illness, and on my own experience. Unless something rings true from all three perspectives, I tend not to be so confident about its value. With that criterion in mind, I slowly developed a list of 12 coping skills for persons with serious mental illness. My standard presentation of these skills takes about two hours, but they can be briefly stated as follows:

1. Denial tends to be part of the disorder. Accepting that you have mental illness is very difficult and needs to be addressed early.
2. Knowledge of the disorder is important. Learn all you can about your disability. Much that we know has only recently been discovered.
3. Medications are usually needed to help us with our disability. But because we have a biochemical vulnerability in our brains, many other chemicals, like street drugs and alcohol, are usually more harmful to us than they are to "normals."
4. Delusional thinking can be seductive. Each of us must carefully study how it occurs in our particular case.
5. Circumstantiality, or a tendency to leave a train of thought, is common even in recovered schizophrenics. We need to teach ourselves to stay on the topic, as normals are seeing the topic of discussion.
6. "Rehearsing" is a behavior we are prone to. We are frequently seen talking to ourselves. We need to reserve this activity to times when we have privacy.

7. For us, immediate memory and decision-making processes tend to be impaired. Precautions need to be taken in these areas. We need to let others understand that we often process information more slowly than they do.
8. Our facial expressions in response to others' addressing us in conversation tend to be delayed. Normal people often will be uncomfortable with this.
9. Developing hobbies, playing, listening or dancing to music, and viewing family pictures can help relieve stress.
10. Stigma, discrimination, and ostracism are serious problems that need to be addressed carefully and systematically.
11. Whether or not to reveal to others that you have this disability can be a difficult decision. Covering for time spent in hospitals or otherwise out of work can require creativity.
12. Networking with others like us is important. Loneliness can be a serious problem for persons with schizophrenia and other forms of psychosis. There are several good organizations with which you can affiliate, including especially the National Alliance for the Mentally Ill and the National Mental Health Consumers' Association.

This is my list of 12 in abbreviated form. I can talk at length about each skill, but space does not permit me to elaborate here. My list is a very pragmatic series of steps or strategies a person recovering from a serious mental disorder might find helpful. It is constructed from my personal experiences during the past 27 years, but it is not based, *per se*, on any particular theoretical framework.

People sometimes ask me if I have insight into the cause of this disorder. Those who believe that insight is necessary for healing are going to be disappointed with my view of recovery. My only explanation for my disorder is that I have inherited a biological vulnerability to schizophrenia and that when faced with extreme criticism and other forms of psychological insult or stresses my mind breaks repeatedly into a schizophrenic mode of functioning.

Insight-oriented therapies are notoriously ineffective with schizophrenia. I personally found these approaches to be invariably too stressful and even damaging. On the other hand, I feel that practical advice regarding how to survive in the everyday world and even to become a contributing member of society is valuable. That is my approach to making a contribution.

Looking Back

I very much enjoy working with the 300 or so patients at our hospital. I can see some of myself in every one of them. As I look back on the past quarter century of my daily experiences with my “brothers and sisters,” I feel, in a way, I have been experiencing a kind of mission. It is not a mission I ever would have chosen for myself. It has not had the earth-shaking importance I felt it would have during my periods of intense inspiration. But I feel most fulfilled by the work I do every day. I find joy with every patient I see.

And what of my own schizophrenia? How do I see it currently and in retrospect? Looking back at my three major episodes, although I do not think I have much insight into what caused them, I do feel I have a modicum of understanding about what was going on in my mind. During the first journey, when I was so certain that some important persons had been hypnotized by the enemies, I really was having my eyes opened to the fact that there are no bad people. Somehow, bad things happen to you because good people allow themselves to become mesmerized by the Enemy and engage in hurtful and unfortunate behavior. I think the metaphor that I became so confident about concerning the powers of the Enemy was perhaps not so different from other

metaphors used throughout our Judeo-Christian history. In my excitement I just became a little confused about who the real Enemy was.

When, in Milwaukee, I was breaking the code of the universe, I discovered the power of the Trinity as I have come to know it. My experience taught me that directly to approach the Deity in such a presumptuous manner can be fraught with terror and disaster. Such a thing is far too powerful an experience for a mere mortal to handle. I still have a code, of course. You may have noticed that I have used a generous sprinkling of sevens, twelves, and forties, as well as threes, as I constructed this narration. These religiously oriented mystical numbers give me little bits of joy as I go about any of my work. I know that this does not make rational sense, but I am most confident that neither I, nor anyone else, is a totally rational being. And my “secret code” unlocks innumerable joys for me throughout each day.

My adventure number three, in which I went forth to proclaim the unity of the human family, showed me that we all have messages in our hearts. We all know we are one in the Family of Humankind. But I know now that Great Truths that come into our hearts are perhaps best held for a while before being proclaimed to the world. Sometimes it may be best not to speak of them at all.

I am quite certain we each have our own Inner Light. We are each given our special mission. Each of us has a mission; finding it can be a most wonderful, but also perhaps terrifying, experience.

Thank you for taking this time to peek into the world of a person like me. I hope this will help you to understand a little better the next time you encounter one of us in your neighborhood, in your family, or, although we pray not, perhaps even in yourself. ☸



AIDS Quilt.

Photo courtesy of Impact Visuals, New York. Photographer: Sharon Stewart.

Mandatory HIV Testing and the Character of Medicine

Keith Berndtson

FEELINGS ARE PART OF EVERYDAY HUMAN REALITY, and when it comes to settling conflicts about values, reality has a way of getting the last word. If we want ethics to confront reality, then we want ethics to confront how emotions shape our value judgments and motivate our behaviors. Consider the following two examples.

Imagine that I show you a family portrait: a mother, a father, a preschool daughter, and an infant son. I tell you that the father got infected with the human immunodeficiency virus (HIV), which moved through his wife to his son. Then I tell you that all three died of the acquired immunodeficiency syndrome (AIDS). Then I tell you that the father was a closet homosexual. You register a response.

If I tell you instead that the father was a surgeon who contracted HIV on the job, is your response different? Even the simplest human stories are value-laden, and these values prompt feelings that occur before we've had a chance to pause and reflect. Rational thinking begins after we react emotionally to the facts.

Keith Berndtson is medical director of Rush Corporate Health Center, Rush-Presbyterian-St. Luke's Medical Center, Chicago, Illinois.

For citation: Berndtson, Keith. 1994. "Mandatory HIV Testing and the Character of Medicine." *Second Opinion* 19, no. 3 (January): 27–33.

Example two. You're in the hospital with acute appendicitis, and the surgeon whom you would prefer tells you that she is HIV-positive, and that, based on current estimates, the highest risk of getting infected from the procedure is 1 in 28,000 per hour of surgery (Lowenfels and Wormser 1991). Would you want a different surgeon? You'd certainly think about it. Even if you counted up to 28,000 by ones, you'd think about it. When doing ethics, we should acknowledge that emotions are part of the picture.

Where should an ethical inquiry begin? Most analyses are informed by theory, and most theories of ethics can be boiled down to their first questions. Aristotle, for example, began with the questions "What is my purpose?" and "What is good?" Kant began with the questions "What is my duty?" and "What is right?" My favorite first question comes from an ethical tradition founded by the theologian H. Richard Niebuhr (1963:63–68), who began by asking "What is going on?"

This question focuses our attention on getting the facts relevant to the issue at hand. It also reminds us that, whatever the issue, we had best stand humble before the possibility that a higher power may hold us accountable for how we choose to act

with what we are given. For purposes of this discussion, we are given a devil of a retrovirus that is exceptionally good at ruining human lives.

By the end of 1992, over 13 million people around the world had been infected with HIV. Roughly 3 million have developed AIDS, and of these, over 90 percent have died (Mann 1992:2). As many as one million Americans are thought to be infected with HIV (Anderson and May 1992:59). That's one in every 250 of us, most of whom are destined to suffer from AIDS within 10 years. Well over 100 million could be infected worldwide by the year 2000. We have seen more than enough HIV-related suffering to know that something must be done to control this pandemic. We also know that control measures have a greater payoff when they are taken earlier rather than later in the course of an epidemic. What role, if any, should mandatory HIV testing play in our fight against the spread of AIDS?

HIV Transmission Risks in Health Care Settings

TO DECIDE WHETHER THE MANDATORY TESTING of patients or health care workers for HIV is ethical, we need to know something about the risks of transmitting the virus in health care settings. HIV is not spread through the air or water. It is not passed along the fecal-oral pathway or by insects. HIV is blood-borne, and there appears to be but one method for transmission by various routes: the commingling of certain body fluids, be it via sex, intravenous drug abuse, transfusion, or other forms of contact.

It is in the health care setting that we are most concerned about these other forms of contact: needlesticks, other injuries from sharps, or exposure of infected fluid to non-intact skin or mucous membranes. If such exposures happen in emergency rooms, operating rooms, and other health care settings every day, does routine, involuntary screening of patients or health care workers make sense from a

public health perspective? If so, what are the ethical implications?

One study in a Baltimore hospital found that 3 percent of all emergency room patients were HIV-positive and that they accounted for 16 percent of patients seen because of trauma (Baker et al. 1987). Yet the AIDS Case Surveillance System of the Centers for Disease Control and Prevention shows that the prevalence of HIV in health care workers (Chamberland et al. 1989) is roughly the same as in the general population (Bureau of Labor Statistics 1988:93-94), suggesting little or no occupational hazard. More recent reports, however, suggest a small but as yet undetermined occupational risk to health care workers (Chamberland et al. 1991). This occupational risk appears to be more strongly related to the frequency of occupational exposures than to the infectiousness of the virus, which is generally thought to be quite low. Several postexposure studies suggest that the risk of transmitting HIV from infected patients to health care workers is about one per 300 exposures (Centers for Disease Control 1988a; Gerberding et al. 1987; Marcus et al. 1988).

Mandatory Testing of Patients

WE CAN TENTATIVELY CONCLUDE that transmitting HIV from patients to health care workers in an occupational setting is almost entirely preventable through the disciplined use of universal precautions, increased alertness when using sharps, and attentiveness to detail when performing invasive procedures (Centers for Disease Control 1988b; Nichols 1992; Gerberding 1991; McCormick et al. 1991). But if surgery, emergency medicine, and other health care work involving invasive procedures are more prone to result in the commingling of body fluids (Pittman et al. 1987; Hussain et al. 1988), should we consider routine testing of patients in these environments? We can scratch emergency room patients from the list because, to be useful, screening requires lead time during which corrective action can presumably

take place. But what about hospitalized patients, or at least patients scheduled for elective procedures?

Physicians in Illinois can test patients for HIV without their consent if they believe that it is in the patient's best interest to do so. Granting legal sanction for selective, involuntary screening would appear less ethically problematic than widespread mandatory testing, but this policy is no less vulnerable to criticism.

First, it permits resources to be wasted in indiscriminate testing, because most Americans (249 of 250) are *not* infected with HIV. Second, with all due respect to standard procedures, it is difficult to guarantee confidentiality about HIV-positive results, and this creates potential for HIV-related prejudice and discrimination. Third, physicians can easily confuse the patient's best interest with the desire to reduce their own anxiety, and no strong informed-consent safeguards are currently in place to protect the patient's rights. Fourth, selective screening may lower the incentive to observe universal precautions by providing false reassurance about HIV-negative status. Fifth, knowing a patient's HIV status is not required to improve adherence to universal precautions.

If these criticisms apply to a policy of selective testing without consent, they apply even more to a policy of mandatory testing without consent. As the epidemic unfolds, we may find ways to justify the selective, involuntary testing of certain patients in certain situations, but *carte-blanche* testing of patients for HIV without their consent appears morally reckless at best.

In performing mandatory testing of patients for HIV, then, we are making significant moral sacrifices—but for what? Insuring peace of mind for health care workers is a worthy goal, especially for those engaged in exposure-prone jobs, but it is also something of an illusion because of the problem of false-negative results. We should not waste scarce resources or trash long-standing ethical traditions in order to chase the illusion of a risk-free health care environment.

Mandatory Testing of Health Care Workers

WHAT ABOUT TRANSMISSION from health care worker to patient? In 1991, Illinois governor James Edgar appointed a task force of experts to consider the merits of mandatory testing of health care workers for HIV, based on reports of HIV transmission from a Florida dentist to as many as five of his patients (Governor's Task Force 1992; Moen et al. 1990). This Florida case, however, despite dozens of retrospective studies involving thousands of patients potentially exposed via procedures performed by HIV-infected health care workers (Danila et al. 1991; American Medical Association 1991), remains the only documented case of transmission from a health care worker to a patient. Based on fairly extensive experience, the risk of accidental transmission from health care worker to patient is virtually nonexistent. This is not to say that groups of surgeons should never volunteer for periodic pre-exposure testing or routine postexposure testing, because such studies can incrementally advance our understanding of the transmission dynamics and occupational risks of working with HIV-positive patients. But these kinds of studies do not hold promise for major preventive breakthroughs.

A policy of mandatory HIV testing for health care workers violates their rights to privacy and self-determination and cannot be justified by claims concerning public welfare or epidemic control. It wastes resources, it creates false impressions about patient exposure-proneness from surgical procedures, it discriminates against surgeons and other health care personnel, and it creates unnecessary administrative and liability headaches for physicians and hospitals. In short, it's unethical. So why all the fuss?

Politics, Law, Public Health, and Inertia

THERE'S A FUSS BECAUSE PUBLIC HEALTH POLICY in the U.S. is driven more by political than by medical expediencies. Politicians naturally respond to their loudest and most powerful constituents. But HIV is making its way into the population via the disenfranchised, who are neither loud nor powerful. Public health policy seems driven by twin fears: the fear of AIDS and the fear that decision makers may alienate their constituents, most of whom lack sophistication about AIDS or epidemic control.

Thus far in the epidemic, there is a lesson for policymakers: while political insiders look to the polls for ways to win votes, outside, in the real world, HIV is being spread by citizens who don't get polled or simply don't vote: teens, addicts, prostitutes, and poor ethnic minorities. Transmission rates among homosexuals are decreasing (Centers for Disease Control 1993), in large part because of the gay community's ability to organize preventive education efforts. But public health experts seem to spend more time slugging it out with a misinformed public than with the virus itself, and enlightening discussion tends to get drowned out by acrimonious debate. As is so often the case, medicine and ethics seem helpless spectators as one issue after another gets punted to the courts.

Courts will see the issue of mandatory testing as one of balancing private rights with the public interest. Two examples of court opinion serve as relevant precedents. In a famous case where a psychiatrist failed to warn a patient's girlfriend about his homicidal threats against her, the court ruled that "the protective privilege ends where the public peril begins" (*Tarasoff v. Regents of the University of California* 1976). But where, in the case of AIDS, does the public peril begin? At a risk of one in 28,000? One in 300? One in 250? In another landmark case which sought to determine where to draw the line concerning one's responsibility to foresee and prevent low-risk accidents, the court

ruled that "the risk reasonably to be perceived defines the duty to be obeyed" (*Palsgraf v. Long Island Railroad* 1928). A risk of contracting HIV from an infected surgeon of one in 28,000 per hour of surgery is like having a gun with one bullet and 28,000 chambers pointed at your temple. How many people would have peace of mind about such a low risk if a gun was actually at their temple? Yet virtually every activity in life carries some risk of death. Ordinarily we don't think about our daily activities in these terms. The gun with many chambers is always there, whether we like it or not, but it's only when we're conscious of the danger that it threatens our peace of mind.

One problem with relying on the law to manage this epidemic is that we can't afford to *wait* for courts to point the way. Another problem is that the law seems to have an even harder time than ethics of making emotions part of the picture. But the fear of AIDS *belongs* in the picture. Behind our fear of AIDS is a fear as old as time about the triumph of death, and as the prevalence of HIV increases, so will our fears.

Fear and Courage in the War against AIDS

A POLICY OF MANDATORY TESTING FOR HIV is a misguided attempt to escape the fears that we have about suffering and death. Mandatory testing would waste much, accomplish little, and trample ethical traditions along the way. If we want to be ethical, we're stuck dealing with an unpleasant emotion. What can we do with the fears we have about this virus?

Consider the parable of the lions. A shrewd pride of lions figured out a way to capture prey without having to work very hard. They sent the old toothless grandfather off to the far side of the plain, and the rest gathered behind the tall grass. Whenever potential prey came through the plain, the weak old lion would let loose a fearsome roar, and the prey would run straight into the clutches of death. The lesson,



Saint Michael Trampling the Devil. Oil on canvas by Raphael, ca. 1518.

Collection of the Louvre, Paris.
Photo: Scala/Art Resource, New York.

of course, is that we are better off facing our fears than running away from them. If we run away from our fears of HIV and AIDS, we will surely get ourselves into deeper trouble.

Once again, the problem isn't necessarily where the noise is. We need to wage war against drug abuse, unsafe sex, and the conditions that breed these behaviors. Our society can hardly be expected to wage an effective war against the AIDS virus if health care workers are being driven to distraction on the front lines by their own fears of HIV.

A painting by Raphael is called *Saint Michael Trampling the Devil*. In other settings, I have referred to it as "The Patron Saint of Physicians Enacting Tort Reform." For our purposes, it could be "The Patron Saint of Health Care Workers Taming Our Fear of AIDS." Fear yields to courage. Where do we get courage? Like any virtue, it can be inspired. An ethical analysis of mandatory HIV testing leads to a simple question about the character of medicine, namely, how do we inspire the courage needed to deal with the fear of AIDS?

In addressing this question, it is appropriate to consult the legacy of physician Benjamin Rush. It was Rush who said, "To spend and be spent for the good of mankind is what I chiefly aim at" (Butterfield 1951:lxixiii). Rush made his mark in history by inspiring others to virtue in both medicine and politics (Binger 1966:281–301). Two hundred years ago Rush led the battle against a yellow fever epidemic in Philadelphia. His letters are the sole historical account of this devastating plague. It is obvious from his account that the risks to physicians at that time were great, but few, including Rush, backed away from their tasks. Rush may not have had the right idea about the causes or treatment of yellow fever (in fact, his ideas were way off), but he understood that physicians and caregivers over the ages have had to contend with the occupational risks of contracting disease, and that facing these risks required great courage. He also believed that, when it came to controlling fearsome infectious diseases, good public health policy should trump politics as usual. This too can take courage.

The threat of AIDS seems to have us spellbound. Meanwhile, the virus makes its way into more bodies and more lives. It's early in the epidemic, but the clock is ticking away on policies that stand to have their greatest impact if implemented now. If we don't step up our response, I dread to think what we'll be saying and feeling about this virus and our response to it 10 years from now.

We can start to break the spell by acknowledging and, where possible, emulating the physicians, nurses, and allied caregivers who observe universal precautions to the letter; by respecting and learning from those who make a special point of handling sharps with care at all times; by honoring those who, when they perform invasive procedures, are able to demonstrate the extreme attentiveness to detail that this virus demands; and by supporting those who take political risks for the sake of medically and morally sensible AIDS policies. These colleagues are modeling our most highly ethical response to HIV-related risks in the health care setting and in the broader social setting. When the medical com-

munity models this kind of courage and commitment, we can ask the rest of our society to do the same.

When we face our fears about AIDS courageously, we will be better able to balance private rights with the public interest. If we can inspire courage in each other as we work together to manage this epidemic, voluntary screening based on informed consent will be able to assume its rightful place as the ethical standard for HIV testing in all settings.

Conclusion

POLITICS AND THE LAW have not done much to inspire courage in our fight against AIDS. Perhaps the inspiration can come only from medicine, the true front line. The accompanying photograph shows the AIDS quilt, laid out at the convention center in Houston. Many pieces of this quilt tell stories of remarkable courage. We need to imagine that the courage remembered on the AIDS quilt is present in a different form, filling the air around us. We need to breathe it in, because we'll need a great deal of courage if we're going to make a real dent in this epidemic. As health care givers, we need to look our fears in the eye and get on with our work.

We don't need mandatory testing. We need to acknowledge the doctors, nurses, and other front-line caregivers who are leading the way by taking the precautions that can and should be taken to prevent the spread of the AIDS virus in the health care setting. We should honor the health care professionals who are working through their fear of exposure to HIV to deliver competent and compassionate care where it is needed most.

The medical profession is undergoing a test of character. We can send the societies of this world a strong and positive message about controlling the AIDS epidemic. By modeling courage in the war against AIDS, we in the health care fields can reassure our fellow citizens that to spend and be spent for the good of humankind is our chief aim. ☸

NOTE

This paper was adapted from a presentation given as part of the Annual Alumni Grand Rounds of Rush Medical College in June 1992. I wish to thank Steven Bines, Jeffrey Lisowski, Harold Kessler, Renslow Sherer, Jr., and Russell Burck for their input.

REFERENCES

- American Medical Association. 1991. Board of Trustees Report VV (I-91).
- Anderson, Roy, and Robert May. 1992. "Understanding the AIDS Pandemic." *Scientific American* 266, no. 5 (May): 58–66.
- Baker, James, Gabor Kelen, Keith Sivertson, and Thomas Quinn. 1987. "Unsuspected Human Immunodeficiency Virus in Critically Ill Emergency Patients." *Journal of the American Medical Association* 257:2609–11.
- Binger, Carl Alfred Lanning. 1966. *Revolutionary Doctor: Benjamin Rush, 1746–1813*. New York: Norton.
- Bureau of Labor Statistics. 1988. *Employment and Earnings* 35, no. 13. Washington, D.C.: U.S. Department of Labor.
- Butterfield, Lyman Henry. 1951. *Letters of Benjamin Rush, Volumes I and II*. Princeton, N.J.: Princeton University Press.
- Centers for Disease Control. 1988a. "Update: Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus Infection among Health Care Workers." *Morbidity and Mortality Weekly Report* 37:229–39.
- . 1988b. "Update: Universal Precautions for Prevention of Transmission of HIV, Hepatitis B, and other Blood-borne Pathogens in Health Care Settings." *Morbidity and Mortality Weekly Report* 37:372–88.
- . 1993. "Update: Acquired Immunodeficiency Syndrome—United States, 1992." *Morbidity and Mortality Weekly Report* 42:551–57.
- Chamberland, Mary, Lois Conley, and Timothy Bush. 1989. "Surveillance of AIDS in Health Care Workers in the United States" (abstract). *Programme and Abstracts*, International Conference on Blood-borne Infections in the Workplace, Stockholm, Sweden, 28–30 August.
- . 1991. "Health Care Workers with AIDS: National Surveillance Update." *Journal of the American Medical Association* 266:3459–62.
- Danila, Richard, Kristine MacDonald, and Frank Rhame. 1991. "A Look-back Investigation of Patients of an HIV-infected Physician: Public Health Implications." *New England Journal of Medicine* 325:1406–11.
- Gerberding, J. Louise. 1991. "Does Knowledge of Human Immunodeficiency Virus Infection Decrease the Frequency of Occupational Exposure to Blood?" *American Journal of Medicine* 91 (Supplement 3B): 308S–311S.
- Gerberding, J. Louise, Charyl Bryant-LeBlanc, Kathleen Nelson, Andrew Moss, Dennis Osmond, Henry Chambers, James Carlson, Lawrence Drew, Jay Levy, and Merle Sande. 1987. "Risk of Transmitting the Human Immunodeficiency Virus, Cytomegalovirus, and Hepatitis B Virus to Health Care Workers Exposed to Patients with AIDS and AIDS-related Conditions." *Journal of Infectious Disease* 156:1–8.
- Governor's Task Force on AIDS in Health Care. 1992. "Recommendations." Chicago: Illinois Department of Public Health.
- Hussain, S. A., A. B. A. Latid, and A. A. A. A. Choudary. 1988. "Risk of Surgeons: A Survey of Accidental Injuries during Operations." *British Journal of Surgery* 75:314–16.
- Lowenfels, Albert, and Gary Wormser. 1991. "Risk of Transmission of HIV from Surgeon to Patient." *New England Journal of Medicine* 325:888–89.
- Mann, Jonathan, ed. 1992. *AIDS in the World: Report of the Global AIDS Policy Coalition*. Cambridge, Mass.: Harvard University Press.
- Marcus, Ruthanne, and the CDC Cooperative Needlestick Surveillance Group. 1988. "Surveillance of Health Care Workers Exposed to Blood from Patients Infected with the Human Immunodeficiency Virus." *New England Journal of Medicine* 319:1118–23.
- McCormick, Rita, Mary Meisch, Fran Ircink, and Dennis Maki. 1991. "Epidemiology of Hospital Sharps Injuries: A 14-year Prospective Study in the Pre-AIDS and AIDS Eras." *American Journal of Medicine* 91 (Supplement 3B): 301S–307S.
- Moen, Michael, Dorothy Reier, Joan Le Tourneau, Mary Sheehan, Joann Armstrong, Mitchell Bender, Michael Osterholm, and the Investigative Team. 1990. "Possible Transmission of Human Immunodeficiency Virus to a Patient during an Invasive Dental Procedure." *Morbidity and Mortality Weekly Report* 39:489–93.
- Nichols, Ronald Lee. 1992. "Percutaneous Injuries during Operation." *Journal of the American Medical Association* 267:2938–39.
- Niebuhr, H. Richard. 1963. *The Responsible Self*. New York: Harper.
- Palsgraf v. Long Island Railroad*. 1928. 248 N.Y. 339, 162 N.E. 99.
- Pittman, Michael, Hamish Laing, and Nicholas Hall. 1987. "Safer Surgery for All" (letter). *British Medical Journal* 295:725.
- Tarasoff v. Regents of the University of California*. 1976. 17 Cal. 3d 425, 551 P.2d 334 131 Cal. Rptr. 14.



Consideration. Oil on canvas by Alfredo Casteñeda, 1986.

Photo courtesy of Mary-Anne Martin/Fine Art, New York.

Does “No” Mean “Yes”?

The Continuing Problem of Jehovah’s Witnesses and Refusal of Blood Products

Dena S. Davis

A TOPIC OF CONTINUING INTEREST in law and medicine, and in biomedical ethics, is the appropriate response to Jehovah’s Witnesses who refuse blood transfusions when doing so may endanger their lives. In theory, it is settled law that competent adult Witnesses may not be forced to accept transfusions. In practice, however, Witnesses are often subject to intense coercion by medical personnel. For example, physicians often threaten to obtain court orders. Sometimes they actually seek such orders, and occasionally they obtain them (such an order may also be overturned on appeal, but it will be too late for the individual Witness involved).

In these cases many physicians, lawyers, members of hospital ethics committees, and others believe that Witnesses actually wish to be coerced—that is, the thinking goes, the Witness believes that she is forbidden under pain of damnation to ask for or agree to a transfusion, but if she puts up a token resistance and is then forced to a transfusion by court order, the religious consequences do not apply.

Dena S. Davis is assistant professor of law, Cleveland-Marshall College of Law, Cleveland, Ohio.

For citation: Davis, Dena S. 1994. “Does ‘No’ Mean ‘Yes’? The Continuing Problem of Jehovah’s Witnesses and Refusal of Blood Products.” *Second Opinion* 19, no. 3 (January): 35–43.

Ethicists have tried to address this issue with leaders of the denomination, but they have not obtained a clear answer (Jonsen 1986:92). Leaders have not definitively stated whether coerced transfusions carry the same stigma as freely accepted ones; nor will they confront the possibility that some of their flock may be fainthearted enough to wish secretly that legal coercion will save their lives.

The unfortunate result of this situation is that many physicians, hospital counsel, and others believe that when faced with a Jehovah’s Witness, “no means yes.” I use the sexual-coercion metaphor deliberately, because I argue that the consequences are equally serious. Just as a great deal of “acquaintance rape” occurs because some men are socialized to believe that women can’t really say yes but don’t expect or want their refusals to be taken seriously, so coercion against Witnesses occurs because physicians and others see the refusals as formulaic rather than sincere. From the perspective of the physician who believes this, the Witness “wins” when she can go on saying no but receive the transfusion anyway. One can readily see how difficult, even impossible, it would be for a Witness to convince her physician otherwise, because every protestation would be treated as a predictable move in this

“game” they are playing (and because physicians are powerfully motivated to provide treatment when treatment exists). Witnesses have made the point that being transfused against their will, with or without a court order, is akin to being raped (Ridley 1990:17). One woman, a Witness herself and a lawyer for the organization, reiterated this point in a letter to me: “I would equate a forced blood transfusion with rape. It is not a matter which is minimized by the existence of a court’s order or a doctor’s decision that an emergency exists” (Carolyn Wah, 17 July 1990).

Another unfortunate consequence of this belief concerns sick children: Physicians who believe that parents’ refusals are formulaic rather than sincere will simply go for the court order (which they are almost guaranteed of obtaining) rather than exploring the possibility of alternative treatments that could satisfy both therapeutic and religious imperatives. As we shall see further on, safe, alternative treatments, such as blood volume expanders, are sometimes available to physicians who are both aware of these alternatives and skilled in their use.

Yet another harmful result of this “no means yes” belief goes beyond its impact on Jehovah’s Witnesses. Health care personnel who “learn” that they are not to take one group of people seriously may find it easier to override or trivialize the inconvenient beliefs of other patients as well.

We are faced, therefore, with an ethical dilemma. On the one hand, we find some confusion about the religious status of Witnesses who are transfused against their will; on the other, as I show below, in at least some cases “no” really may mean “yes.” To treat those cases as if no meant no would be to lose some lives that could have been saved. On the other hand, to refuse to take no for an answer coerces some Witnesses in ways that are offensive to our legal and ethical notions of privacy, self-determination, and religious freedom, and arguably weakens respect for patient autonomy and informed consent overall.

The Jehovah’s Witness Perspective

THE JEHOVAH’S WITNESSES are a Christian denomination with unique interpretations of a number of biblical passages. Founded in 1872 in Allegheny, Pennsylvania, by Charles Taze Russell, the movement currently claims more than four million members in more than 200 countries. Their refusal of blood stems from their reading of Genesis 9:3–4, in which God, after the Flood, says this to Noah:

Every creature that lives and moves shall be food for you; I give you them all, as once I gave you all green plants. But you must not eat the flesh with the life, which is the blood, still in it. (NEB)

That passage is familiar to observant Jews as the basis for the Jewish practice of koshering meat (that is, draining the blood through specific butchering practices). Jews, of course, do not interpret the passage as barring them from the medical use of human blood, but Witnesses do, quoting other biblical passages to ground their interpretation—for example, Leviticus 17:10–11:

If any Israelite or alien settled in Israel eats any blood, I will set my face against the eater and cut him off from his people, because the life of the creature is the blood.

Witnesses view this injunction as absolute, even in life-and-death emergencies.

Witnesses are often asked why they “pick and choose” among the laws God gave to the Israelites, insisting on abstaining from blood but not following other Jewish practices, such as the prohibition on mixing milk and meat. Their answer is twofold. First, the seven laws given to Noah, and therefore to the entire human race, were meant to apply to everyone, not only to those who later in the Hebrew Bible were set apart as God’s covenanted people. Second, the apostles dealt with the issue of which

Jewish practices applied to Christians in the book of Acts, where they settled the important question of whether non-Jews who accepted Christianity needed to become circumcised. According to Acts 15:28–29, the council decided that only a few essentials were required:

The holy spirit and we ourselves have favored adding no further burden to you, except these necessary things, to keep abstaining from things sacrificed to idols and from blood and from things strangled and from fornication. If you carefully keep yourself from these things, you will prosper.

In other words, to a believing Jehovah's Witness, accepting blood in any form, whether by mouth or by intravenous administration, is as serious a sin as fornication.

The official policy banning transfusions was announced in 1945, about the time that blood transfusions became a common medical practice. Official policy (set by an 18-member governing body) has gone back and forth on related medical issues. Organ transplants were banned in 1967, but that ban was reversed in 1980, and transplants are held to be a matter of individual conscience, as are gamma globulin and other serums that contain a blood component. Furthermore, an early ban on the use of blood particles by hemophiliacs was reversed in the late 1970s (Cumberland 1986:474–77).

Witnesses believe that the end of history is very near, and many Witnesses expect to see it in their lifetime. As a Witness pamphlet title puts it, "Millions Now Living Will Never Die." Witnesses believe that the end will begin with a great battle, in which Satan and all wicked human beings will be destroyed. A number of true believers, 144,000, will be born again and go to heaven to rule with Christ. On Earth, Christ will establish a new and perfect kingdom where the remainder of his righteous followers will dwell in everlasting peace.

Some non-Witnesses persist in trying to discover just exactly what terrible consequence Witnesses expect if they do accept blood. Will they be

damned forever? Will God refuse to forgive them? Will they be disfellowshipped here and now? Witnesses have usually refused to be explicit about this, talking instead in more general terms like these:

A Christian's happiness and continued life in the future are based upon faith and obedience. For that reason, the early Christians were willing to risk their present life rather than go contrary to their religious beliefs. Jehovah's Witnesses today are just as determined to maintain their good relationship with God. (Watchtower Bible and Tract Society 1977:61)

This preoccupation by non-Witnesses with the exact punishment for accepting blood is often inappropriate and offensive. If we talk with a Quaker who goes to jail rather than bear arms, or a Jew who refuses to work on the Sabbath, we usually focus on the positive aspects of their obedience to their religious convictions rather than on the stick-and-carrot aspects of their religious belief. In any case, it is quite difficult to ascertain the relationship between the Witness belief in the afterlife and obedience to biblical precepts here on Earth. Some evidence from the early days of this controversy indicates that Witness authorities viewed recipients of blood—whether children or adults—as having lost their chance of resurrection. At the very least, adult Witnesses who willingly accept blood products can be disfellowshipped if they do not repent. In contrast, my extensive discussion of this point with Jehovah's Witness elders has made it clear that people who are transfused against their will are treated with comfort and consolation, as victims of an assault, and are not stigmatized.

Certainly, at times, one might need to ascertain what the earthly consequences will be for a Witness who is transfused against his will. For example, in a recent case in a midwestern hospital, the patient was a retarded adult who had been raised as a Witness and was living at home, well cared for by his loving family. The patient needed a blood transfusion to have a reasonable chance of surviving surgery. If a

court order forcing the family to accept blood transfusions for their retarded son would stigmatize the patient in his family's eyes and, perhaps, even isolate the family from the rest of the community, the loss to this patient of his supportive environment could be so great that the transfusion might not be in his best interests. Terence F. Ackerman (1980), discussing a related situation, argues that the pediatrician must take the well-being of the family unit into account, and that the parents' provision of psychosocial support can be seriously undermined if the stress of being in transgression of God's law exacerbates the stresses of serious illness.

Recently, Witnesses have attempted to buttress their religious tenets with medical arguments against the use of blood products (Watchtower Bible and Tract Society 1990; Ridley 1990). What may surprise the newcomer to this discussion is the extent to which alternatives to blood products are available, so that it is often quite inaccurate to pose the dilemma in a life-or-death fashion. (It must be remembered that Witnesses object only to blood products, and not to medicine, *per se*. In this they are quite different from, for example, Christian Scientists.) Witnesses are alert to every medical nuance that affects them, and their tracts are full of quotations from the most prestigious medical journals. The pamphlet "How Can Blood Save Your Life?" quoted an editorial in the *Mayo Clinic Proceedings* as saying that one of the few "benefits" of the AIDS epidemic was that it "resulted in various strategies on the part of patients and physicians to avoid blood transfusion" (Watchtower Bible and Tract Society 1990:16). The same pamphlet discusses such alternatives to blood products as boosting the patient's ability to produce red blood cells with the use of synthetic erythropoietin, introducing volume expanders to guard against shock from blood loss, priming patients before surgery with extra fluids, and so on. Several surgeons have pioneered high-risk surgery with Witnesses and report that the risk is not substantially greater than for the population as a whole.¹ Unfortunately, many practitioners do not know that alternatives are often

effective, or they are not interested in achieving the high level of care and skill that are required to treat Witnesses safely.

The "No Means Yes" Perception

Legal Cases

1. THE FIRST AND MOST FAMOUS CASE that raised the no-yes strategy was *Georgetown College* (1964), in which Judge Skelly Wright ordered a 25-year-old woman, Jessie Jones, to undergo blood transfusions that the hospital physicians claimed were necessary to give them even a 50 percent chance of saving her life. This opinion is poorly reasoned, and it is unfortunate that it is often cited approvingly today. Judge Wright analogizes the religiously based refusal of blood products to suicide, despite the fact that in the next paragraph he agrees that Mrs. Jones did not seek death. Wright also uses the analogy of making decisions for children, relying on the spurious argument that Mrs. Jones was, at the point where he was called in, in extremis and not mentally competent. In doing so, he ignores the fact that she was a longtime Jehovah's Witness and that her husband, also a Witness, was steadfastly refusing transfusions on her behalf. His description of visiting Mrs. Jones in her room is paternalistic and condescending:

Her appearance confirmed the urgency which had been represented to me. I tried to communicate with her, advising her again as to what the doctors had said. The only audible reply I could hear was "Against my will." It was obvious that the woman was not in a mental condition to make a decision. I was reluctant to press her because of the seriousness of her condition and because I felt that to suggest repeatedly the imminence of death without blood might place a strain on her religious convictions. I asked her whether she would oppose the blood transfusion if the court

allowed it. She indicated, as best I could make out, that it would not then be her responsibility. (*Georgetown College* 1964:1007)

The following nugget of the opinion is most relevant to our discussion:

Mrs. Jones had no wish to be a martyr. And her religion merely prevented her consent to a transfusion. If the law undertook the responsibility of authorizing the transfusion without her consent, no problem would be raised with respect to her religious practice. Thus, the effect of the order was to preserve for Mrs. Jones the life she wanted without sacrifice of her religious beliefs. (*Georgetown College* 1964:1009)

Unfortunately, Judge Wright doesn't tell us in his opinion where he got *that* idea, and it isn't to be found in any Witness literature. Mr. Jones, who continued adamantly to oppose the transfusion, could not have been the source of Wright's bland certainty that "no problem would be raised with respect to her religious practice." It appears that Judge Wright, faced with the waste of a young life for reasons that doubtless seemed irrational to him, came up with a convenient fiction by which everyone can be said to have won.

2. The second case occurred a year later, at a Veterans' Administration hospital in Connecticut (*United States v. George* 1965). At least as we hear the tale from the judge's perspective, the patient and court eagerly colluded to absolve the patient of responsibility, and the decision to order the transfusion thus appears morally justified:

Mr. George appeared to the Court to be coherent, rational and rather strong. However, doctors in attendance agreed his outward appearance was deceiving and his internal condition was most serious. When the Court introduced himself, George's first remarks were that he would not agree to be transfused but would in no way resist a court order permitting it, because it would be the Court's will and not his own. His "conscience was clear,"

and the responsibility for the act was "upon the Court's conscience." He stated he would rather die than agree to a transfusion. The Court advised George it had no power to force a transfusion upon him, and he was free to resist the transfusion, even by the rather simple physical maneuver of placing his hand over the area to be injected by the needle. George stated he would "in no way" resist the doctors' actions once the Court's order was signed.

Mrs. George, citing certain passages from the Bible, was adamant in her opposition to the transfusions. She insisted that the Court had no right to order the transfusion in violation of their religious beliefs. Two other Jehovah's Witnesses, visiting the patient, concurred in Mrs. George's remarks (*United States v. George* 1965:753).

This case presents a good example of the situation as doctors envision it when they encounter Witnesses: the patient wants to have blood products if they will mean the difference between life and death but is unwilling to come out and say so. Furthermore, the family and religious advisors at the bedside appear, from the physicians' and judge's perspective, to be pressuring the patient to adhere to religious orthodoxy. In this situation, imposing a court order on a passive patient is a strategy that appears to save both life and "face."

3. The final example also occurred in 1965 and is worth quoting for the judge's impassioned opinion alone (*Powell v. Columbia Presbyterian Medical Center*). The story begins with Mrs. Willie Mae Powell, who had suffered extensive bleeding after a Cesarean section and, according to her doctor, was now in danger of losing her life:

The patient, based upon her religious beliefs as a member of Jehovah's Witnesses, refused to give her prior written authorization for the administering of blood transfusions. In this refusal she had rebuffed the pleas of the hospital staff and other members of her family. Mrs. Willie Mae Powell is the mother of six children. There was danger that at any moment such refusal might result in her death. (*Powell* 1965:451)

Judge Jacob Markowitz tells us that “never before had my judicial robe weighed so heavily on my shoulders” (1965:451). He says that after reading *Georgetown College*, he was convinced of the “proper course from a legal standpoint,” but that ultimately he rested his decision on “more fundamental precepts,” which unfortunately he never articulates logically:

It became clear to me that the crux of the problem lay, not in Mrs. Powell’s religious convictions, but in her refusal to sign a prior written authorization for the transfusion of blood. She did not object to receiving the treatment involved—she would not, however, direct its use. I was also convinced that the hospital, having obtained a signed release of liability . . . , took the view that it had fulfilled its obligations to this patient and would not, under these circumstances, administer blood transfusions even if necessary to save the patient’s life. How legalistic minded our society has become, and what an ultra-legalistic maze we have created to the extent that society and the individual have become enmeshed and paralyzed by its unrealistic entanglements! I was reminded of “The Fall” by Camus, and I knew that no release—no legal absolution—would absolve me or the Court from responsibility if I, speaking for the Court, answered “No” to the question “Am I my brother’s keeper?” This woman wanted to live. I could not let her die! (*Powell* 1965:452)

But *how* did it “become clear” to the judge that the crux of the problem lay in the patient’s objection to signing the form rather than to receiving the treatment? Did he, like Skelly Wright, actually go to the patient’s bedside? If so, he doesn’t say. What seems clear is that the focus of moral decision making moved from Willie Mae Powell to Jacob Markowitz, and the question here is not how Mrs. Powell will live or die with her convictions, but how Judge Markowitz will live with his. In the process, he shows a tenderness for his own moral convictions that he does not extend to Mrs. Powell.

Recent Commentary

ALTHOUGH THESE THREE CASES ALL OCCURRED in the mid-sixties, the notion that legal coercion nullifies or mitigates the sinfulness of receiving blood products remains common today. In an essay that originally appeared in 1980, for example, philosopher Joel Feinberg criticizes a decision in which the mother of three young children was allowed to die rather than being forced to accept blood transfusions. Without further comment, Feinberg states that “the parents’ ‘sin’ would certainly be mitigated by the fact that it was ‘committed’ involuntarily under government duress” (1992:81). If Joel Feinberg is a religious man, his God surely makes the same scrupulous distinctions that Professor Feinberg himself does so well. But that’s not sufficient reason for assuming that the God of the Jehovah’s Witnesses behaves in comparable fashion.

In a careful and sensitive article describing how a hospital ethics committee grappled with the problem of pregnant Witnesses who refuse transfusions, Ruth Macklin, a bioethicist and philosopher, drew the following conclusions:

Ambivalent patients under stress may, in extremis, decide to accept transfusion or even indicate their wish to be coerced, so that the transfusion is administered, in words often uttered by Jehovah’s Witness patients, “against my will.” Conversely, some patients strongly desire the transfusion but in the presence of a church member or under pressure from a family member, continue to refuse despite their wish to live. (1988:16)

I suspect Macklin is right. The problem is, how does she know this? Has she had patients speak privately with her later and tell her that they were glad to have been coerced? I strongly doubt that. And assuming that “some” patients are looking for this loophole, how do we know which ones they are?

From my own research, I can report that a very high number of health care workers, hospital lawyers, and so on, do believe that no means yes. For

example, a social work student told me that this is what she was taught in class, when the subject of Witnesses came up. A Jewish lay hospital chaplain, a member of his hospital's ethics committee, told me a long story about a recent Jehovah's Witnesses' case, in which he blandly repeated as fact the nurse's proffered explanation that the family "would feel more comfortable" if a court order were obtained. And recently, the legal counsel for a prestigious midwestern hospital told me as fact that when Witnesses are given blood over their objections, the "stigma does not apply." When I asked him how he knew that, he said the chair of the bioethics office at his institution had told him so.²

What makes this situation so baffling is that Witnesses themselves almost never engage this issue directly. Although they have pamphlets that address every legal, medical, and religious aspect of the "blood question" with impressive thoroughness and sophistication—sometimes showing an acute sensitivity to the perceptions and motivations of doctors and judges—none mentions the issue I am addressing. In discussion with a Jehovah's Witness lawyer who is active on his church's behalf, I simply got the pat response about "the right of the individual to refuse medical treatment."

My conversation with Gene Tenke, the chair of the Jehovah's Witness Hospital Liaison Committee in Cleveland, Ohio, however, was an exception. He and one of his associates were willing to look at this question with me. They agreed that Witnesses sometimes avail themselves of the no-means-yes strategy and that they hope for legal intervention. They went on to say that such Witnesses were typically new members or "weak in the faith." But that need not concern us here. What does concern us is that as long as the no-means-yes belief is pervasive among non-Witnesses, and as long as at least some Witnesses see this as a lifesaving strategy, our ethical issue is difficult indeed.

The Philosophical Problem

IF WE COULD BE POSITIVE that every Jehovah's Witness *meant* no when he said no, we would have an obvious resolution to this problem. Judges, doctors, and other decision makers would have to be educated to understand that no never means yes, and that to treat it as yes is an unacceptable delusion. Witness refusals would have to be honored for two reasons: first, respect for individual autonomy and the free exercise of religion; second, the negative effect on respect for patient autonomy generally, especially among doctors, if a no-means-yes strategy is acceptable for one group. (I remember that, for example, when "natural childbirth" and the general philosophy of pregnant women as active participants in their medical care were first promulgated in the late 1960s and 1970s, doctors commonly said that women felt forced by fashion and peer pressure to refuse pain medication, C-sections, and so forth and were secretly glad to have their wishes overridden.)

Unfortunately for the easy solution, some Witnesses may rely on a no-means-yes strategy to give them an "out." So, here is our quandary: Do we insist that people mean what they say and respect their stated wishes, thus losing some lives that might have been saved? Or do we override when we suspect (on what grounds?) that the patient secretly wishes us to do so, thus coercing some people who truly wished to live and die by their religious convictions? (Of course, even going the first route does not preclude us from using strategies that allow the Witness to change his mind, for example by insisting that he repeat his refusal when he is alone with his doctor.)

Each of these choices presents gains and losses. If we respect the patient's *no* and make it clear that we will not get a court order for a competent adult, we may "fail" some patients who were looking for the paternalistic "out." (Of course, we will never know how many.) Some lives will be lost, and some children will be parentless. We gain, however, an increase in respect for patient self-determination and, arguably, an expansion of alternative medical modalities.

If, on the other hand, we allow doctors to intuit which patients really want to be coerced (and in the case of *United States v. George*, assuming it is accurately reported, the intuition seems correct) and respond with court orders, we will certainly be committing a terrible assault against the dignity and autonomy of some patients. We will also be sending a message to doctors that religious views are not to be taken seriously and that courts will collude with physicians who refuse to respect patients' refusals.

There already exists a good deal of concern about the validity of advance directives and treatment refusals. Health care providers and ethicists worry that paranoia, depression, or ambivalence may undermine a true expression of patient preference (Howe 1993). Patients often must make crucial decisions when they are ill, frightened, or in an emergency situation. In an attempt to get a better sense of patients' true desires, a number of ethicists have suggested elaborate "values histories" (Doukas and Gorenflo 1993; Vinicky and Kanoti 1987). In contrast, the typical

**Health care personnel who
"learn" that they are not to
take one group of people
seriously may find it easier to
override or trivialize the
inconvenient beliefs of other
patients as well.**

Witness presents with a signed statement, made while she was in good health, evidencing a long-standing commitment to a religious community for which refusal of blood is a central tenet. Of course, illness or injury may cause her to change her mind, and it is important that she be given the opportunity

to do so. But if she stands by her religious convictions, it seems to me that this is a paradigm of an authentic decision. If we cannot respect this refusal, what decisions *will* we respect?

My conclusion is that courts, hospital ethics committees, and other decision-making and advisory bodies should make it clear that they *will* take competent adults at their word.³ This

puts the responsibility where it belongs: on the shoulders of the patient who is making health care decisions for herself. Only she can weigh her religious convictions against the possibility of death. We simply cannot afford the erosion of respect for individual liberty that the continued charade must inevitably engender. ☸

NOTES

I am grateful to my research assistant Christopher Janezic and to colleagues who read earlier drafts of this essay, including Rebecca Dresser, David Forte, Joel Finer, and the Works-in-Progress Group of the Case Western Reserve University Center for Biomedical Ethics. I am especially indebted to Gene Tenke, chair of the Cleveland Jehovah's Witness Hospital Liaison Committee. His unfailing sense of humor and generous spirit toward an "outsider" were invaluable as he helped me track down resources, invited me to Kingdom Hall meetings where "blood" was on the agenda, and arranged for me to meet with others of his faith. This work was supported by a research grant from the Cleveland-Marshall Fund.

1. Recently, I invited a Jehovah's Witness to talk to my class on church and state issues; when I reached the man by phone, he informed me that he would be delighted to come despite the fact that he was recovering from a triple cardiac bypass done, without the use of blood products, at the Cleveland Clinic. His appearance in my class, looking remarkably healthy, was a public relations tour de force!
2. I have discussed this topic over a three-year period with students (often with health care backgrounds) in my biomedical ethics classes, with health law professors in the Medical Institute for Law Faculty (run jointly by the Cleveland Clinic Foundation and the Cleveland-Marshall College of Law), and with physicians and nurses at the Cleveland Clinic and the Metro Health Medical

Center. The majority of health care professionals have heard the myth at some time and have rarely seen any reason to deconstruct it. The myth continues in the legal world through such confused passages as the following: "[C]ourt authorizations involving adult Jehovah's Witnesses have applied to patients who said they would not resist the transfusion if ordered. Thus, the authorization was designed to protect the patient from fellow adherents, not to override the patient's wishes. The protective effect of court authorizations has been eliminated by changes in church doctrine, so fewer patients agree not to resist" (Miller 1990:263). I asked Miller, in a telephone conversation, what "church doctrine" he was referring to and how it had "changed," but he could not tell me, other than a vague reference to "what everyone knew."

3. I am arguing only for the right of *adult* Witnesses to refuse blood products. Because my conclusion is grounded in the principle of respect for autonomy, my argument does not extend to children. I do not believe that children are competent to make such important decisions for themselves, nor do I believe that parents have the right to "make martyrs of their children," as Justice Rutledge said in one of the earliest Jehovah's Witnesses cases (*Prince v. Massachusetts* 1944:170). Feinberg (1992) is surely correct to say that every child has "a right to an open future," which means at the very least that the state should intervene to protect the child's right to life, health, and a basic education.

Nonetheless, there is a significant "gray" area where creative and sympathetic doctors who respect the sincerity of Witnesses' beliefs can often attempt safely to treat children without the use of blood products (for example, by limiting the number of times a newborn's blood is drawn or by the use of "cell savers," which circulate the patient's lost blood back into her body, a technology Witnesses accept). Doctors and judges who believe that parents who refuse blood for their children do not really want to be taken at their word will be less likely to search for these alternatives.

REFERENCES

- Ackerman, Terence F. 1980. "The Limits of Beneficence: Jehovah's Witnesses and Childhood Cancer." *Hastings Center Report* 10 (August): 13–18.
- Cumberland, William H. 1986. "The Jehovah's Witness Tradition." In *Caring and Curing: Health and Medicine in the Western Religious Traditions*, ed. Ronald L. Numbers and Darrel W. Amundsen, 468–85. New York: Macmillan.
- Doukas, David John, and Daniel W. Gorenflo. 1993. "Analyzing the Values History: An Evaluation of Patient Medical Values and Advance Directives." *Journal of Clinical Ethics* 4, no. 1: 41–45.
- Feinberg, Joel. 1992. "The Child's Right to an Open Future." In *Freedom and Fulfillment: Philosophic Essays*, ed. Joel Feinberg, 76–97. Princeton, N.J.: Princeton University Press.
- Georgetown College*. 1964. 331 F.2d 1000, *cert. denied*, 337 U.S. 978.
- Howe, Edmund G. 1993. "The Vagaries of Patients' and Families' Discussing Advanced Directives." *Journal of Clinical Ethics* 4, no. 1: 3–7.
- Jonsen, Albert R. 1986. "Blood Transfusions and Jehovah's Witnesses: The Impact of the Patient's Unusual Beliefs in Critical Care." *Critical Care Clinics* 2:91–100.
- Macklin, Ruth. 1988. "The Inner Workings of an Ethics Committee: Latest Battle over Jehovah's Witnesses." *Hastings Center Report* 18 (February/March): 15–20.
- Miller, Robert D. 1990. *Problems in Hospital Law*. 6th ed. Rockville, Md.: Aspen Publishers.
- Powell v. Columbia Presbyterian Medical Center*. 1965. 267 N.Y.S.2d 450.
- Prince v. Massachusetts*. 1944. 321 U.S. 158.
- Ridley, Donald T. 1990. "Accommodating Jehovah's Witnesses' Choice of Nonblood Management." *Perspectives in Health Care Risk Management* 10:1–6.
- Stroup, Herbert Hewitt. 1987. "Jehovah's Witnesses." In *The Encyclopedia of Religion*, ed. Mircea Eliade, 564–66. New York: Macmillan.
- United States v. George*. 1965. 239 F. Supp. 752.
- Vinicky, Janicemarie K., and George A. Kanori. 1987. "Informed Consent, Bioethics, and Patients' Value Histories." *Physician Assistant*, August, 87–93.
- Watchtower Bible and Tract Society of Pennsylvania. 1977. "Jehovah's Witnesses and the Question of Blood." New York: International Bible Students Association.
- . 1990. "How Can Blood Save Your Life?" New York: International Bible Students Association.

First in a series edited by Arthur W. Frank

Editor's Introduction

Case Stories and the Ethics of Voice

Arthur W. Frank

WHEN THIS SERIES BEGAN I was immediately drawn to the editors' choice of "Case Stories" rather than the conventional "Case Studies." In their introduction to the series, Kathryn Montgomery Hunter and Steven H. Miles placed the forthcoming stories and commentaries under the rubric of *narrative ethics*. To introduce a second phase of the series, I want to focus on the importance of *voice* as an issue for narrative ethics. The concept of voice both explains and deepens the commitment to stories.

What distinguishes a story from a study? Stories are popular in the sense of being for anyone. Studies are professional; cases are described according to relevances that are self-consciously specialized. Stories claim only the particularity of their lived moment; their universality requires the hearer's imaginative connections. Studies claim universal generalizability because, like judicial decisions and scientific experiments, they exemplify rational principles of knowledge and process. Stories address people and their ethical concerns directly through

shared experience. Studies are part of an accumulation of expertise that remains the purview of experts and is shared only in moments of application.

Perhaps most important, people tell stories about themselves; the storyteller's perspective is primary involvement. Studies are narrated from the stance of a detached observer. We need both studies and stories, but the modern emphasis on scientific rationality often skews our priorities, privileging studies and leaving stories as residual.

The impulse of narrative ethics is to privilege the story over the study. The question that such an ethics can underscore is, Whose narrative is being told, by whom, for whom? The narrative may be *about* an ill person, but is that person the narrative subject or object? Narrative ethics requires asking whose *voice* is telling the story. To put this issue more sharply, Whose voice is privileged by the way the story is told? Attention to this issue of voice is not self-evident, as a confessional note of my own can illustrate.

Many years ago a graduate school application required me to write an essay on what I intended to do with my education. I based my statement on a reflection by Albert Camus about the task of the intellectual. At least in my memory, Camus said

Arthur W. Frank is professor of sociology at the University of Calgary, Calgary, Alberta, Canada.

For citation: Frank, Arthur W. 1994. "Editor's Introduction: Case Stories and the Ethics of Voice." *Second Opinion* 19, no. 3 (January): 44–48.

this: Our justification, insofar as we have one, is to speak on behalf of those who cannot. Written in post-Holocaust Europe, the statement was necessary. But the task of witness changes, and today an intellectual's claim to speak on behalf of others raises concerns. These concerns have transformed *voice* from a technical matter of literary perspective into an ethical issue.

No lesson of intellectual work during the last 30 years seems more important than the new level of respect accorded the claims of persons who were once spoken *for* to speak in their own voices. Black power, feminism, gay liberation, postcolonial criticism, and much of the current recovery movement all take place under the general rubric of "finding our voices." Disempowered people have recognized that their situations will never change until their *own* words are taken seriously. Restatement by professionals, no matter how well intentioned, always involves the danger of redefinition of relevances. The ethical imperative for professional service providers thus shifts to stepping back and honoring their clients' voices, no matter how divided and faltering these voices may sound to professional ears. The client is credited with already knowing her own truth, though she may need help to learn to speak it.

Clinical ethics has a hard time hearing the voices of those it ought to serve. Nancy Dubler, staff ethicist for New York's Montefiore Medical Center, certainly intends some irony when she calls her work "SWAT team ethics," but she proposes the label seriously (Dubler and Nimmons 1992). Hospital ethics is a SWAT operation: darting here and there throughout the organization, advising, correcting, smoothing over. Whatever the intentions of such ethicists, they remain hospital employees, responsible to medical and administrative interests.¹ Making the ill person heard in medical decision

making is a task that ethics consultants are curiously unprepared for.²

Helping people to *find* their voices rather than responding to voices already claiming attention is a clinical task that, if recognized at all, lies outside the scope of applied hospital ethics work. But until people have found their voices, they cannot participate in decisions about themselves, and without the participation of those affected by these decisions, ethics remains an inquiry practiced from above. The model is I-it rather than I-thou: the decision is made

by a professional subject for a lay object, rather than proceeding from a dialogue between subjects who may be differently abled but are as equally empowered as possible.

Scholarly ethics as opposed to applied clinical ethics is no SWAT operation,

but here the ill person's voice often recedes even further from consideration. I once attended what was billed as a "consensus conference on doctor/patient communication." The last session was a panel reformulating the various messages of earlier sessions into the purported consensus. All six members of the panel were physicians, all white, all at mid-career. So much for a consensus of doctors and patients. The physicians were, I don't doubt, fine individuals, but the organizational gesture of exclusion is paradigmatic of what is wrong in medical ethics.³ While hospital ethics has become an organizational necessity, academic ethics has become a "literature" for and among scholars.

Thus we return to the need for case *stories*, as opposed to more case *studies*. A study takes the ill person as the object of investigation; the story lets her be the narrator. A journal that places ethics in the context of faith should feature case stories, because faith itself is built on stories, whether these are the parables of Jesus or the tales of Hasidism, and personal faith is often achieved through the realization that these stories are our story. Here also is the

Making the ill person heard in medical decision making is a task that ethics consultants are curiously unprepared for.

ground of the ethical: the recognition of oneself in the other's story. Once I have seen that the other is myself in another guise, then the great moral imperative to "do unto others" becomes a concrete possibility rather than an abstract ideal.

Narrative medical ethics begins with and ultimately returns to the stories ill persons tell of their experiences. The primary ethical gesture is to honor the voices that have been submerged and let those who have been spoken for now speak for themselves. Let me single out five such voices, each stating a fundamental truth not just about illness but about suffering in general. I will not analyze these voices; rather I want them to serve as epigrams to the series that will follow.

First the voice of a woman given the pseudonym of Gail. She suffers from chronic pain that possibly originates in her jaw. Gail says,

And all these people in pain . . . all these people with aches and all these people suffering. We walk in different dimensions. We have access to different experiences, different knowledge. And there are so many of us, too. What would happen if we all knew what it really meant and we all lived as if it really mattered, which it does. We could help the normals and the whitecoats both. We could help them see that they're wasting the precious moments of their lives, if they would look at us who don't have it. I'm convinced only sick people know what health is. And they know it by its very loss. (Quoted in Garro 1992:129)

A second voice is that of Barbara Rosenblum, writing a circular letter to her friends describing her life with the cancer she died from eight months later:

I am committed to sharing this process with you, to make it more intelligible, more clear, and more real. To lessen my feelings of isolation. To connect with friends. To tell the truth, no matter how painful that truth may be. The truth is that this is a hard time and I rage against my fate. And another truth is that feelings come and go, fall and rise, manifest themselves and fade, change, become trans-

formed. I am sure that more kinds of feelings will emerge as I pass from stage to stage along this path. I am certainly hoping that lightness and peace will come back soon. (Butler and Rosenblum 1991:125)

The third voice belongs to the late Audre Lorde, writing in response to her first incidence of breast cancer:

I was going to die, if not sooner then later, whether or not I had ever spoken myself. My silences had not protected me. Your silence will not protect you. But for every real word spoken, for every attempt I had ever made to speak those truths for which I am still seeking, I had made contact with other women while we examined the words to fit a world in which we all believed, bridging our differences. (Lorde 1980:20)

The fourth voice is spoken to a physician, Fernando Silva, who is working on Christmas Eve in the children's hospital in Managua, Nicaragua.

He took one last look around, checking to see that everything was in order, when he heard cottony footsteps behind him. He turned to find one of the sick children walking after him. In the half light he recognized the lonely, doomed child. Fernando recognized that face already lined with death and those eyes asking for forgiveness, or perhaps permission.

Fernando walked over to him and the boy gave him his hand.

"*Tell someone, . . .*" the child whispered. "*Tell someone I'm here.*" (Galeano 1991:72)

The final voice is that of a theologian, John Carmody, who suffers from multiple myeloma:

Can it be that we must lose our lives to find them? Can trouble actually become our friend? Now and then I've found myself thanking my myeloma. It doesn't last, but for a moment I feel held by something dazzling. Would that I might always trust it. (Carmody 1993:79)

Many themes are heard in these quotations: the special knowledge that only being ill can bring, the responsibility to be a witness to this knowledge, the problem of speaking and the need to speak, the need for connection and sharing of suffering, the inability of any theory to capture the flux of lived experience, the desire not to be forgotten—to have those outside continue to speak your name—and finally, the dark night of the soul and the spiritual insights that come from that darkness. Above all, these voices speak a need for the truth of lived experience.

After these voices have been heard, the practical decisions of institutional ethics still remain, and the parameters for making these decisions have hardly changed. But in the echo of these voices perhaps these decisions *mean something different*, and perhaps their resolution can be approached differently. The claim of narrative ethics seems to me both incredibly modest and impossibly far-reaching.

If voices witnessing illness-experience echo loudly enough, perhaps that echo can give clinical ethics and institutionalized medicine the humility to relinquish the voice so accurately satirized by black feminist bell hooks.⁴ This voice of authority writes about “Others” who live on the margins. To these Others it says:

“No need to hear your voice when I can talk about you better than you can speak about yourself. No need to hear your voice. Only tell me about your pain. I want to know your story. And then I will tell it back to you in a new way. Tell it back to you in such a way that it has become mine, my own. Re-writing you, I write myself anew. I am still author, authority.” (hooks 1990:151–52)

The reality that bell hooks’s mimicry warns us against is described by Timothy Diamond (1992:127), writing about the use of medical charts

in homes for the elderly: “The women living here did not write in these documents, nor did they read them. They did not speak in their charts. They were spoken about.” The condition of being spoken about is contested when case stories honor the ill person’s voice.

Where does this leave the voices of nurses, physicians, volunteers, family, and other caregivers? First, these groups should be encouraged to speak of their *own* suffering in their work and lives. Professionals are too often taught to express themselves only in the third person, thus suppressing their feelings at great personal cost to themselves and indirect cost to their patients. Second, ill people often need caregivers to elicit, if not to author, their narratives. Sometimes this story can then be returned to the ill person for revision; in cases of death or some disabilities, the witness’s story must stand as best it can.

By way of summary let me suggest three recognitions that a concern with voice introduces. The initial recognition is that social situations, including but hardly limited to medical encounters, involve differences of *privilege*. The second recognition is that privilege is reinforced by the *voice that controls* the telling of the story being lived and written. The third recognition is that people who have had their voices taken away can *learn to tell* their own stories. We have begun to recognize that healing requires the restoration of voices;⁵ we now need to make restoration of voice a fundamental concern of ethics.

The narrative ethics I propose takes faith: the faith that stories themselves and the distressed people who struggle to tell them have the power to teach us. What we can learn is the profound moral responsibility embedded in the recurring biblical tag line that is also a Zen koan: “He who has ears, let him listen.” ☸

NOTES

1. For an ethnographic observation of this point, see Bosk 1992:159.
2. See Maciunas and Moss 1992. After stressing the importance of having the ethics consultant elicit the patient’s narrative, they note that “ethics consultants are not uniquely skilled at obtaining a patient’s narrative” (1992:289). My point is that such skills ought to be the core of the consultant’s training and work.

3. Bernie Siegel (1993), writing as a physician, makes this point with regard to euthanasia discussions.
4. I wish to express my appreciation to Naomi Scheman for making me aware of this quotation, though in a different context.
5. Among the clinical writers who make this point, see Kleinman 1988 and Herman 1992.

REFERENCES

- Bosk, Charles L. 1992. *All God's Mistakes: Genetic Counseling in a Pediatric Hospital*. Chicago: University of Chicago Press.
- Butler, Sandra, and Barbara Rosenblum. 1991. *Cancer in Two Voices*. San Francisco: Spinsters Book.
- Carmody, John. 1993. *How to Handle Trouble: A Guide to Peace of Mind*. New York: Doubleday.
- Diamond, Timothy. 1992. *Making Gray Gold: Narratives of Nursing Home Care*. Chicago: University of Chicago Press.
- Dubler, Nancy, and David Nimmons. 1992. *Ethics on Call*. New York: Harmony Books.
- Galeano, Eduardo. 1991. *The Book of Embraces*. New York: W. W. Norton.
- Garro, Linda C. 1992. "Chronic Illness and the Construction of Narratives." In *Pain as Human Experience*, ed. Mary-Jo Delvecchio Good, Paul E. Brodwin, Byron J. Good, and Arthur Kleinman, 100–137. Berkeley and Los Angeles: University of California Press.
- Herman, Judith Lewis. 1992. *Trauma and Recovery*. New York: Basic Books.
- hooks, bell. 1990. *Yearning: race, gender, and cultural politics*. Toronto: Behind the Lines.
- Kleinman, Arthur. 1988. *The Illness Narratives*. New York: Basic Books.
- Lorde, Audre. 1980. *The Cancer Journals*. San Francisco: spinsters/aunt lute.
- Maciunas, Kristina A., and Alvin H. Moss. 1992. "Learning the Patient's Narrative to Determine Decision-Making Capacity: The Role of Ethics Consultation." *Journal of Clinical Ethics* 3 (Winter): 287–89.
- Siegel, Bernie. 1993. "Going Native." *Hastings Center Report* 23 (January–February): 46.

The Case

An Eloquent Region

James Fitchette

A note from the author: *I am a 45-year-old writer. For 12 years I have been writing articles, primarily about golf, for magazines and newspapers; I also have published two pieces of short fiction in literary journals. Three years ago I was diagnosed as having a brain tumor.*

In writing "An Eloquent Region," I drew on my own experience of brain surgery, radiation treatment, and hospitalization. I chose to write in the third person with an omniscient narrator because that allowed me to enrich the medical events with scenes from other parts of my life and with scenes from my imagination. I did not want to write a journalistic report.

The parts of the story about the surgery and the hospitalization are all true. They happened to me. The story's final episode on Cavendish Beach at Prince Edward Island happened exactly as I have described it. But names, towns, the hospital—all have been changed in this story.

STAN TOMLIN LIES DOWN TO RECEIVE THE LOCAL anesthetic. He gets several small shots along the ear line and then a big shot that goes into the muscle below the ear, which hurts for a minute. As the skull freezes on the left side, Stan reflects on his history of

surgery. His first was unexpected. It came one evening, an event from the blue, while he and his wife were on vacation: a seizure, confusion at the hospital, a CAT-scan revealing a mass. Thirty-six hours later, the mass was out. After four more days, the verdict: cancer in the brain, a tumor called glioblastoma multiforme. One year to live, on the average.

There were signs of the illness before his seizure: for two weeks he had frequent early morning headaches (controlled somewhat by pills), and he had difficulty finding words. He could not remember authors and names of books. Records and musicians. Politicians. Movie stars. At a party Stan was shocked when he could not recall the author of *The Emperor of the Air*, one of his favorite books. Who wrote it? Ethan Canin. It came to him two days later.

Next came a round of radiation, five days a week, five weeks, 5,000 rads. Then a second surgery, called brachytherapy. Stick a piece of radioactive iodine in the tumor and see what happens. Four days later, take it out. If he lived long enough, the doctors said, he would have a third surgery a year later to remove the dead tissue. Now he has lived 14 months since his first surgery; he's beaten that statistic. But this time the surgery will be riskier: there is no cyst around the tumor. Some or all of his language ability

For citation: Fitchette, James. 1994. "The Case: An Eloquent Region." *Second Opinion* 19, no. 3 (January): 49–56.

may be lost because the tumor is in the part of the brain that produces language. "It's Wernicke's area, an eloquent region," remarks the medical resident Kamieniecki as he finishes with the shots.

Stan goes to the operating room, where 13 people are waiting for him. Some are looking at machines, others just waiting. Stan gets situated on the operating table and lies on his side; neurosurgeon Marvin Eisenreich takes charge. "Let's get the blanket up over his head," he says. This way Stan will be able to talk to the anesthetist, who sits at the end of a 20-inch tunnel formed by the blanket and a frame. He has to keep up a constant line of talk with the anesthetists, Dr. Alexandra Irvine and Dr. Derek Cole: he has to let them know if he can speak as the operation proceeds. Stan will talk to Dr. Cole, who is from South Africa. They can talk about anything—sports, music, politicians, writers. But periodically the surgeons ask him to count backward rhythmically from 20: "20-19-18-17-16-15-14-13-12-11-10-9-8-7-6-5-4-3-2-1," over and over again, while they probe his brain. If he gets to 17 and experiences a blank or simply pauses, it's too risky for the surgeons to cut there. If the surgeons make a "mistake," Stan may never again be able to speak or read or even understand what is being said to him. Dr. Eisenreich starts with the "flap," the skin on his head. After that comes the skull—sawing sounds. Next comes the dura, which Stan knows will be sensitive; he'll need another local anesthetic. This entry into the brain will take an hour at least. Dr. Cole checks with Stan every 30 seconds as the surgeons work; they'll have a conversation—one way—when the doctors start probing the brain.

IN THE WAITING ROOM LINDA TOMLIN WAITS. Her friends are with her, Pam Reardon and Carol Horn, and Stan's brother, Chris. Linda's going on about Dr. Eisenreich.

"Can you believe what Eisenreich said to me?" says Linda. "When I asked him where I should stay during the operation, he said, 'Go home.' I said, 'What?' And he goes, 'That's an order, not a request. I'm ordering you to go home. I'll call you there when

the operation's over.' I couldn't believe what he was saying. I said, 'You're not the boss of me. I'll be here in the waiting room, wherever it is.' He goes, 'Go home. I'll phone you there, but I won't look for you around here. I guarantee it. I'm not searching this area for you.' The man has no bedside manner."

"Unbelievable," says Pam.

"The anesthetist had the right idea. Dr. Irvine just came by after Eisenreich and said to call her in surgery at about 11 A.M. with an urgent message that she had to get right away. She said to sound like a nurse. Then she'll come out and tell me what's happening. So I'll do that when the time comes. You'll probably notice that she'll have no trouble finding me. God, what a jerk Dr. Eisenreich can be sometimes." Linda is trying to be positive, but the doctors can upset the balance so easily. Sometimes they act as if the patient were just a piece of machinery.

Chris and Carol want a cigarette: they'll go outside. "Want me to get you some coffee while we're away?" asks Carol. "A Danish? Croissants? How about a shrimp cocktail? Maybe some veal medallions and a side order of linguine?" Carol tries to lighten the mood. Linda laughs. "Some coffee, maybe a Danish."

WHILE THEY SAW THEIR WAY INTO THE BRAIN, Stan thinks of a thousand things. He remembers Marna Dempsey, a student with him at McGill. His girlfriend at the time. He remembers driving to her house one Saturday when the autumn leaves were splendid, flaming in the sun. He wanted to take a ride in the country. She said, "What? The leaves . . . Forget it, the leaves are the same colors every year." He'd give anything to be looking at the leaves with the same colors now. Maybe the surgeon could remove all traces of Marna from his brain. That might be a surgical procedure you could appreciate.

Stan remembers high school, his old friends Gary, Jimmy, Kathy, Sandi, and all the rest. He thinks of Jimmy's big '57 Chevy. He went on a few double dates in that car. Where are they now? Do they have cancer? They might be dead already. So



The Moon in My Mind at 2,998,773. Acrylic on canvas by Jonathan Borofsky, 1986.

Photo courtesy of Paul Cooper Gallery, New York.

Photo by Geoffrey Clements. Collection of Eli Broad Family Foundation, Santa Monica, Calif.

many people. Stan wonders how many people he has met in his life. Ten thousand? He recalls an article in the paper with that statistic. Maybe if he were an idiot-savant he'd recall all their names.

He remembers how having a brain tumor used to seem the worst thing that could happen, except maybe being totally paralyzed. When he woke up after the first surgery and Linda told him what the doctors had found, he couldn't take it in. Cancer in your brain. What was the word? Brain tumor. He couldn't get that label in his head. Over the next two days he occasionally had to ask the nurses what his condition was called. He kept forgetting the word *tumor*. He had to tell himself again and again: "I have a brain tumor."

After that first surgery when he was recovering in the hospital, the sound inside his head was a cacophony of clicks, buzzes, hums, whirs. The rhythm of the skull as it healed. It sounded like an old washing machine, thumping and grinding away. He wonders, What do they see when they look at my brain? The report of the first surgery said the tumor was pinkish. Pink: the color of baby girls' sleepers, the color of my golf shirts, the color of roses, of lips, of pigs, of Pepto-Bismol, of flamingos, of lemonade, of woozy elephants, of sunrise and sunset. Brain surgery is strange, he thinks. With all these wonderful medical machines, they still have to go at your skull with a saw, open your head and pull some bad stuff out, and then sew your head up with wires. He imagines the doctors are playing machine shop with his brain. What if they slip?

Stan needs to think of something else. The previous night he had watched a television show about the Celts. In one legend, a Celt asked the wise men what was the sweetest sound in the world. Stan tries to recall their answers. One Celt said it was the waves washing over pebbles on a beach. One said the ring of a spear upon a shield. Another said the bellowing of a stag across water. Another said the cry of hounds in full pursuit. Another said the laughter of a kissed girl. Then the wisest man said, "The sweetest sound in all the world is the music of what happens." He feels

peaceful as he meditates on the thought. Or maybe it's the anesthetic: he hasn't moved a muscle in an hour.

LINDA WORRIES THAT STAN WILL DIE. They had made it through two surgeries, but how many more could there be? The doctors are so awful, and yet Stan's in their hands. They're good at what they do, of course, but they make it so hard. She tries to think of how she would keep on living without Stan. What if he dies right there on the operating table? What would she do? So much love to have, to share, and for what? She'd get on with her life, she'd have to. But this loss . . . It's too much. They haven't even lived. Their trip to Scotland, to the Caribbean. Shot to hell. What about their plans for kids?

Linda wonders, "How can I stand this? I can't stand it. Please, please get him through this . . ." She frowns and puts her face in her hands.

"Are you okay?" asks Pam.

"No."

STAN FIGURES THEY ARE JUST ABOUT THROUGH the skull. Time to start paying attention. The anesthesiologist has been checking with him every 30 seconds, but now Stan has to talk to him constantly. He's discussing baseball when he feels the dura, the layer of skin outside the brain. "Time for some local anesthetic," Stan says in some pain. They get that frozen, and then they begin probing the brain. Where will they cut?

Dr. Eisenreich asks Stan to count backward from 20 rhythmically so they can notice any delay or stop. In this way they find a path to cut through, although it seems to take a long time. Eisenreich is genial with Stan: it seems that when he does surgery, he takes his time, he is patient, he makes sure everything is done right. When he discusses this surgery—with the other doctors and with Stan—he speaks calmly, unhurriedly. He explains what he is doing and why. But when Stan has an appointment at the clinic—every third month—Dr. Eisenreich can be abrupt, impatient, particularly if the CAT-scan shows no growth in the tumor. Then he seems rushed, in a hurry to see the next patient. He does ask if Stan's

been having any problems or side effects from the medication. "I've had some seizures," Stan said at one clinic visit. "The first one was an 'absence.' It started at the dinner table and lasted about 20 seconds. I felt sort of spacey, and . . ."

"It's a fit. You had a fit."

"What?"

"Next."

"Well, my second seizure was also an absence. It lasted about 30 seconds. I was feeling kind of, kind of . . ."

"Next."

"Okay. My third seizure was more dramatic. A tonic-clonic. I was on the golf course by myself. My head started jerking out of control, I couldn't stand up, I had to get on my knees. I couldn't stop my head jerking for two minutes. Then I had lots of saliva in my mouth . . ."

"Next."

"That's all. Maybe another absence or two."

"You'll have to expect these seizures. There's nothing bad about them really. They happen because of the 'insults to the brain'—the surgery, the dead tissue, the tumor. Test your Tegretol level with your family doctor. Okay. See you later." Stan felt deflated, insulted. Fortunately Eisenreich is part of a team: Antoine Riviere, an oncologist; Stuart Langston, a neurologist; and Janice Medina, a nurse. He can get the answers he needs from the rest of the group, who are all amiable and even good-humored. Dr. Riviere is the most approachable, so Stan deals mostly with him.

What a contrast with his neurosurgeon in the first surgery in Ottawa: Dr. David Cardinal. He was there well before the surgery, asking him about his job, his family, his hobbies. He did the surgery and then spent time with Linda, telling her the probable outcome, although the lab reports would take four days. Dr. Cardinal came by three more times, always sitting down on the bed or in a chair and never leaving until Stan was finished with questions and comments. Then six weeks later he was there again with the head nurse, drawing pictures to explain things. Stan would have considered going back to

Ottawa for further surgery, except that Dr. Eisenreich had charge of his case now, and in the meantime, Dr. Cardinal had moved to the medical school at Stanford University.

For now, though, Dr. Eisenreich is calm and focused: maybe he's at home in neurosurgery and no place else, at least at work. After what feels like 500 repetitions of the backward counting, they find a way into the brain. They extract the dead tissue, while Stan talks at the anesthetist. They replace the bone, sewing it with wire, which is uncomfortable. It feels like his head is coming apart. Finally they sew up the scalp, and Stan goes to the intensive care unit. Everything seems to be in order.

STAN EXPERIENCES DIFFICULTY after a few hours in ICU. He's nauseated, and the heart machine keeps beeping every few minutes. The nurses seem alarmed. He passes the physical tests each hour—hands held aloft without shaking, gripping the nurse's hands and applying pressure, pushing his toes forward and backward with the nurse's hands against them—but his language performance is abysmal.

"What hospital are you in?"

"Ottawa Orthopedic Hospital."

"Try it again."

"Toronto Western Hospital."

"What's the date?"

"It's October 31, 1992."

"Try again."

"October 31, 1990."

"Try once more."

"October 31, 1988."

"Hmm . . . Who is your physician?"

"Dr. . . ."

"What's your name?"

"Stan Tomlin."

"Can you spell it?"

"Stan T . . . ho . . . l . . ."

"Spell the last name."

"Tohoo . . . l . . . n."

"Try it one more time."

"T . . . roh . . . Trol . . . Trooml . . ."

"What's your wife's name?"

". . . Caroline. No, it's . . . with an L . . ."

By 4:00 that afternoon, Dr. Eisenreich visits Stan and decides to run another CAT-scan, in a hurry, no waiting for the dye to take effect. The prospect is scary; will he need more surgery? What is wrong? Stan is wheeled into the CAT-scan room and photographed immediately. The doctors look at the scans and decide there is no problem. The pictures say it all: he is suffering from swelling, nothing else. Now it's just a case of seeing if and when the swelling subsides. Stan goes through the one-hour wake-ups, always doing well with the physical parts, doing less well with the verbal parts: 2 A.M. to 6 A.M. are the worst. He still has trouble remembering his own name, not to mention the date and name of the hospital. He starts to improve by 7 A.M., although now he is taking 32 mg. of Dexamethasone, instead of 12 mg. That will help the swelling, but if he has to maintain that dose, he'll get even fatter. He's been taking steroids since his first surgery: his cheeks are so big it looks like he's got a mouth full of marbles.

BY 11:00 IN THE MORNING, Linda and Chris are there with him. By 1 P.M., Stan's in a private room. His speech is a little better: he knows where he is, when the surgery was, who the doctor was, and so forth. Now the problem is making statements about himself. Linda and Chris are asking him questions, and the answers are not as clear as they could be.

"You should have seen the residents this morning in ICU. They come in, three of them, and one asks me some questions. Meanwhile one of the others comes around and just yanks off the shunt, I mean just reaches under the head dressing and pulls it until it comes out. I'm still half asleep and trying to wake up, and this jerk's pulling at the shunt. It was really painful and this guy says nothing. It's crazy."

"Tell us about your local anesthetic."

"Okay . . . They started with some needles around the ear. Some hurt, especially the last one. It went straight into the muscle below the ear. But it froze up pretty fast. They rolled me into the emergency room . . . no, operating room . . . and there

were 13 people in there I could count. Then they . . . they tried . . . oh, they took back . . . Blanket. They put a blanket over me, but so I could see Dr. Cole and talk to him. Then they removed the flap, they call it the flap, don't you love it? And then they . . . they cut through the skull. I could hear the saw. They're sawing my head, dammit. Then they argued about . . . no, no . . . they tried . . . they . . . they made pasta . . . What am I saying? They quarr . . . They . . . I think I better stop."

STAN WAKES UP TWO HOURS LATER. He feels better, in command of more language, he thinks. Linda hugs him; no one gives him more love, no one could. After a while she goes out for some fresh air; Chris stays behind. There is some small talk while Stan tries to be more awake. Chris has been such a support during all these surgeries. He was there after the first one, with their mother, despite a 10-hour ride to Ottawa. Then he came back to Toronto in October. For that week, he took Stan to the Regional Cancer Centre for his radiation therapy. They drove all over the city so Chris could go to the hobby stores. Chris drove Stan to one of his favorite golf courses and caddied for him.

They really hadn't spent much time together in all the years they were growing up. Chris was eight years younger, so naturally they had different sets of friends. Then Stan was off to Cornell University, and then he immigrated to Canada. Chris went to the University of Missouri for journalism; the last two years he spent in Boston, working for the *Globe*. They were separated by age and miles. They didn't get together often. Now in their time of crisis, Chris was right there. His brother in arms.

They talk that afternoon about their dead father—Stan, the way they played golf together and got to know one another; Chris, the way he was absent, the way he had to beg for attention when their father was around. They talk about Saturday nights with popcorn and Coke and the whole family watching "Gunsmoke" and "Have Gun Will Travel." They talk of football games at Harvard or Boston College and then lobster at The Seascape

afterward, esoterica from the *Baseball Encyclopedia*, playing catch, computers, model planes, their classmates, their mother.

Linda comes back, and Chris gets up to leave for the day. Stan hugs him, and they both get choked up. Stan begins to understand the way that his illness affects the people around him. Some go away—they don't want to know about cancer; but others come closer.

THE NEXT MORNING AT 7:00, THE RESIDENTS are back to see how Stan is doing. It seems to Stan that as long as he is awake and not bleeding profusely, everything is fine. He answers a few questions while a resident comes around and peels away his head dressing, causing some pain. "Take it easy!" says Stan. "This is the only head I have!" The resident seems not to notice and finishes the job. The head resident mentions a session with a speech pathologist, and then they're gone. Stan tries to clean off some of the dried blood on his head. He calls a nurse to help, and they get some more off, but it will take a few days because the stitches have to heal.

The speech pathologist is Ruth Varsho, M.Sc. and something else. She is cordial, and Stan progresses through the easier parts of the tests without incident. Stan starts by saying specific words after she does; next he reads sentences after she does. Then he reads sentences without her help. Next he has to read sentences with missing words that he has to fill in. He does fine except for one example, so he's feeling pretty cocky. Then Stan starts having to generate his own thoughts: first, he has to name items that are pictured in a book. He gets most of them right except for "latch," "pelican," and two other things he cannot remember. Then Stan has to say all the words he can that start with the letter *F* in one minute: "fat, feel, felt, fall . . . fell . . . flag . . ." He couldn't think of any more. That's 6 right answers in one minute: unbelievable. He tries all the words beginning with *S* in one minute: "see, saw, secret . . . sirloin . . . secret . . . whoops, I said that one . . . secure . . . sponge . . ." Six right answers

again. Stan thinks he should get 60 right answers. Next comes all the animals you can name in one minute: "dog, cat, lion, tiger, cheetah, panther, salmon . . . perch, bass . . . monkey." Ten answers. He should get 60, 1 for every second. Why is this so hard?

Ruth tells Stan his condition is called anomia: he has trouble generating words sometimes. He's at a grade 11 level. With the decrease in swelling around the tumor site, she feels some of the difficulty may decrease, but probably he'll have a delay in finding a specific word here or there, or maybe he'll just have to describe the word and have to ask. In order to keep the conversation moving forward, Stan should try to say, "You know the word, it sounds like . . ." or "It looks like that thing . . ." or "It's kind of like a . . ."

Stan is devastated. He didn't expect to get this news, although now that he thinks about it, it matches his experience with the speech pathologist in Ottawa a year before. Ruth even checked the records and found that the result was the same: anomia. Stan feels damaged. He cannot drive a car because of his seizures; he cannot throw a ball anymore; he's given up golf because of his loss of balance, poor control of his arms, and inability to put some snap into his swing. Now he cannot even talk, or at least not at what he considers his standard. Grade 11? He wants to puke.

LATER THAT NIGHT STAN LOOKS out the window. The sun has gone down, but there's still a brilliant sunset remaining: dark overhead, purple and pink below, the few clouds mingling to form plateaus. He thinks back to his trip with Linda last year to Prince Edward Island, where they saw a similar sunset. After a visit to St. Ann's restaurant, where they had lobster, they stood on the boardwalk that leads down to the beach at Cavendish. Red sand everywhere, red rock walls with layers like baklava. They watched the sun setting over the water, pink skies with dark blues and black all at once, and they had that same feeling: a few distant clouds like plateaus. They were waiting for the stars to appear; they had their

binoculars ready. It looked like a good night for stars.

Then came a gang of teenagers, maybe 20 of them, whooping, laughing, and upsetting the scene. They walked by and headed to the beach below. God knows what they had in mind. It had become quite dark on the beach now, the sand no longer red, the water black. The teenagers started a small bonfire, continuing to punctuate the air with their unintelligible noise. Stan and Linda considered leaving—the effect was spoiled—but they still wanted to see the stars. They were going to look for Cepheus, Cassiopeia, Bootes, and the Corona Borealis. Suddenly the invaders became quiet. What were they

waiting for now? Probably some joke and then more screaming. A moment later, though, something happened: they started singing hymns in exquisite harmony. Stan and Linda looked at each other, bemused, smiling. They sang “Holy, Holy, Holy,” “Angels We Have Heard on High,” “Call Him Up,” “Mary.” They were transformed into angels.

Maybe there is room for hope in the coming days, Stan thinks. The sun was gone, but images of timelessness, of paradise, remained: the sifting sand, the burgeoning pools of water. The wind through the changing leaves. The flash of the firefly in the night. The stars in their mystery, shining from the past, the spangled pearls of the sky. ☸

Commentary

When Music Is Last to Be Lost— A Neurologist's Perspective

Harold L. Klawans

IF LANGUAGE MAKES US HUMAN, then loss of language is the most poignant and painful of human losses, and one of the most difficult to imagine. There are too few literary discussions of language loss. Most of these, for better or worse, have been written by neurologists who, despite their arcane knowledge and even empathy, remain detached observers. Stan Tomlin is not detached, we can be sure; it's his loss.

Stan has a glioblastoma of the dominant hemisphere—a very bad tumor, in a very bad place. To the physician this tumor presents a therapeutic and diagnostic dilemma for which there may be no right answer. I remember discussing this problem with my chairman when I was a resident. Should you be aggressive, operate, and risk precipitating aphasia, as happened to Stan to a mild degree? Or be less aggressive, perhaps trading a somewhat shortened survival for more months of good speech? The person with the tumor has many ways to live and to ap-

proach death. Aphasia, to most of us, is not a very good one.

Stan's operation leaves him with nominal aphasia, or anomia. The images are still there, as beautiful and meaningful as ever. Only the names have become difficult, at times impossible, to recall. Aphasia is the loss of the symbolic use of language. The problem is not enunciation of speech. The printer—speech production—is not malfunctioning; it's the word-processing program itself.

Aphasia is always due to a lesion of the dominant hemisphere for speech. In right-handed individuals this is always the left hemisphere, and in left-handers it is still usually the left hemisphere.

If the patient has more trouble producing words than understanding them, the problem is located toward the front of the dominant hemisphere. If the patient can produce speech fluently but cannot understand what is said to him and cannot follow commands, the lesion is farther back in his brain.

Neurologists have described dozens of minor variations of these speech disorders, and their classifications vary: no two agree about which variants or syndromes are separate disorders or about which names to use. But this lack of terminological consis-

Harold L. Klawans is a neurologist and the founder of the Section of Movement Disorders, Department of Neurological Sciences, Rush-Presbyterian-St. Luke's Medical Center, Chicago, Illinois.

For citation: Klawans, Harold L. 1994. "Commentary: When Music Is Last to Be Lost—A Neurologist's Perspective." *Second Opinion* 19, no. 3 (January): 57–60.

tency makes little difference to most practicing clinicians or to most of our patients. What patients experience is loss, most commonly loss of nouns. Nouns are a late acquisition of the human brain; naming is not the essence of language but a by-product. What was added last is, commonly, the first to be lost.

Can surgery be justified if aphasia is a risk? Neurosurgeons, by training, experience, attitude, and personality tend to be aggressive. Neurologists, by the same parameters, tend to be conservative. The patient then has to choose between the conflicting advice these two camps often offer. Can the patient possibly give informed consent, which requires knowing all the relevant facts, including the risk of aphasia? Of course the patient can be *told* the risk of aphasia, but can a patient be expected to make a decision based on knowing what it may be like to *live with* aphasia? This question has no right answer. The patient has the right to choose, to give informed consent. But statistics and descriptions of complications are hardly enough to make that choice a truly *informed* one.

However well or poorly Stan was informed of the risks of aphasia, he undergoes surgery. Will his anomia clear completely? I am skeptical. Stan is right. He is damaged, and the nature of his tumor is that the damage will get worse.

WHAT DOES STAN'S SITUATION LOOK LIKE from the neurologist's side of the examination room? Last week I saw a patient in consultation named Sam Kreevich. He was in his seventies and had had a stroke.

I asked him his name.

He said nothing.

I introduced myself.

He looked at me alertly but made no response.

"How are you?" I asked.

"Fine," he said. A single word.

"Where are you?"

"Fine." A single word repeated when it was no longer appropriate.

"Who are you?"

"Fine." And repeated yet again.

I held out my watch and asked him what it was. "Time." The wrong word. Close, but no cigar.

I pointed to the watch band and asked my same question.

"Time," he repeated.

I waited and pointed to the stem of the watch. I got no answer. "What is this called?" I asked.

"What do you do with this?" I altered my question, still pointing to the stem.

No response.

"Show me."

He did. He took the watch and rotated the stem. Function without needing the name. The brain at work.

In the end, I was able to observe that Mr. Kreevich had all the classic manifestations of a Broca's aphasia. His speech was subfluent, telegraphic. All he could say were a few words and occasional short phrases. He had difficulty naming simple objects but could follow complex commands and could understand ideas. His aphasia was caused by an acute stroke involving Broca's area or the tracts deep in the brain leading to and from Broca's area, but had it been a glioblastoma, the aphasia would have been no different.

"What else can he do?" I asked one of the students who was with me. She had spent an hour examining the patient. She didn't understand my question. "Can he sing?" I asked her.

She didn't know. She hadn't asked. Of course, she realized that asking might not have helped.

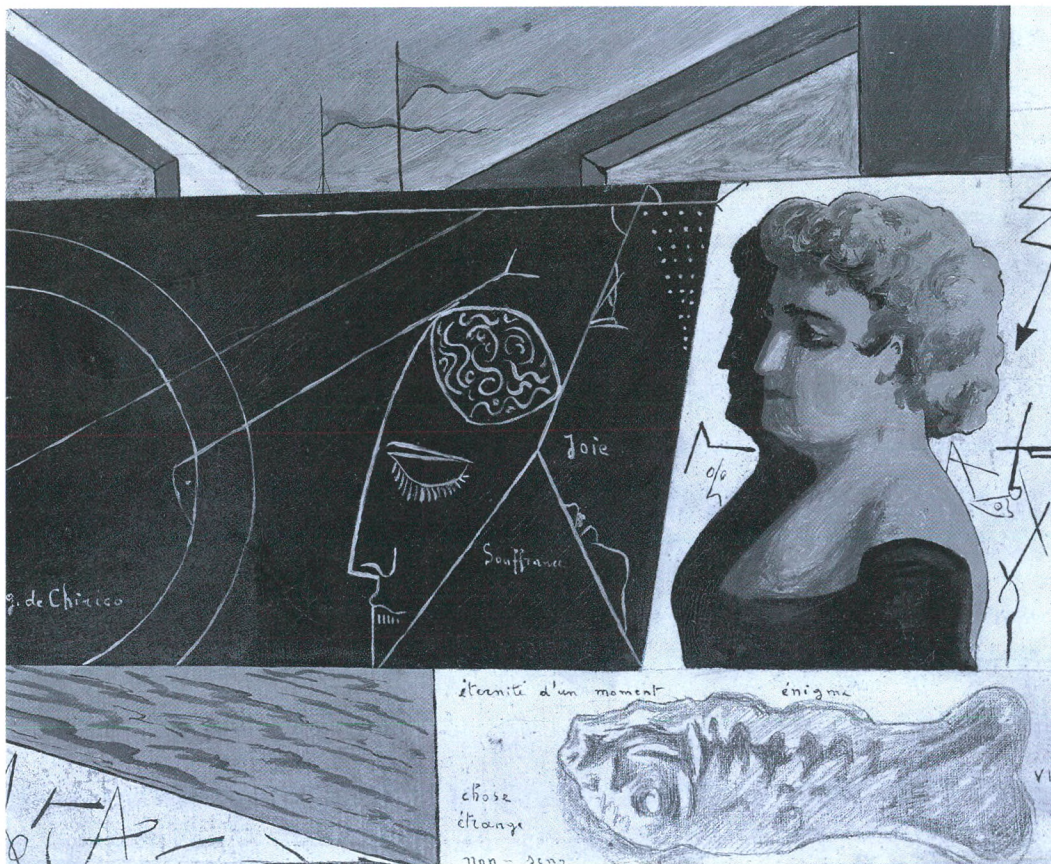
I smiled. She was right—it was not a question one could ask him. Instead I began to sing. "Oh say, can you see . . ." I stopped. "Sing with me," I said, and started again. "Oh say, can you see . . ."

Mr. Kreevich began to sing with me. "By the dawn's early light . . ."

I stopped.

He continued. "What so proudly we hailed . . ." He was still singing as we left his room.

The student immediately grasped the significance of what she had observed. The ability to sing is not lost in a Broca's aphasia. That meant that singing, although it involves words and language,



The Fatal Temple. Oil by Giorgio de Chirico, 1913.

Collection of the Philadelphia Museum of Art. A. E. Gallatin Collection.

© Estate of Giorgio de Chirico/VAGA, New York 1994.

does not pass through Broca's area. A lesion of Broca's area prevents expression of spoken language but not of singing. "Where is singing controlled?" she asked.

"The minor hemisphere," I replied. The minor hemisphere is also referred to as the nondominant hemisphere. In right-handers this is invariably the right hemisphere. In left-handers it is still usually the right hemisphere.

Stan Tomlin continued to be moved by singing.

He could hear each sung word and was able to repeat the titles of what he heard and repeat them accurately. No word substitutions. No "you knows" despite the advice. He said the actual words. Even the nouns. And the names.

That's the way aphasia is.

That is the basis for his hope. But in the end, I'm afraid, the music will not be enough. And all the efforts of all the professionals will become mere commentary. ☸

Overview

Hearing and Editing Good Stories

Arthur W. Frank

WHEN I LISTEN TO ILL PEOPLE, whether live or in print, I ask myself two questions. Assuming that illness narratives are like onions, that stories are being told within stories, I try first to keep asking what *else* the person is saying. Talking about illness is hard. Most people are plunged into such talk unpracticed; when they become experienced, they get into a rut, saying the same thing over and over. I ask myself what more their words are trying to say, which is also to ask what the storyteller wants. Of course he wants to get well, but most people's storytelling really takes off only when getting well isn't possible. What *else* does he want?

The other question I try to keep asking, and I mean *keep* asking, is how am I resisting the story I'm hearing? My first level of resistance is to refuse to recognize its status as a story at all. My next resistance is to maintain that the person is telling the story wrong: she's confused, or he doesn't understand his condition. My growing pile of detractions and doubts then reminds me that I'm in the middle of a privileged event: these resistances tell me I'm hearing something I don't want to hear, and for just that

reason I can learn something. Perhaps if I attend to both what is struggling to be said and what I struggle not to hear, I will expand my horizons as a human being. I may also give the storyteller a sense of having his or her suffering recognized.

The Danish philosopher Søren Kierkegaard used the metaphor of the editor to describe the ethical life: to be ethical is to read our lives like a manuscript, deciding what parts deserve cutting and what parts should be expanded upon. Editing thus exemplifies moral reflection: in order to edit, you have to think not only about what you want to express but equally about what others need to hear. Editing your own life, and your own writing, is hard enough; editing the lives of others should make us tremble, when we imagine editing in Kierkegaard's sense. How can we suggest what they should leave out of their writing and their lives?

As editor of this series, I gave Harold Klawans—and will give future commentators—an impossible task: I asked him to comment on a story. Stories do not lend themselves to commentary; against the immediacy of the story, commentary sounds cool and abstract; the story is turned into a study. Klawans takes the best course by telling a story of his own, but we cannot fail to note the contrast:

For citation: Frank, Arthur W. 1994. "Overview: Hearing and Editing Good Stories." *Second Opinion* 19, no. 3 (January): 61–63.

where James Fitchette speaks for himself, in the persona of Stan, Sam Kreevich is spoken for. Could it be otherwise? I read Klawans as mapping the boundary between first-person patient narrative and physician's clinical tale.

What I like best about Harold Klawans's commentary is its tact. Klawans does not set himself up as editor of Stan's (James's) story. He lends some neurological expertise by pointing to the dilemma James's disease poses to the practicing physician. As a physician Klawans has the humility, perhaps the sense of tragedy, to step back and acknowledge that whatever is done, there is no right answer.

To say even this about Klawans is to create a fiction. James Fitchette told me that he wrote his story as a story about Stan partly because he realized he was creating fictions when he entered the minds of others (his wife primarily) and tried to guess what they were thinking and feeling. In my sociological view, most of social life as such is a creation of fictions. To make it through the day we must constantly guess what others are experiencing. The ethical issue is whether we impose our characterizations on them or we find ways to allow others to resist the fictions we create about them. Tact is the ethic of nonimposition—a minimal ethic, but significant nonetheless.

My fiction of Harold Klawans's medical practice imagines him becoming accustomed to stories like Sam Kreevich's that are especially hard to hear, in the minimal sense of putting the phrases together. The minimal stories that a neurologist must often hear seem to call for a minimal ethic of tact. Stan/James tells an expansive story, but however Klawans as novelist might react to the fiction he is told, Klawans the neurologist responds with the same minimal tact he offers Sam Kreevich. At first I resist Klawans's minimalism; then I ask myself what I want, not just from Klawans's commentary but from all the physicians whom I have known and know. I want Klawans to join in the singing: if Sam Kreevich cannot sing himself back into speech, then at least his physician can offer him the fellowship of a duet. Probably, Klawans leads me to conclude, I

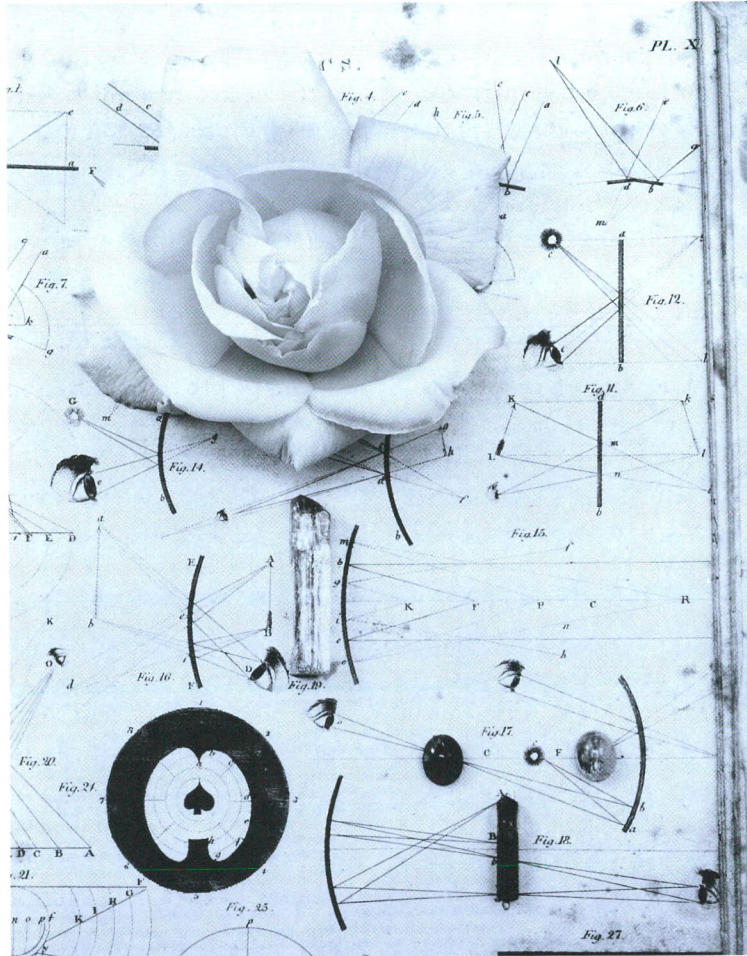
want more than it is the physician's business to provide.

Harold Klawans concludes his commentary with the observation that in the end, the music will not be enough. That may be true, and that may be necessary for the physician to believe, but for me it is too minimal. I would say the music has already been enough. The hymns that Stan and Linda hear on the beach may not cure Stan's brain tumor, but they give a sense of rightness to his story, which is also James Fitchette's *stories*, because the rightness goes through all the layers to the core. Stan/James lives a whole life, and a whole illness, during the time that darkness falls on that beach. At first there is high expectation: the perfect scene for the perfect vacation. Then the unwanted guests intrude, noisy and out of place. Expectations seem spoiled. But in the end the ruffians turn out to be angels, and the noise becomes divine praise.

I wonder that after this epiphany James still needs to tell his story in the persona of Stan. Rationales for this third-person voice are readily available: especially during illness, our own lives can become too complicated, and too painful, to edit; writing about someone else is a way of cutting through the noise, past the loss, and getting to essentials, when essentials count and time is short. Ill people find voices where and how they can. But the same part of me that wants Harold Klawans to drop his persona as neurologist wants James to drop Stan. Editing becomes dangerous at just this point. Remember James's parable: if those ruffian teenagers on the beach had looked like angels from the start, would the final music have sounded as sweet?

Other people's stories, especially those of ill people and physicians, often do not sound the way we want them to. The patients sound obsessed; the doctors, detached. But to recommend another hearing of these stories, perhaps it is when they *do* sound as we want that we should worry about imposing our fiction on their lives.

In my capacity as an editor of articles, which I am grateful are only fragments of lives, I want to offer readers a good story but not such a neatly



Contact. Polacolor print by Olivia Parker, 1978.

Courtesy of the artist.

packaged story that they forget how the live, unedited stories sound or how much work has to be done to hear those unedited stories. To take James Fitchette's metaphor through one more permuta-

tion, were those teenagers really singing hymns, or had Stan and Linda suddenly found the grace to hear them as they might be? If narrative ethics is not about learning to hear, then what is it? 🌀



Sita (formerly titled *Evocation*).
Pastel on paper by Odilon Redon (French, 1840–1916), ca. 1905. 52.1 x 36.3 cm.

Collection of the Art Institute of Chicago. The Joseph Winterbotham Collection, 1954.320.
Photograph © 1993, the Art Institute of Chicago. All rights reserved.

Holistic Healing in the New Age

Mary Farrell Bednarowski

WHEN I WAS ASKED by the *Second Opinion* staff to provide a survey and interpretation of ideas on holistic healing in the New Age movement, I saw the project as an opportunity to focus on an aspect of the New Age that I had mentioned briefly in other works (Bednarowski 1989, 1990, 1991, 1992) but had not fully explored. It did not take long for me to confirm one general impression: *Holistic healing* is one of the central themes of the New Age movement, and it is a concept that extends far beyond concerns about physical health. In fact, my research leads me to agree with American religious historian Catherine Albanese's (1992) contention that the New Age can be looked upon as a new healing movement in American culture.

This essay is an effort to survey some of the popular sources and interpreters of alternative healing in the New Age movement and to indicate both differences and overlapping themes in worldviews and therapies. I am not a medical professional, one of whose tasks is to offer evidence about the kinds of therapies that are most successful in the treatment

of physical disease. Neither am I a theologian with an obligation to interpret and sometimes defend the boundaries of a particular religious tradition. My perspective is that of a religious studies scholar, primarily a historian, with a long-standing interest in how new religious movements in nineteenth- and twentieth-century American culture have offered alternative ways of responding to questions about what God or ultimate reality is like, the limitations and possibilities of human nature, and the requirements for living a morally purposeful life.

Historian of medicine Norman Gevitz (1988) has already pointed to the scholar of unorthodox medicine in America as one often considered too sympathetic to alternative medicine by regular physicians and not sympathetic enough by alternative practitioners. This can also be the plight of the scholar who studies new religious movements. Criticisms come from spokespersons for the established religious traditions as well as from members of new religions and even occasionally from fellow scholars who are not convinced that new religions are worthy of serious attention. To take on a subject that involves both alternative medicine and religion may be asking for more trouble than anyone needs, but I proceed on a set of assumptions under which I have worked for many years.

Mary Farrell Bednarowski is professor of religious studies, United Theological Seminary of the Twin Cities, New Brighton, Minnesota.

For citation: Bednarowski, Mary Farrell. 1994. "Holistic Healing in the New Age." *Second Opinion* 19, no. 3 (January): 65-85.

Methodological Assumptions

FIRST, WHATEVER ELSE MAY BE TRUE about new religions that emerge in any culture, the members of these groups are lively contributors to broad cultural conversations about theological matters. Theological energy and creativity are not confined to the churches or to the academy. To ignore what is going on in new religions, to categorize them automatically as heterodox or lacking in depth and sophistication, or to consider them simply as sociological phenomena is to miss a very large arena of theological creativity.

Second, it is not possible to make helpful or firm judgments about new religions until we have paid careful attention to what they say and until we know something of the fruits of their beliefs and practices. This process involves what theologian Robert Bryant calls "critical empathy," the attempt to understand a religious worldview from the point of view of its participants, insofar as that is possible. Political scientist Fred Frohock uses a similar phrase, "extended sympathy," to indicate the attempt to enter the mind or self of another person, and he offers a realistic discussion of the difficulties involved (Frohock 1992:186–87). In *Ritual Healing in Suburban America*, a study of alternative healing groups in a suburban area of northern New Jersey, sociologist Meredith McGuire speaks of "methodological empathy," or "trying to see things as believers see them and use their categories of thought in the organization of experience" (1988:209). None of these critical perspectives asks that the scholar agree with a worldview or act from it—only that one's critique issue from as accurate an understanding and portrayal as possible. In this effort I find it helpful to include a number of direct quotations in order to add the voices of those I am studying to my own.

Third, implicit—and sometimes very explicit—in the theological constructions of new religions are critiques of other institutions (frequently characterized as "science" and the established religions), whose responses to ultimate questions are considered inadequate. Careful atten-

tion must be paid to these critiques because they offer insights into cultural issues and conflicts that elicit theological responses not just from professional scientists and theologians but from the popular culture as well. "Grass-roots theology" has produced numerous religious movements, some of which survive. Mormonism, Adventism, and Christian Science are good examples of that phenomenon in American religious history.

Fourth, the work of sociologists Rodney Stark and William Sims Bainbridge gave me a valuable framework for maintaining open-mindedness as I thought about new religions. In *The Future of Religion: Secularization, Revival, and Cult Formation* (1985), they suggest that in the religious economy of a culture at any given time three processes are going on: secularization, or the diminishing of obvious distinctions between established religions and the secular culture; revival of what are considered more primitive and therefore purer forms of religious traditions; and innovation, the emergence of new religious forms and beliefs. If religious innovation is perceived as a normal part of religious activity, the study of new religions will more likely be shaped by questions about what forms they take at a particular time in the history of a culture than by alarmist speculation about why innovation is occurring in the first place. This does not mean that there is never cause for alarm about new religions; only that the alarm—or lack thereof—should be the result of stopping first to describe and analyze new movements before proceeding to evaluate them.

Religious innovation, of course, does not occur only in new religions, nor does it refer to the creation of theological ideas never before heard of on earth. It also involves reinterpreting traditional concepts (for example, models of God); reemphasizing parts of a tradition that have long been ignored; or integrating influences from other religious traditions or from the sciences. In the case of a new religion, its members are often dealing with what they consider a "new revelation."

What Is the New Age Movement?

STATED SIMPLY, THE NEW AGE MOVEMENT IS ONE of the forms that religious innovation has taken during the last quarter of the twentieth century. But it is not an easy phenomenon to study. If scholars of the New Age movement have anything in common, it is their immediate acknowledgment that the movement is diffuse. Even the history of the movement provokes dispute. Some historians trace its beginnings to the so-called occult explosion of the 1960s; others to the metaphysical religions of the nineteenth century, particularly spiritualism and Theosophy. A third group finds ties to first-century gnosticism, to alchemy and various forms of Renaissance magic, and to the search for the “perennial philosophy,” understood as a body of religious truths that has persisted through centuries in many different forms and cultures. For example, the 1992 publication *Modern Esoteric Spirituality*, edited by Antoine Faivre and Jacob Needleman, was advertised as recording the roots of esoteric spiritualities from their ancient and medieval roots and “culminating in contemporary New Age spirituality.”

As familiar as the term *New Age* has become, it is used so broadly and appears at so many different levels in the culture¹ that it seems at first nearly useless for purposes of definition or interpretation. One encounters New Age in discussions of world religions, quantum physics, twelve-step spirituality, liberal theology, ecology, feminist spirituality, evolutionary science, vitamin therapy, and management techniques that stress cooperation rather than conflict. In the popular media New Age is most often associated with various paranormal activities, including the use of crystals and channelers. There is a New Age category in most music stores and in the catalogue of the Quality Paperback Book Club.

As a descriptive term, then, New Age has very fluid boundaries. But as an evaluative term—which it also is—it elicits some precise and very strong

responses, both negative and positive. Negative assessments include accusations of everything from self-serving foolishness and exploitation of the gullible to idolatry and satanism. Such negative connotations are sufficiently widespread that some people who seem obvious participants in the New Age movement have no interest in claiming that label and in fact repudiate it. “That’s garbage,” said a French woman I recently met, when I asked if she considered herself a New Age practitioner. She had just told me about her Tarot reading and psychic healing practice in Paris and Normandy and was inquiring what I knew about crystal healing among the Amerindians, as she called them. I had been so confident of her self-identification that I nearly didn’t ask the question. Her response is an appropriate caution that not all the healers mentioned in this essay would be inclined to call themselves “New Age,” even though I place their interpretations of healing in that broad category.

By contrast, for those who see the New Age as portending a time of badly needed cultural change in religion, science, medicine, education, economics, politics, ecology, relationships between men and women and between humankind and the planet, the term can have almost militantly positive meanings. One catches the spirit of this approach in *The Aquarian Conspiracy*, a well-known book by Marilyn Ferguson (1980), in which she chronicles changing patterns in many different disciplines and uses phrases like “new mind” and “benign conspiracy.” Ferguson speaks of a cultural crisis: “Our institutions—especially our governing structures—are mechanistic, rigid, fragmented. The world isn’t working” (1980:191). She sees the paradigm shifts called for by the New Age movement as the antidote to the ills caused by a mechanistic and fragmented worldview and is optimistic about the possibility of drastic change in the culture. She is insistent that “we can choose our mode of participation in the world, our response to life. . . . Once we become aware of our habitual responses, we can see the ways in which we have perpetuated many of our own tribulations” (1980:110).

The New Age Critique of Science, Religion, and Medicine

THE POLARIZED OPINIONS about the nature and value of the New Age and the numerous belief systems and practices that fall under that heading are not as difficult to make sense of as they first appear. From the numerous manifestations of the New Age emerges a consistent critique of why the world is not working and an equally consistent set of suggestions about what might make it work better.

Many New Age thinkers accuse the established religious traditions, particularly Judaism and Christianity, of overemphasizing and thus distorting the doctrine of divine transcendence. The result has been a concept of God as totally other, inaccessible, and almost completely separate from the workings of the world. And they indict Newtonian science for having drained the universe of the divine presence entirely. In the New Age view, both religion and science have colluded in fostering destructive splits between spirit and matter, mind or soul and body, male and female, science and religion, thinking and feeling. The critique is not simply that these polarities are considered opposites of each other but that they are perceived as antagonistic and as hierarchically arranged. Thus one must be considered better than the other. Spirit is better or more real than matter, for example, or vice versa.

According to New Age critics, the churches promote such dualistic thinking by walling off the sacred in various ways: by depriving church members access to spiritual experiences other than through prescribed rituals conducted by authorized experts; by stressing an empty, legalistic morality over spiritual transformation; by preaching a doctrine of human sin and helplessness that keeps men and women from recognizing the presence of God within and from assuming responsibility for themselves and for the creation.

Science is perceived as arrogantly, or at least ignorantly, refusing to acknowledge the reality of central aspects of human experience—those concerning feeling, the inner, the spiritual—and thereby devaluing these experiences and ways of knowing. The result is a desacralized world devoid of spirit or consciousness and an understanding of human nature as alien to the rest of creation and autonomous from its workings.

When this double critique of science and religion is leveled at the response of these institutions to illness and healing, the focus is usually on the ways medicine and established religion have split apart aspects of the whole person and divided the territory between them. Religion concentrates on spirit and gives care of the body to medicine, praying from afar that its ministrations will succeed. Medicine in turn treats the body as a collection of parts rather than as a multidimensional whole. It fails to consider the networks of relationships that affect the well-being of suffering persons—family, work, culture, even the workings of cosmic forces. Both institutions, in the view of many New Age thinkers, have rigid understandings of what is “real.” They deny the efficacy of little-understood healing energies and substances long acknowledged by folk medicine, Eastern and Native American religious systems, and esoteric spiritualities.

Obviously, more and less subtle renderings of these critiques by New Age thinkers appear within different disciplines. The more thoughtful and sophisticated—for example, David Spangler (1984, 1993), Matthew Fox (1988, 1993), David Griffin (1988), David Toolan (1987), Brian Swimme (1984), and Marilyn Ferguson (1980)—are well able to acknowledge the strengths of the sciences, including medicine, and established religious traditions, and their critiques emerge from the desire not to denounce and obliterate but to offer new perspectives on possibilities for broad cultural change.

Immanence and Interconnectedness as Antidotes to Fragmentation

A NEW WORLDVIEW, in the opinion of New Age thinkers, will restore the Western world to wholeness, thereby healing destructive dualisms as they affect both individuals and institutions. This worldview insists on the immanence of the divine and the interconnectedness of all things. It is difficult to underestimate the importance of immanence in the New Age movement: in one form or another it is the metaphysical foundation of religious systems that are in most ways very different from each other and that have originated in different cultures.

Immanence is not a foreign concept in Western religion. Judaism and Christianity have long maintained a tension between the immanence and the transcendence of God. For an interpretation of immanence in the New Age movement as it relates to wholeness and holistic healing, however, the one that emerges from Theosophy is more useful. It is broad enough and versatile enough to cross the boundaries of numerous New Age healing systems. Founded in 1875 by Helena P. Blavatsky and Henry Olcott, Theosophy has understood itself as reclaiming the ancient wisdom that at one time held together both science and religion. Theosophists acknowledge the influence of Eastern religions, occult metaphysics, and the revelations given to Madame Blavatsky by the Mahatmas or Ascended Masters of Indian tradition. Contemporary interpreters of Theosophy speak of ultimate reality as “an omnipresent, eternal, boundless and immutable Principle on which all speculation is impossible, since it transcends human conception.” This Principle, sometimes referred to as the Absolute or the One, pervades the entire universe without exhausting itself, and it manifests itself in both spirit and matter. These apparent opposites, along with all others in the physical world, are in actuality “polar

aspects of the One unity in which they are synthesized” (Weber 1992:319). Thus there is a unity underlying all appearance of diversity. Most important for understanding holistic healing in the New Age is Theosophy’s insistence that the One is made manifest in the many—in every atom of the universe, including human consciousness, in which it is most highly developed. Because this is the case, two other things are also true: human persons have access to ultimate reality, and they are connected with each other and with every part of the universe through this sharing in ultimate reality.

As will become apparent, many of the healing techniques of the New Age depend on the use of therapies designed to make both sufferers and healers aware of their own access to the source of healing power that lies within each person. Physical, mental, and spiritual illness are signals that the natural healing capacity issuing from the source of ultimate reality has been impeded in some way. Healing is understood as holistic insofar as it can restore harmony and wholeness at all three levels. Renée Weber, a philosopher who writes frequently about Theosophy, suggests that “the Holistic Hypothesis postulates as primary cause of disease the disconnectedness from this flow and rhythm of the whole, both within the single organism and also among groups of organisms” (1985a:28).

Varieties of Healing in the New Age

INTERPRETATIONS OF IMMANENCE and interconnectedness are essential to an understanding of holistic healing in the New Age movement, but the necessarily abstract nature of the discussion masks the differences in worldview among the healing therapies considered “New Age.” A visit to a New Age bookstore like Present Moment Books and Herbs in Minneapolis is a quick reminder that many approaches to healing are considered compatible with holistic healing. Present Moment’s flyers ad-

vertise essences; aroma therapy; Western, Chinese, and Ayurvedic herbs; vitamins and supplements; and health-spiritual, metaphysical, and New Age books, videos, CDs, and tape cassettes. The winter/spring 1993 schedule includes courses on astrology principles, the historic use of herbs, first-degree Reiki, soul healing, karmic and emotional healing, Tibetan Buddhism, flower essences, crystals and stones, origins and legends, the basics of homeopathy, Chinese tonic herbs, diagnosis, tongue and pulse reading, Chinese patent remedies, the history of homeopathy, foot zone therapy, reflexology, yoga for meditation, and acupuncture training.

According to the young woman who categorizes and shelves the books, 10,000 healing traditions are represented by the store's holdings. Even if 10,000 seems an overly optimistic number, these books offer a great variety of worldviews, techniques, claims, and definitions of illness, health, healing, and human nature. They state or imply differing understandings of the boundaries that intersect dominant and alternative religions, science, and medicine. The people who work at Present Moment see the bookstore as a center for information about New Age healing techniques.

Present Moment publishes a small quarterly newsletter that includes articles about healthy living and holistic healing and advertisements for various healers. It does not appear to espouse any particular kind of healing as more effective than others, only the conviction that healing must be holistic. This noncommittal stance toward specific traditions is made clear in an article by chiropractor Nancy Anne Schrauth, who defines herself as "a holistic health practitioner involved with people who are committed to holistic health in varying degrees—some only minimally by seeking chiropractic care instead of an allopathic medical doctor, and some who are living a well-developed holistic lifestyle" (1992:7).

Schrauth's brief article offers a primer on most of the major elements of holistic healing that turn up in New Age sources. Holistic health, she says, requires the integration of body, mind, and spirit. The body has a powerful, innate ability to heal itself,

and a holistic practitioner is one who will "listen, respect and support this innate ability and use natural therapies and remedies that encourage the body's natural functions, not drugs that suppress them." She does not contrast holistic healing with allopathic medicine other than to suggest obliquely at several points that allopathic means of healing are less natural and that traditional medicine has a few things to learn from holistic healers.

Schrauth devotes most of her article to a discussion of spirituality, which she considers the most elusive aspect of holistic health but at the same time the essential component to physical and mental health. "By cultivating our spiritual aspect," she asserts, "we can change mental and emotional patterns from within, thereby establishing attitudes and beliefs that lead to life-long health and well-being."

Schrauth refers to the *contents* of spirituality, however, only generally and suggests that readers seek out any of the abundant spiritual resources of the Twin Cities—traditional spiritual organizations (by which she means established religious traditions), New Age groups, or an individually cultivated spirituality based on fostering attitudes of forgiveness, gratitude, and love. She insists not on any particular spirituality but on the need to "seek out whatever provides you with inspiration to contemplate within yourself a sense of connectedness with the universe." Schrauth believes that it is impossible "to enjoy full health as an isolated, separate being," and she suggests that even traditional medical doctors agree that there is more illness among people "who have no meaningful connections in their lives" (1992:7).

How are the outlines of Schrauth's definition of holistic healing fleshed out within the context of specific religious systems? Several popular writers on healing who have been designated by their publishers as New Age show how general categories like immanence, interconnectedness, and "innate healing capacity" are articulated within the boundaries of very different worldviews. Here one gets into the realm of what Fred Frohock in *Healing Powers: Alter-*



The Music Behind the Moon (frontispiece). Wood engraving by Leon Underwood, 1926.

native Medicine, Spiritual Communities, and the State calls “deep pluralism.” Frohock maintains that “followers of traditional, or allopathic, medicine and holistic medicine do not simply see the world differently; they see different worlds” (1992:213). Many New Age healing systems push hard at the outer limits of what is considered “real” in Western culture in their claims about what unseen forces or entities are at work in the healing process. Deepak Chopra, Diane Stein, and Medicine Grizzlybear Lake offer glimpses into the worlds of Ayurvedic, women’s, and Native American healing, all with different understandings of what makes up the whole of their particular universe and what constitutes its parts.

Deepak Chopra, an endocrinologist, also practices Ayurvedic medicine, a system of healing that originated in India over four thousand years ago. Ayurveda makes use of pills, exercises, diets, and meditation, but Chopra indicates that it is medicine in the broadest sense: he translates *Ayurveda* as “the science of life.” Chopra has published *Quantum Healing*, a best-selling book about mind-body healing in the Ayurvedic tradition. “When you look at Ayurveda’s anatomical charts,” observes Chopra, “you don’t see the familiar organs pictured in *Gray’s Anatomy*, but a hidden diagram of where the mind is flowing as it creates the body” (1989:6). Chopra understands the body “to be created out of consciousness” and healing as a process that is mental rather than physical. As he sees it, the doctor or healer must help the patient activate the healing capacity of the mind at its deepest level so that the healing by the body of a life-threatening disease like cancer becomes as natural and unsurprising a phenomenon as the healing of a cut finger.

To activate the healing power of the body, the healer must take into account more than “the disease.” In Chopra’s opinion Ayurvedic medicine is better equipped to do this than traditional medicine. In speaking of a patient with a blood disorder, he says, “To a hematologist, it is largely irrelevant if Aaron is tense, driven, full of dubious substances, and panicked at the thought of dying. To an Ayur-

vedic doctor, these are primary inputs to his sickness—they have entered on the quantum level, where he turns into the person he is” (1989:141). Chopra likens the search for holistic healing techniques that take into account the entire person and his or her relationships to the quest of the ancient *rishis*, authors of the most ancient Vedic texts, to discover whether nature is ultimately unified (1989:178).

For Chopra disease is a “distortion of intelligence.” Mind and body have been separated from each other so that it is no longer apparent, as it was to the ancient *rishis*, that healing, what Chopra calls “quantum healing,” is “the ability of one mode of consciousness (the mind) to spontaneously correct the mistake in another mode of consciousness (the body)” (1989:257). The ancient *rishis* were able to heal because they understood the true nature of reality: that it is shaped by intelligence, which is different from either mind or body but infuses both. Thus, according to Chopra, “theirs was a medicine of consciousness, and their way of treating disease pierced the body’s matter and went deeper into the core of mind” (1989:5–6).

Chopra makes it clear that it is not his intention to deny the reality of body over mind, only to state his conviction that they have come apart from each other and that the knowledge that a unified source of healing undergirds them has been lost. The highest goal of existence, as he sees it, is to acknowledge the reality of both mind and body and to achieve “two hundred percent of life.” The part that unifies mind and body and accords them their full reality, the part that has been left out of the whole, is that mysterious realm lying beneath the workings of both mind and body. In their healing techniques, Chopra says, the *rishis* knew how to go “straight to the field of unity that automatically hits upon the solution, which the mind-body then carries out—that was the *rishis*’ shortcut” (1989:228). Ayurvedic herbs, meditation, yoga, and sound therapy help restore the patient to the deep level of relaxation at which the healing power of the body resides.

Women’s healing attributes illness and suffer-

ing not just to the separation of mind and body but to the separation of the male and female principles of the cosmos. Considered missing from the whole is the female principle, sometimes expressed as the maternal principle or the goddess or the magnetic (as opposed to the electric) center. In many New Age writings, women's healing is thought to be of an order different from men's healing—more psychic, more tactile. Allopathic medicine is frequently identified as male and holistic healing as female (Langford 1985).

Diane Stein, author of *The Women's Book of Healing*, speaks of women's healing as psychic healing, based on intuition and aura awareness. She sees it as "an outgrowth of feminism and the radical women's movement, of the New Age and women's spirituality" (1987:xxii). Stein maintains that women's healing has "real things" behind it. She bases her claim on the complex Theosophical understanding of the human person as made up of seven sheaths or bodies, an acknowledgment that we experience our lives physically, emotionally, mentally, and spiritually at all times and with many gradations between.²

In Stein's opinion women are particularly skilled at connecting the seen levels of existence with the unseen. For this reason their healing power goes deeper and is directed at all levels of existence, not just the physical. In her view allopathic healing is partial rather than holistic, and it cannot heal completely: "A woman with a headache takes another aspirin, and her pain is gone for four hours. She has had it for three days and it returns" (1987:6). Stein does not discount the benefits of allopathic healing, but she is convinced that sufferers resort to its therapies too quickly before attempting by psychic means or the laying on of hands to get at the underlying cause of illness. The headache returns, as Stein sees it, because the taking of aspirin does not affect the deeper levels of the woman's being wherein lies the cause of the recurring headache.

Stein insists that women use their healing powers not just on behalf of individuals but in much broader arenas: "Women are the healers of the

universe and Earth, the positive civilizers, inventors, comforters and homebuilders of the planet, the guardians of peace and well-being, and the mothers, caregivers, listeners and priestesses of the life force" (1987:xvii). Stein offers a lengthy critique of traditional religion and established medicine, concluding that "male medicine and patriarchy fragment the parts of woman's Be-ing. They not only separate the seen from the unseen whole, but separate the physical self" (1987:5). Stein uses crystals, auras, the laying on of hands, chakras (considered the seven major energy centers of the body), and colors in her healing work designed to address all aspects of the person. In her worldview all these therapies are interconnected because they draw on the innate healing power within each person.

New Age healers refer to women's healing in other ways as well. Linda Osborne, minister at Lake Harriet Community Church in Minneapolis, formerly the Church of Religious Science, has her own healing practice and teaches courses at her church. According to her understanding of healing, we are electromagnetic beings, and the qualities that we embody are reflections of the godhead. The electric center is male, and the magnetic center is female. Women, like men, draw their healing power from the godhead. If there is an overabundance of electric power in the godhead and an insufficiency of magnetic power, the power in the godhead is not enough to sustain women (who are 65 percent magnetic) in their healing work on earth. It is Osborne's understanding that we are moving into an era in which the magnetic power in the godhead is greater than the electric, thus signaling a time when women's healing will become more prominent. Women, Osborne claims, are closer to the earth and therefore are more natural healers.³

Demetra George describes women's healing in Jungian terms in *Mysteries of the Dark Moon: The Healing Power of the Dark Goddess* (1992). She contends that the part that has been left out of the whole is the dark phase of the moon, which symbolizes the realm of the psyche. The psyche in contemporary culture is perceived as the underworld, a dwelling

place for unclaimed fears and desires, and therefore it is looked upon as a dangerous part of the person in which to probe. In reality, she says, this underworld is a place of healing and transformation: "As we become less fearful and allow ourselves to look at what we have hidden, we can begin to reclaim the dark feminine and heal our psyches" (1992:55). George does not believe that this journey is open only to women; nor do Stein and Osborne insist that women's healing can benefit only other women. All three, in different ways, attempt to make the point that unless healing includes feminine aspects, it cannot be considered holistic.

Medicine Grizzlybear Lake identifies himself as a Native healer (a term he prefers to *shaman*, which in his opinion connotes sorcery). He has contributed articles about his practice to numerous New Age magazines and is the author of *Native Healer: Initiation into an Ancient Art* (1991), a recent best-seller put out by the Theosophical publisher Quest Books. Lake's universe is the world of nature, a world filled with spirit. Charlie Thon, another Native healer and author of the foreword to Lake's book, claims that "our powers come from our relations in Nature. They are our advisors and allies. Their hides, claws, furs, teeth, and feathers are our spiritual tools. These are the powers we use for healing, ritual, ceremony, and to keep the world in balance" (1991:xi).

Lake cites the "ancient and esoteric creation stories" of the Native elders as teaching that everything in nature is made up of two sides, the spiritual and the physical. From the Native perspective it is the spiritual side of nature that is missing from the healing paradigm of traditional medicine. Lake speaks of his own power, not surprisingly, as coming from the grizzly bear, but this power is connected with many other things in nature as well: "the Sun and Moon, lightning and thunder, mountains and rivers, hummingbirds and plants, deer and wolves, ravens, hawks, and eagles, snakes and rocks, water and fish, wind and rain, and many other relations in Nature" (1991:13).

Lake contends that one must use other-than-human persons in order to speak adequately about

wholeness. He points as an example to plants as a "whole" species and as a "people": living things with minds, bodies, and spirits, with families, extended families, tribes, and nations. If one is to use the healing power of plants in a holistic way, according to Lake, it is necessary to acknowledge the reality of the plants' many relationships and to act on the knowledge that harvesting plants in natural and fitting ways and at appropriate times will intensify their wholeness and make their healing powers greater. "Harvesting plants with prayer, ritual, and knowledge (communication formulas)," Lake says, "will insure that the spirit of the plant stays with the body of the plant. . ." (1991:147).

In the Native universe in which Lake participates, *spirit* is considered natural, not supernatural, and it has many sources from which Native healers derive their power: "from the Great Spirit, from within themselves, from the spiritual and physical forces and powers in Nature." For Lake, "All things in Nature, seen and unseen, are considered a source of spiritual power which certain Native healers might be connected to and use in healing" (1991:3). The kind of power used defines what kind of healer one is—a trance doctor, a sucking doctor, a hand healer, or a spiritual healer. Whatever the source of the healer's power, it belongs to the community—to the Great Creator and to the people (1991:4, 7).

Other Native healers, including Ed McGaa (1990) and John Redtail Freesoul (1986), echo Lake's conviction that all things created in nature are infused with spirit that may be called upon for healing. McGaa refers to this perspective as "Mother Earth Spirituality" and believes it can overcome the modern assumption that all human connections with nature have been cut. In his opinion the perceived separation from nature is a mirage resulting from ignorance and the "arrogant belief that a human being is unlike animal beings and plant beings and rock beings." For McGaa, the Native American understanding of spirituality and holistic healing is not a back-to-nature movement; it is built on "the realization that we can never leave nature"

(1990:xv). Nature, in the Native American view, at least as expressed in New Age literature, is the whole of which we are a part.

Chopra, Stein, Osborne, George, Lake, McGaa, and Freesoul have very different ways of understanding what fragmented parts of the universe need to be restored in the process of healing. But each speaks of a unified source of all reality, a Whole that is immanent in the universe and available as a source of healing power to healers and to those needing healing. Rituals, yoga, meditation, massage, special diets, the use of crystals, gemstones, plants, and colors are all ways to generate greater consciousness of this healing power and to activate it in the suffering person.

Healing as an Innate Capacity

DIFFERENCES AMONG NEW AGE HEALING SYSTEMS blur again when discussion turns to healing as an innate capacity in each person. Whatever the worldview, whatever the rituals, whatever the naming of the power invoked, it is understood that we heal ourselves, even though we may derive essential assistance from healers and from healing communities. This idea is not confined to the New Age movement but is a major part of its healing ethos. Martin Rossman, founder and director of the Collaborative Medicine Center in Mill Valley, California, says that his own work in preventive medicine and chronic illness is “based on the premise that healing is a natural occurrence, an innate mechanism of the organ.” For Rossman, any approach to healing must eliminate the factors hindering the body’s innate capacity for self-healing and increase the factors stimulating that ability (1989:78). From this perspective, Marilyn Ferguson suggests, “there is always a doctor in the house” (1980:248).

Many New Age practitioners speak of healing as the process of self-discovery, of learning to listen to the inner wisdom, of discovering the basic wholeness that is one’s birthright, one’s natural state. In general, most contend, healing must proceed from

inner to outer rather than the reverse. As the authors of *The Mystery of Healing* put it, “There are still too few who realize that healing is primarily a spiritual process proceeding from within outwards, from the spiritual centre to the circumference of the physical body” (Theosophical Research Centre 1981:5).

The insistence on the power of healing as a capacity that lies within each person and even within each atom of the cosmos functions as a basis of critique against both traditional medicine and faith healing as it is understood in established Christianity. For the most part, New Age critiques of traditional faith and medicine do not deny the validity of whatever good they might accomplish. In keeping with an emphasis on wholeness, New Age healers point instead to ways in which they are incomplete, fail to address all aspects of the person that need healing, and promote false understandings of both illness and healing.

Whether considered natural or spiritual in origin, the power to heal or to be healed is not typically understood by New Agers as conferred by God in some miraculous way. Nor do they assume that the universal source of healing power is the property of any one religious tradition. Implicit in this perspective is the critique of any tradition that claims exclusive rights to call upon or mediate it. Dora Kunz, a clairvoyant who developed the healing system called Therapeutic Touch and who has been president of the Theosophical Society in America, describes the healing power from which all healers draw as having three characteristics: order, wholeness, and compassion. She understands it further as universal and part of nature, and therefore “it does not matter who calls upon it nor by what name. It is not for any race nor any particular religion” (Weber 1985b:294).

An excerpt from Meredith McGuire’s *Ritual Healing in Suburban America* illustrates the religious interpretation of illness and healing refuted by most New Age healing systems. In her study of one conservative Christian group, the nondenominational Pentecostal fellowship Women’s Aglow, International, McGuire observed that healing was

always perceived as coming from God. Illness was attributed to human sin, individual and corporate, and to the work of Satan. As one member of the fellowship put it, "There are germs and things like that in this world, and I believe that they came with the fall of Adam. When God drove Adam out of the Garden of Eden, then he was exposed to the things of the world, the diseases and the illnesses that were already present outside the Garden, because of the fall of Satan" (McGuire 1988:47). McGuire concludes from her study not that Christian groups have no sense of the need for holistic healing but that they understand healing as coming ultimately from without, from a transcendent deity, whatever the needs or the disposition of the person needing healing, and whatever the gifts of the healer.

Some alternative healers maintain that churches are unaware of the power of what they claim as their own healing technique: prayer. In an interview published in *The Quest*, the journal of the Theosophical Society in America, Larry Dossey refers to scientific studies conducted on the healing power of prayer. Dossey, a physician whose name appears frequently on lists of alternative healers, believes that science and medicine are not meddling in the churches' business when they look into the power of prayer because "the people in the churches . . . are some of the most poorly informed people I have run into about the data suggesting that prayer works." Dossey says he can't really distinguish between the effectiveness of prayer and other healing techniques like visualization. But he cites numerous well-grounded scientific studies showing that "prayer has a remarkable impact in changing the course of biological activity of organisms from bacteria to human. . . . Nobody in the churches seems to care about this" (Metzger 1992:43).

If the New Age movement considers traditional religion's view too spiritual in that it relies too much on petitioning the aid of a transcendent deity, it sees traditional medicine as too materialistic. Grounded in a Newtonian, Enlightenment, modern (rather than postmodern), scientific understanding of how the universe operates, traditional medicine validates

as real only that which can be seen (if only under a microscope or with X rays), measured, and analyzed. It does not sufficiently address the "more" of human make-up and experience that the New Age tries in various ways to describe and activate.

The worldview of traditional medicine *cannot* be invoked to explain or activate healing, says Renée Weber, because it gives rise to "materialism, positivism, reductionism, behaviorism and other crude versions of physicalism" (1985a:23). This is the understanding of reality that dominates the life sciences, contends Weber, and therefore also medicine. It confines the meaning of *natural* to the physical realm. It prevents medicine from seeing a phenomenon like the spontaneous remission of cancer as anything other than an anomaly, when it is really a comprehensible activating of the body's natural, innate ability to heal, a capacity that medicine should be cultivating, says Weber, rather than denying or ignoring.

Some advocates of New Age healing suggest that the term *miracle* needs to be redefined, whether it is used by the medical community to point to a recovery that can't be explained or by religious communities to testify to their conviction that God has intervened in the natural workings of the universe. As one Theosophist puts it, "Intelligent people can only see a miracle as a fulfillment of law, not as an abrogation of it, an intensification of nature rather than something unnatural" (Bendit 1981: Foreword).

Whatever their objections to the world of traditional medicine, practitioners of New Age healing do not typically suggest dispensing with it. I have not encountered in New Age sources the contention of Christian Science that spiritual healing and traditional medicine are totally incompatible and cannot be used effectively together. Most people in the various metaphysical, psychic, occult, and meditation groups that McGuire studied, for example, used both traditional medicine and alternative healing techniques. For some the choice is a matter of an eclectic pragmatism, using whatever is available, whatever works, in order to bring about healing. For others it is an acknowledgment that alternative

kinds of healing have not yet developed enough in Western culture that they can be used exclusively. Deepak Chopra claims that the two medicines, in his case traditional and Ayurvedic, “do not have to be antagonists, but for the moment they clearly face in opposite directions” (1989:141). Chopra writes of wanting to keep one foot in his endocrinology practice: “Although I felt in tune with Ayurvedic theory, I was still nervous about its results” (1989:251). Sometimes using both approaches is a matter of expediency. Medicine Grizzlybear Lake relates that often “my doctoring was supplemental because we have all become dependent upon Western medicine for survival. Thus my role has been a combination of medical and religious, part priest, part psychologist, and part physician” (1991:116).

Often the acceptance of traditional medicine is simply an acknowledgment that the body is no less real than the mind or the spirit. Larry Dossey cautions that the enthusiasm for mind healing should not cause us to abandon “the physically based therapies that are right and humane, always recalling that the world, including the body, does have a way of manifesting in the most obdurate physical ways, and that when it does so, physically based therapies may be appropriate” (1989:176). Dossey cautions against what the *Quest* interviewer describes, interestingly, as “new-agers, people who go overboard wanting to heal everything by visualization.” He insists that an overreliance on consciousness techniques is both dangerous and inhumane. “For God’s sake,” he says, “the treatment for appendicitis is still surgery, it’s an appendectomy. Nothing else even comes close in terms of cure rate” (Metzger 1992:46).

Illness as Learning, Healing as Mystery

THERE IS WIDESPREAD AGREEMENT in the New Age movement that healing is a mysterious process, that no one technique works all the time, that most

work at least some of the time. In the sources I looked at I found surprisingly few exclusive claims for one technique or another. The more spirited defenses tend to be of worldviews rather than of techniques.

Dolores Krieger, a professor of nursing well known along with Dora Kunz for her development and teaching of Therapeutic Touch, maintains that “healing is a mystery that does not easily yield to the casually worded question. True healing elicits response from depths of the human condition that are not well understood” (1985:ix). Janet Macrae, another nursing professor and instructor of Therapeutic Touch, expresses her own confidence in the healing effects of Therapeutic Touch and at the same time acknowledges that “essentially it remains a mystery, as does life itself.” Macrae’s experience does not offer a simple answer even to the question, “Who is doing the healing?” Is it the innate healing potential within all living things? Is it the life energy, a universal force that has order as its basis? Is it the practitioner, who serves as a conduit or an instrument? Or is it a combination of all three at a crucial moment?” (1991:xiii).

The mystery of healing has a spiritual function in the eyes of many New Age healers. If it were discovered, says L. J. Bendit, “a man would lose his particular prerogative, which is that of constant enquiry, and investigation of the world in which he lives” (1981: Foreword). Accomplishing the broader mind/body/spirit healing advocated by so many in the New Age movement is understood to be precisely the goal of a human life. There exists a reciprocal relationship between seeking one’s inner self and being healed, and health is a by-product of this quest. Stephen Levine, former director of the Hanuman Foundation Dying Project and widely known among alternative healers for his work with the dying, maintains that “the reason we take birth is to rediscover the deeper, wiser parts of ourselves. By becoming aware that our lives are a continual process of healing, we can learn to come to peace with any illness or injury that may manifest” (1989:187).

Another strand in the New Age literature is the

belief that physical or emotional illness can offer lessons not easily learned otherwise and that these lessons are learned irrespective of technique. Levine relates that the most successful healings he has witnessed—whether into life or into death—involve a self-reliance that goes beyond techniques: “Each seemed to share a common attitude that discomforts were not a curse or a punishment but rather a teaching, almost an initiation” (1987:266). Martin Rossman speaks of illness as the body’s way of getting attention for broader needs that are not being met. “We can actually learn something from an illness,” he says, “that helps to bring us back into alignment with our potential for wellness.” He cites pediatrician Rachel Naomi Remen’s suggestion that illness functions as a Western form of meditation. It slows people down, forces them to reevaluate their lives and take stock of what is important to them. When one slows down, there is always the opportunity for healing, if not curing (Rossman 1989:79).

Alternative healing literature is filled with stories of people who experienced serious illness as a threat to their most basic identities and discovered eventually that in the midst of suffering they had created a new self. Kat Duff, a therapist with chronic fatigue and immune dysfunction syndrome, interprets this transformation as a kind of alchemy. She relates, “After I had been sick for several months, it became clear to me that I was changing in fundamental ways and that I would never go back to my ‘old self.’ One day . . . I heard myself muttering under my breath, over and over, like a droning chant, ‘I don’t know who I am anymore. I don’t know who I am’” (Duff 1993:39).

Duff began to think of her illness in terms first of chemistry and then of alchemy, one of whose central tenets is that physical decay is the beginning of the Great Work, the changing of base metal into gold. Duff elaborates on the alchemical process and its emphasis on the relationship and combination of opposites, which also forms the foundation of homeopathic medicine—that health grows from the same root as the disease. This realization, Duff says, “is also echoed in the words of many sick people who

discover, after searching in vain for a cure, that the answers cannot be found outside oneself; they must come from within” (1993:41).

Healing into Death

SUCH BROAD DEFINITIONS of holistic healing are compatible with the view that even physical death can be understood as a healing event rather than as a failure of the healing process or of a specific technique. In that sense many New Age healers participate in the growing cultural awareness that curing and healing are not the same phenomenon. The curing of disease is not identical to the restoration or transformation of self that the experience of being healed, of being made whole, brings with it. Even death, then, is not necessarily incompatible with being healed.

Stephen Levine is among the best-known interpreters of healing into death. Levine derives many of his insights about living, healing, and dying from Buddhism. In response to a cancer patient who asked, “Should I stop trying to heal and just let myself die?” Levine says he began to think about that question as an “old mind” question, one that assumes a duality between living and dying. The better question, he discovered, is “Where is healing to be found?” or “What is completion?” Levine’s experiences with the dying revealed to him that “though each seemed to experience a greater wellness, a sense of quiet completion, not all who opened to life survived in the body. Each healed into life. Some experienced their body returning to wholeness. Others experienced the wholeness of death” (1987:3–5).

The Role of the Healer

JUST AS THE PROCESS OF HEALING is considered mysterious, so is the way in which the healer works, although the primary role of the healer, it is agreed, is to activate the sufferer’s innate capacity for heal-

ing. The authors of *The Mystery of Healing* see the healer, in this case any doctor who has some sense of the spiritual aspects of healing, as a channel for “vast healing influences.” To exert these influences does not require that the doctor adhere to any particular religious creed. The ability “arises from or is associated with one’s fellow human beings and dedication to their welfare” (Theosophical Research Centre 1981:15). Several healers, when asked to define “the golden thread” that underlay all healing processes, cited love—the healers’ love for themselves and for those seeking to be healed (Carlson and Shield 1989:3). One of the first tasks of the healer in the New Age understanding is to refrain from seeing the one who needs healing as other, as bad, as less than whole, and the illness as somehow wrong: “All that healers can do is the best they can,” according to Hugh Prather, a crisis therapist and minister of The Dispensable Church in Santa Fe, New Mexico. “The instant their minds begin attacking, true healing becomes impossible, because they have betrayed their calling” (1989:16).

Meredith McGuire observes that the healer in alternative medicine is often considered more the guide than the expert (1988:183), and many New Age healers speak of the reciprocity, the mutual identity, between healer and patient. According to most healers, the release of healing energy can occur no matter what technique the doctor has prescribed. Rachel Naomi Remen resists the understanding that only certain people are healers. “This,” she says, “just separates people from the naturalness of their own healing” (1989:96). In a true healing relationship, as she sees it, both heal and both are healed: “When only one person is seen as the healer, the relationship might be said to be a curing relationship but not a healing one” (1989:92). Dolores Krieger makes the same point another way: “It is not that *a* the healer is healing *b* the healee but rather that both are expressions of a unified therapeutic interaction” (1985:ix). McGuire’s research indicated yet another sense of reciprocity in the healing process. In the alternative groups she studied in suburban New Jersey, she discovered that “the majority of persons

had no financial interests whatsoever. Many healing situations were simply friends or fellow believers seeking healing for each other” (1988:8).

If reciprocity is a major theme in the relationship between the healer and the person being healed, another is the need for detachment—the fostering of an autonomous integrity on the part of both persons. Dora Kunz defines *detachment* as “a conviction that each patient is first of all a human being with a point of wholeness within, which is unaffected by the pain and frailty.” The healer needs to meet that wholeness with her own sense of innate wholeness (Weber 1985b:300). Linda Osborne puts it a little differently. She says that she doesn’t have the vaguest idea of what people need when they come to her for healing, and she doesn’t care. “If I care,” she says, “then I get into controlling. What I care about is that people come to know their self-worth.” Osborne does not consider her form of detachment indifference but rather an acknowledgment that the healer needs to relinquish control of the process. Fred Frohock makes this same point in describing spiritual healing: “All spiritual healing requires a surrender of private authority. The individual transfers autonomy to some more expansive force, whether it be to God, the universe, or cosmic energy” (1992:164).

The Responsibility of the Patient

WHAT IS THE ROLE, particularly the responsibility, of the one needing to be healed? What is the difference between taking responsibility for one’s spiritual, emotional, and physical health and blaming oneself for getting sick in the first place and then not getting well when one’s body apparently does not respond to either traditional medicine or alternative healing? This problem issues from the contemporary emphasis on visualizing or imaging the defeat of illness and the body restored to health. This new form of positive thinking has been around long

enough for people to be aware that, whatever the benefits, thinking positive thoughts and fostering healthy visions can be a form of works-righteousness. "Negative thinking" in its various forms becomes just as threatening to health as sin or germs or viruses. Such positive thinking as popularly understood takes many forms: thinking the thoughts of the God who created us as perfect reflections of the divine self; imaging healthy outcomes of therapy; having the right attitude; being open to the healing moment; espousing the conviction that in illness we are dealing ultimately with thoughts, and thoughts can be changed. Whatever the form employed, it takes a fair amount of sophistication to refrain from assuming that we made ourselves sick or let ourselves get sick, and now it is up to us to make ourselves well. "People are horrified," says Deepak Chopra, "to think that they are to blame for their diseases" (1989:208–9).

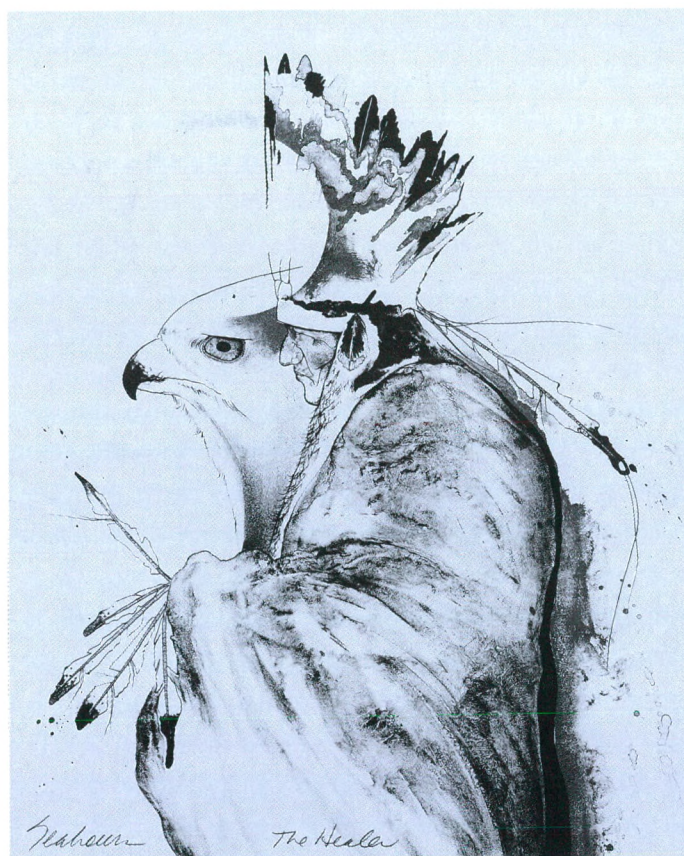
Many New Age worldviews have been influenced by Eastern thought, and they have likewise repudiated Christian theodicies that regard illness as punishment or test. For these two reasons the concept of *karma* often comes up in discussions about responsibility for illness. H. Tudor Edmunds, at one time chair of the Science Group of the Theosophical Research Centre in England, claims that "health, like everything else in life, follows basic karmic laws, so it is impossible to think that some new healing method or wonder drugs will quickly restore good health and excuse one from dealing with [one's] original mistakes. Nature cannot be deceived or bribed, but she welcomes cooperation in her work" (Edmunds 1985:72).

Edmunds's interpretation of illness as the expiation of previous mistakes may sound to many people more punitive than comforting; that is the case with many interpretations of karma, at least as Westerners respond to them. In a chapter on karma and health in *The Mystery of Healing*, the authors work at interpreting karma as a cosmic system of opportunity rather than blame, an obviously tricky task. They are very clear that "whatever difficulties occur, they are self-created; and equally, that only

the self which created them can—in the long run—deal with them effectively" (Theosophical Research Centre 1981:86). But, they explain, the system must be seen as a dynamic enterprise of subtle and intricate forces generated over many lifetimes rather than a "book-keeping transaction resulting in a credit or an overdraft on the bank of life." New influences, they say, are constantly present to alter the total karmic pattern, and thus one cannot respond with either unfeeling or fatalistic indifference to suffering. This book is addressed primarily to doctors, who are advised by the authors never to think of themselves as interfering with karma: if they had no contribution to make, they would not be there (1981:84–87). Dora Kunz also emphasizes this last point. She acknowledges that if one accepts karma as a hypothesis, then determinism enters the picture to some extent. But one of the forces that may alter the outcome is the healer: "The intervention of the healer may also be part of that person's karma" (Weber 1985b:291).

In *Healing into Life and Death* Stephen Levine (1987) takes on the task of reinterpreting both karma and grace in response to those who ask what these two concepts have to do with spontaneous healings. He explores them not because he finds them particularly useful—"they carry such a load of confused meanings," he says—but because they come up again and again as people try to understand the meaning of their illnesses. In Levine's experience, many people equate grace with healing or reward and karma with punishment, an interesting comment in itself on the cross-pollination of religious traditions and the popular interpretation of traditional terms that are central aspects of the New Age movement.

In keeping with the New Age theme that healing occurs from within, Levine denies that grace is a gift "from on high." Instead he believes that each healing moment can be understood as grace, the actualization of our birthright. Levine calls karma the "most merciful and attentive of teachers" and ties it to the New Age emphasis on healing as the restoration of balance. He warns that "to relegate the



The Healer. Stone lithograph by Bert Seabourn, 1976.

Courtesy of the artist, a painter, printmaker, and sculptor from Oklahoma City, Oklahoma.

cause of illness to the irretrievable past as karma or its cure to the unreachable future as some awaited grace creates a sense of helplessness and fatalism" (1987:34).

Louise Hay, author of a best-selling book on healing, *You Can Heal Your Life* (1984), takes an eclectic approach to the issue of responsibility for illness and unhappiness. She combines her own interpretation of karma ("what we give out, we get back") with a metaphysics of idealism ("our experiences are just outer effects of inner thoughts") and includes as well the basic premise of the study curriculum *A Course in Miracles*: "all disease comes from a state of unforgiveness." Healing, according to Hay, takes place when we become willing to change, when we start loving ourselves and stop criticizing ourselves.

The New Age literature contains other perspectives on why we get sick and how we get well that are less oriented to changes in consciousness and feelings. Medicine Grizzlybear Lake says that in the majority of cases he has handled, "the patient's sickness can be directly traced to committing a violation against the natural and spiritual laws, or they may have inherited the violation. This causes the individual to get out of balance, and disharmony causes illness: mentally, physically, emotionally, and spiritually" (1991:117). It may be the case that the patient was not even aware that a violation had occurred. Nonetheless, in Lake's understanding, the healing process must involve a ritualized confession of transgressions.

Healing beyond the Individual

LAKE ACKNOWLEDGES, HOWEVER, that not all suffering in the world is at the level that can be explained in terms of individual violations. His speculations about the role of the Native healer in today's society point to another central theme in the New Age interpretation of holistic healing—that healing efforts must go far beyond the care of individuals and be extended on behalf of the planet.

Lake probes the area of systemic evil in the last chapter of *Native Healer*, where he notes that "there are different kinds of illnesses to deal with now, and not all of them can be attributed to violating the Creator's Natural Laws." He lists diseases caused by pollution in the environment and in food sources, mental illness and abuses caused by addictions and the stresses of contemporary life. "The old-time medicine men and women didn't have to deal with these things," he says (1991:183).

Lake's conviction that some needs for healing lie beyond individual patients and healers is borne out in the works of theologians like Matthew Fox who do their work on the boundaries of the New Age/Christian paradigm. In *The Coming of the Cosmic Christ: The Healing of Mother Earth and the Birth of a Global Renaissance* (1988), Fox posits his thesis that Mother Earth is dying and along with her many other things: the mystical brain, creativity, wisdom, youth, native peoples, their religions and cultures, Mother Church, and mother love, which he defines as compassion. For Fox the hope of healing lies in the restoration of mystical consciousness in the West, a consciousness that will emerge from understanding Christ as the pattern that connects rather than as a historical figure and personal savior.

Ed McGaa (1990) sounds the same theme in *Mother Earth Spirituality*. He sees Native American spirituality, particularly its rituals, as having the capacity to heal not just individuals but the environment. Any individual healing from the New Age perspective of interconnectedness, however, is also a healing that extends beyond the particular person. Stephen Levine maintains that "we see how the work we do on ourselves is clearly of benefit to all sentient beings. Each person who works to open their heart touches the heart of us all" (1987:11). And again, from Diane Stein: "Going within to goddess-within, to power-within, to reclaiming individual strength and self-determination leads outward eventually; women healing themselves begin to heal others and the Earth" (1987:xxii).

Conclusion

THERE IS IRONY IN THE FACT THAT underneath all the alternative worldviews and therapies of the New Age, all the various energies and rituals and interpretations of illness and health, the longings that participants in New Age healing express are not in the least exotic or unfamiliar. Those who suffer—physically, emotionally, spiritually—want their pain to make sense, to have meaning, even if it requires an arena as broad as the workings of the cosmos in which to place it or a time span of many lifetimes. They want to know that they do not have to suffer alone, that those who claim to be able to help them, whether medical professionals or alternative healers, will not exploit them or experiment on them or humiliate them. They want to get well in the very broad sense of that term, and, like the rest of us, they want to live lives that are at least as much joy as pain.

Can any of these longings be satisfied by participation in the kinds of holistic healing that the culture categorizes as “New Age”? There is evidence, much of it anecdotal, that they can. Meredith McGuire indicates that the people in the groups she studied had many successful experiences of healing. She concludes that “alternative healing often works (both for social-emotional and physical problems) by empowering the individual to mobilize internal resources.” And, as she points out, in addition to the therapies offered in such groups, the social and material support they provide strengthen people who are facing illness (1988:16).

Any adequate response to the question posed above requires the pooling of many perspectives: those of medical professionals and alternative healers, as well as those of theologians, historians, sociologists, political scientists, psychologists. For all of us something different is at stake, and our particular responses are shaped by that reality.

With the historian’s luxury of being able to take the long view rather than needing to be the guardian of boundaries, I find it particularly interesting to speculate on why alternative healing is so much a

part of American culture at a time in history when traditional medicine is so sophisticated and apparently has advanced so far beyond what it could do in previous eras. The history of medicine in America indicates that many people sought alternative therapies in earlier times because they were less harmful than established medical practice. Fred Frohock cites the case of George Washington, who was bled of two quarts of blood on the day he died: “His medical care was at the highest level of quality for the historical period.” By contrast, Frohock says, homeopathy was conservative (1992:57).

But why now, at the end of the twentieth century? Why does Present Moment Books and Herbs stay in business? What made Bill Moyers’s PBS special on mind/body healing so popular? What accounts for the fact that when I attempted to borrow Moyers’s *Healing and the Mind* from the Sturgeon Bay, Wisconsin (population approximately 8,000), public library, I learned that 80 people were ahead of me on the waiting list? It simply doesn’t make sense to conclude that so many people are gullible, desperate, easily deluded, superficial. It is more accurate and certainly more intellectually challenging and satisfying to assume that the whole realm of holistic healing, of which the New Age is a large, overlapping part, is a primary arena in which to learn about religious innovation and theological creativity.

Lawrence E. Sullivan, director of the Center for the Study of World Religions at Harvard University and author of several books on healing in the world religions, contends that there are obvious relationships between artistic creativity, healing, and illness: “One reason people are so creative in relation to disease is because it is there that they face elementary forces that both constitute and decompose them. In the symbolism attending sickness, the presence and nature of such forces are revealed” (Draper and Baron 1993:13).

The theological creativity of New Age healing movements emerges in several ways. One is the expansion of the arena in which illness and healing are interpreted: outward to include the workings of

the entire universe; laterally to take in relationships with other people and with nature; inward to encompass the workings of the psyche or the spirit. Because in the New Age view all these levels are connected with each other, the focus in healing likewise expands from an individual, physical body to an understanding of the human person as a highly complex entity who exists in a network of relationships, all of which must be kept in harmony. Such expansion requires experimentation with different models of ultimate reality, with ways to describe human nature that balance autonomy with inter-

connectedness and self-responsibility with the need to surrender to cosmic forces. At one level New Age healing systems represent an effort to reunite religion and medicine in such a way that medicine becomes resacralized. At another they point to the democratizing of medicine. At a third they indicate some of the many ways people attempt to make mysterious forces accessible, comprehensible, and controllable. At all these levels they confirm the reality that theological creativity leaps many boundaries in American culture. ☸

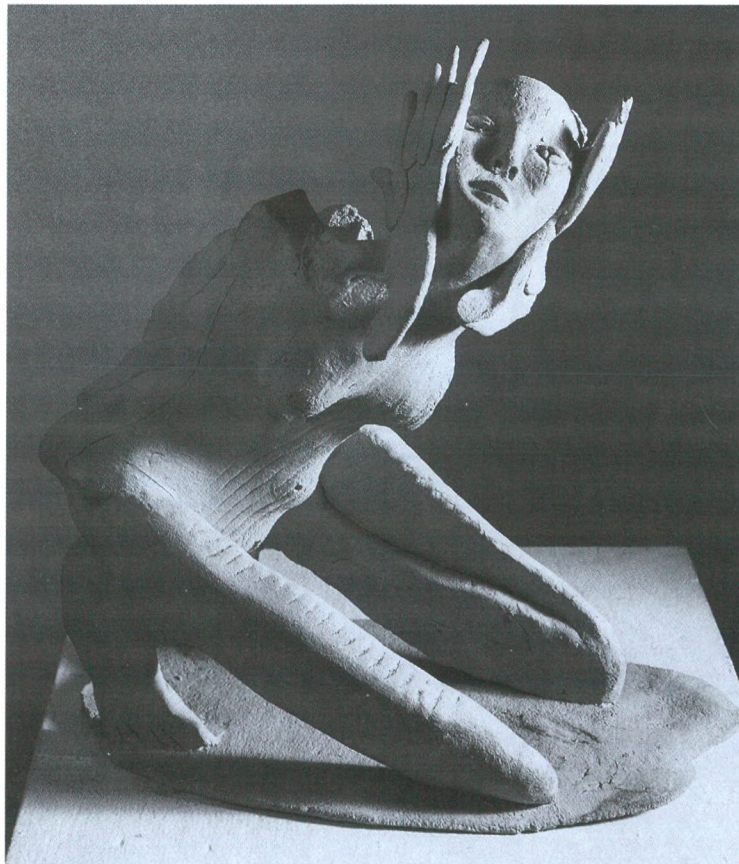
NOTES

1. Spangler (1984) identifies four levels of New Age thinking: *commercial*, which is primarily aimed at marketing; *glamour*, the part of the movement that receives the most publicity and is "populated with strange and exotic beings, masters, adepts, extraterrestrials; it is a place of psychic powers and occult mysteries, of conspiracies and hidden teachings"; *change*, meaning major change in cultural institutions; and *transformation*, the most authentic in Spangler's opinion and concerned with the resacralization of ordinary lives and of civilization.
2. A very clear explanation of the seven sheaths appears in Ellwood 1986:102–6.
3. Personal interview with Linda Osborne, 15 January 1993.

REFERENCES

- Albanese, Catherine. 1992. "The Magical Staff: Quantum Healing in the New Age." In Lewis and Melton 1992:68–84.
- Bednarowski, Mary. 1989. *New Religions and the Theological Imagination in America*. Bloomington: Indiana University Press.
- . 1990. "Cosmos and Sacrament: Roman Catholic Theologians and the New Age Movement." Paper presented at the annual meeting of the American Society of Church History, San Francisco, December.
- . 1991. "Literature of the New Age: A Review of Representative Sources." *Religious Studies Review* 17, no. 3 (July): 209–16.
- . 1992. "The New Age Movement and Feminist Spirituality: Overlapping Conversations at the End of the Century." In Lewis and Melton 1992:167–78.
- Bendit, L. J. 1981. Foreword to *The Mystery of Healing*, by the Theosophical Research Centre. Wheaton, Ill.: Theosophical Publishing House.
- Bliss, Shepherd. 1985. *The New Holistic Handbook: Living Well in a New Age*. Lexington, Mass.: Stephen Greene Press.
- Carlson, Richard, and Benjamin Shield, eds. 1989. *Healers on Healing*. Los Angeles: Jeremy P. Tarcher.
- Chopra, Deepak. 1989. *Quantum Healing: Exploring the Frontiers of Mind/Body Medicine*. New York: Bantam Books.
- Dossey, Larry. 1989. "Mind Beyond Body." In Carlson and Shield 1989:173–76.
- Draper, Ellen, and Virginia Baron. 1993. "Images of Wholeness: Interview with Lawrence E. Sullivan." *Parabola* 18, no. 1 (February): 4–13.
- Duff, Kat. 1993. "The Alchemy of Illness." *Parabola* 18, no. 1 (February): 39–46.
- Edmunds, H. Tudor. 1985. "The Influence of the Unconscious on Healing." In Kunz 1985:68–81.
- Ellwood, Robert. 1986. *Theosophy: A Modern Expression of the Wisdom of the Ages*. Wheaton, Ill.: Theosophical Publishing House.
- Faivre, Antoine, and Jacob Needleman, eds. 1992. *Modern Esoteric Spirituality*. New York: Crossroad.

- Ferguson, Duncan S., ed. 1993. *New Age Spirituality: An Assessment*. Louisville: Westminster/John Knox Press.
- Ferguson, Marilyn. 1980. *The Aquarian Conspiracy: Personal and Social Transformation in the 1980s*. Los Angeles: J. P. Tarcher.
- Fox, Matthew. 1988. *The Coming of the Cosmic Christ: The Healing of Mother Earth and the Birth of a Global Renaissance*. San Francisco: Harper and Row.
- . 1993. "Spirituality for a New Era." In D. Ferguson 1993:196–219.
- Freesoul, John Redtail. 1986. *Breath of the Invisible: The Way of the Pipe*. Wheaton, Ill.: Theosophical Publishing House.
- Frohock, Fred. 1992. *Healing Powers: Alternative Medicine, Spiritual Communities, and the State*. Chicago: University of Chicago Press.
- George, Demetra. 1992. *Mysteries of the Dark Moon: The Healing Power of the Dark Goddess*. San Francisco: Harper San Francisco.
- Gevitz, Norman, ed. 1988. *Other Healers: Unorthodox Medicine in America*. Baltimore: Johns Hopkins University Press.
- Griffin, David, ed. 1988. *The Reenchantment of Science: Postmodern Proposals*. Albany: State University of New York Press.
- Hay, Louise. 1984. *You Can Heal Your Life*. Santa Monica, Calif.: Hay House.
- Krieger, Dolores. 1985. Foreword to *Spiritual Aspects of the Healing Arts*, comp. Dora Kunz. Wheaton, Ill.: Theosophical Publishing House.
- Kunz, Dora, comp. 1985. *Spiritual Aspects of the Healing Arts*. Wheaton, Ill.: Theosophical Publishing House.
- Lake, Medicine Grizzlybear. 1991. *Native Healer: Initiation into an Ancient Art*. Wheaton, Ill.: Quest Books.
- Langford, Anne. 1985. "The Feminine Approach in Healing." In Bliss 1985:216–19.
- Levine, Stephen. 1987. *Healing into Life and Death*. New York: Doubleday.
- . 1989. "The Healing for Which We Took Birth." In Carlson and Shield 1989:196–203.
- Lewis, James R., and J. Gordon Melton, eds. 1992. *Perspectives on the New Age*. Albany: State University of New York Press.
- Macrae, Janet. 1991. *Therapeutic Touch: A Practical Guide*. New York: Alfred A. Knopf.
- McGaa, Ed. 1990. *Mother Earth Spirituality: Native American Paths to Healing Ourselves and Our World*. San Francisco: Harper San Francisco.
- McGuire, Meredith. 1988. *Ritual Healing in Suburban America*. New Brunswick and London: Rutgers University Press.
- Metzger, William. 1992. "Prayer, Healing and Traditional Medicine: An Interview with Dr. Larry Dossey." *Quest* 5, no. 4 (Winter): 42–47.
- Moyers, Bill. 1993. *Healing and the Mind*. New York: Doubleday.
- Prather, Hugh. 1989. "What Is Healing?" In Carlson and Shield 1989:12–17.
- Remen, Rachel Naomi. 1989. "The Search for Healing." In Carlson and Shield 1989:91–96.
- Rossmann, Martin. 1989. "Illness as an Opportunity for Healing." In Carlson and Shield 1989:78–81.
- Schrauth, Nancy. 1992. "Holistic Health Is the Integration of Body, Mind, Spirit." *Present Moment* 1 (Spring/Summer): 7–8.
- Spangler, David. 1984. *Emergence: The Rebirth of the Sacred*. New York: A Delta/Merloyd Lawrence Book.
- . 1993. "The New Age: The Movement toward the Divine." In D. Ferguson 1993:79–105.
- Stark, Rodney, and William Sims Bainbridge. 1985. *The Future of Religion: Secularization, Revival, and Cult Formation*. Berkeley and Los Angeles: University of California Press.
- Stein, Diane. 1987. *The Women's Book of Healing*. St. Paul, Minn.: Llewellyn Publishers.
- Swimme, Brian. 1984. *The Universe Is a Green Dragon: A Cosmic Creation Story*. Santa Fe: Bear.
- Theosophical Research Centre. 1981. *The Mystery of Healing*. Rev. ed. Wheaton, Ill.: Theosophical Publishing House.
- Toolan, David. 1987. *Facing West from California's Shore: A Jesuit's Journey into New Age Consciousness*. New York: Crossroad.
- Weber, Renée. 1985a. "Philosophical Foundations and Frameworks for Healing." In Kunz 1985:21–43.
- . 1985b. "Compassion, Rootedness and Detachment: Their Role in Healing." A Conversation with Dora Kunz conducted by Renée Weber. In Kunz 1985:289–305.
- . 1992. "Theosophy and the Theosophical Society." In Faivre and Needleman 1992:311–29.



Kneeling Woman. Ceramic sculpture by Mary Frank, 1976.

Private collection. Courtesy of Midtown Payson Galleries, New York.

A Voice from the Roadside

Beth C. Junker

A SAMARITAN COMES UPON A MAN lying by the side of the road, injured by thieves. He bandages the man's wounds and turns him over to an innkeeper for care. This is the story of the Good Samaritan, told by Jesus to a man who asked him to identify the neighbor, the one we are all commanded to love. Through this story Jesus tells us that to be a neighbor is to act mercifully, that our neighbor may be a person we least expect to be a neighbor, and that we are to be merciful neighbors to each other. Yet it tells us little about the experience of the victim of violent crime, what it means to act as a merciful neighbor specifically to a victim of violence, and what kind of care is effective in the process of healing after violent assault.

In a society that grows more and more violent, one might expect that people who live in a large city would understand how best to deal with victims of violent crime. It seems self-evident that hospital medical personnel who see the victims of violence day after day would recognize the signs of emotional

trauma, understand that the patient will require more than physical repair to become functional once again, and offer the patient an avenue toward total healing. But my own experience suggested otherwise. Either through ignorance or emotional distancing, medical personnel made the same mistakes anyone else might have, but in the milieu of healing, those mistakes hindered my total recovery.

Four years ago, I was beaten and robbed during a reverie about autumn leaves floating serenely, even in the city. Crossing the street to the grocery store, I was hit in the face by someone behind me. I landed on the pavement with the long strap of my purse tangled around both my arm and the package from the drugstore that was still clenched in my fist. Before I understood that I was being assaulted, my assailants yanked the purse loose so savagely that I was dragged up the curb and onto the sidewalk. I remember feeling my mind split in half: one side believed I would die, and I thanked God that I'd had three years with my husband; the other turned rage on my attackers. I was half their size, but I would repay them with a little fear. I would hang on to the package that had caught the purse strap just long enough to make them believe they might get caught. One of them cut the strap, and they ran.

Beth C. Junker is a free-lance writer who works and lives in Marietta, Georgia.

For citation: Junker, Beth C. 1994. "A Voice from the Roadside." *Second Opinion* 19, no. 3 (January): 87-92.

As I gazed up from the pavement, the Good Samaritan appeared as two middle-aged Polish women and a black-haired man in coveralls. One woman phoned my husband, the other waited with me for an ambulance, and the man offered his jacket as a pillow. I wasn't thinking of the parable at the time, though the analogy was clear. My rescuers were people whom I had come to think of as ordinary and unimportant. They were not the people who make city life beautiful and exciting. They were reminders that city life is tough. Faced with the problem of daily survival amid the frenetic pace of urban life, they had traded stylishness for stamina. Like the Samaritan, these three had no personal reason to come to my aid other than the compassion that moved them that moment. Clearly the event had disturbed them deeply. Their community had been broken by that blow to my face. Their care came as a surprise to me in a place where people, because of their sheer numbers, were often treated as expendable.

Pinned beneath the firm hand of a woman who insisted that I must lie still, I protested that I really wasn't badly injured and I didn't want to go to a hospital. The thought of being picked up and carried off for the sake of a shiner struck me as foolish. But she had the dual advantage of leverage and stubborn demeanor. As soon as I gave up my resistance to the care of the paramedics, I understood that the damage was real. I felt pain for the first time when they packed me up for the trip to the hospital. It started at the head, ended somewhere around the knees, and it just kept coming. My right hip would not immediately bear weight. Something was wrong with my

shoulder. I could not raise my right forearm to create a 90-degree angle at the elbow, and I could not make a fist. I had suffered a hard blow to my right eye that caused temporary blindness. My nose was broken and bleeding, and abrasions on my back were bleeding as well. My top teeth were loose. I would be unable to chew many solid foods for over a year.

It was in the emergency room that the matter-of-fact details of the past quarter-hour gave way to feelings of confusion and vulnerability. Blindness and ice packs totally obscured my vision. I was virtually unable to move. Someone was removing my clothing. I could hear grunting Bears crashing helmets with some other team of beasts on the ER television. Nurses caught the score between visits to the individual tragedies waiting in shrouded compartments. I could hear a woman with a child explain that the earache had come on suddenly and her benefits covered only weekend ER visits. I felt sorry for her, but I also felt impatient when I suddenly remembered the keys, along with the checkbook bearing my address, in my purse.

"I need to talk to my husband," I sobbed to the nurse when it was my turn for her attention. "They have my keys. They know where I live. We have to change the locks!"

She responded with annoyance. "I know it's upsetting. Now stop crying and be quiet. I don't know where your husband is. I'm sure he'll be back." I could hear her soft-soled shoes hurry away, faster even than the rhythm of my heartbeat.

Because I had no health insurance, I was told to report to an indigent-care facility about 15 miles away. It was described as a "good place for eye

**I wanted to share my story
with someone who was
interested in more than a
chronological accounting that
would confirm his or her own
safety, someone who could
accept that life is not always in
our control and who could
empathize with one whose life
had to be reconstructed to
accommodate that fact.**

disorders." Upon admission, I received treatment for my eye and nose injuries, while all the other complaints I'd made in the emergency room were left uninvestigated. Various medical personnel asked what caused the injuries. When I disclosed that I'd been assaulted, the faces I spoke to fell silent for a moment and motionless, then turned back to a chart or X ray. Did I need something for pain? I wondered if they checked their emotions to prevent me from feeling self-conscious in my vulnerability or to demonstrate the dignity of composure in the wake of adversity. Whatever the motive, their detached response delivered two messages. First, emotional behavior on the part of patients was embarrassing and should be avoided. Second, medical professionals are not concerned with emotional trauma. They do not place it among the potentially disabling injuries that require treatment, nor do they take steps to alleviate it.

"This will only take a moment," the ENT specialist insisted. It was now almost 10 p.m., eight hours since the assault and 12 hours since I'd eaten.

"But I feel like fainting and throwing up. I need to lie down." He let me up from the chair so I could move to the examining table. "Do you have a bowl or something I could use?" The doctor didn't move. "I'm going to throw up on your floor." The doctor sighed and got up slowly. He wandered over to a cupboard where he found a plastic basin. He handed the basin casually to my husband, who rushed to my side with it, not a moment too soon. The sound of retching from an empty stomach was brief and resonant. The doctor laughed as I finished.

"What color were they?" he asked.

"Excuse me?" I looked up from the basin I'd thrown up in. I was unprepared to answer him so soon after hearing his laughter over the sound of my retching.

"I said what color were they? The men who assaulted you."

That old question. Was I obliged to use the energy I needed just to stand up to deliver a dissertation on the bigotry latent in generalization?

"They were black," my husband retorted over his

shoulder as he steered me away from this offender and out the door of the examining room.

"You gotta watch out for those dark ones," the doctor called after us as if concerned for our edification.

I looked around the hall. The nurses were black, the patients were black, some of the resident physicians were black. As a white person, I probably got the best this man had to offer.

As we made our way to my assigned room, we passed room after room of empty beds. The facility could not have been more than half full. I longed for the privacy of one of those rooms, to be left in peaceful solitude where I could take a rest from unpleasant encounters. Much later I realized that this terrible fatigue covered a deeper fear that society and its members were unreliable at their innermost core and that any confrontation with people would surely end in more violence and pain. Though silence and isolation would not solve my problems, the peace I saw in them was a clue to my need for safety. Attempting to meet that need might have started me on the road toward healing.

"This is my mother." The older brother turned from the younger one to introduce my new roommate. "She has cataracts. Wow, what happened to you?"

I told him I got hit in the face. He responded with a story of a man who had his wallet sliced out of his pants on the "el" (elevated train) and went home with a bleeding rear end. He continued with a story of a woman who was followed from the "el" to her front door, where her assailant robbed her with one hand while choking her with the other. I told him I was too tired for more stories. The truth was that I could feel my ribs trembling, and I wanted to vomit again.

I wished I had said I was in a car accident, but it was too late. Now I was afraid to tell the brothers to shut up, that I did not want to hear any more stories. When they turned the common television to "The Making of *Psycho*," I bolted from the room in a state of panic. A call to the nurses' station from my husband got the television turned off, an apology

from the brothers (along with yet another crime story), and a stern admonition from a nurse to speak up and take care of myself.

My lack of assertiveness was not unusual behavior for a victim of violent crime. In the years following the assault, I have compared accounts with other crime victims, as well as with family members and friends of people who have been victimized through robbery, assault, or rape. Relating our own stories was an offer of trust, a moment of sharing the experience of vulnerability. The people who told me their stories shared certain emotional reactions, including an overwhelming feeling of vulnerability, the need to share feelings surrounding the experience, fear that sharing these feelings would be met with rejection and shame, a sense that life made no sense or was out of control, and anger potent enough to make the victim fear that she, too, would become a perpetrator of violence. Indeed, I feel certain that my assailants were so brutal in their quest for a cheap purse and a handful of change because they had suffered a similar fate, perhaps many times before. Violence is a cycle that can quickly spin out of control throughout our communities.

Fear is the response of those watching the cycle of violence moving ever closer. People know they can become victims. Standing before a crime victim brings this point home to the emotions and forces one to make a choice: to confront the threat of violence in one's life by putting oneself in the victim's place or to hold the threat at bay either by refusing to identify too closely with the victim or by somehow blaming her for the crime.

Crime stories seem to fill the need to stand close to tragedy, but not too close—perhaps to acknowledge that violence touches us all without having to face the fragility of our own lives. Time and again during my five days of hospitalization, roommates, visitors, and even the resident chaplain told me stories of trauma and gore that had all happened to people unknown to them. At best it was an attempt to say that they knew how I felt or that it could have been worse. But the emotional distance of the

storytellers nullified their empathy. Their fear of the threat of violence that I represented was not processed in those crime stories because the tellers had never put themselves in the picture and then taken a good look. Far from conveying a message of concern, crime stories confront the crime victim with more brutality, even suggesting what may lie waiting for them upon release from the hospital. My fear was as heightened by this confrontation as the storytellers appeared to be relieved by it.

People also defend against the fear of violation by identifying visible “weaknesses” of the victim. As the story of violence unfolds, the listener seeks an explanation that eliminates the possibility the story could one day be his or her own. “She was out late at night, walking alone, wearing something suggestive, flaunting the money in her wallet, wearing high heels, carrying a purse . . . Oh, she's such a victim!” People push away the victim, make the crime her fault, draw the lines of difference—class, race, gender. We all do it. And in the end we are alone with only our fear to protect us. We hide this fear behind silence too thick to penetrate with words or touch. Once a person is victimized, this silence grows more painful, but intensified fear makes speaking more difficult. Any action seems dangerous from a state of total vulnerability, so the victim remains silent. Fear, too, spins around us.

Back in the hospital, I walked the halls searching other patients' faces for signs of the same fear and confusion I felt. I imagined that someone would recognize their own fear in my eyes and share their story with me, ending with a referral to the staff professional whose job it was to care. I found no such patients and no such professionals. So I concluded that my emotions were misplaced. I took on the belief that violence was something to be tolerated in the city, like crazy drivers and self-serving aldermen, and that I should prepare now for the pain of inevitable future assaults, whatever form they might take.

I put on silence like armor. I could no longer say what I needed. I could not assess my expectations for my care and question the obvious shortcomings of

the institution. Now that human society was no longer reliable for me, my state of vulnerability seemed like an invitation to attack. I felt I had no choice but to go on looking for someone with the power to protect me, one who would recognize my vulnerability without requiring that I risk confessing it, one who would volunteer to protect me.

Recognizing the signs of despair, my husband asked the ophthalmologist in charge of my case about a psychological consultation. The best she was able to offer was a referral to the staff social worker. The messages my husband left for the social worker were not returned until three months later, when she called our home to say it was her last day on the job and she was cleaning off her desk. In the meantime, we found that the city's three largest support programs for victims of violent crime had been closed the previous year for lack of funding.

I met with lack of understanding from many people in the following months. Colleagues who previously met me for coffee each morning suddenly became too busy. Once the bruises on my face faded, I was no longer avoided, but not even members of my church had much support to offer when my emotional distress continued. "Aren't you over that yet? It's been four months!" Some responses that may have been intended as consolation only added to my confusion and my inability to make clear statements of fact or belief. "They were poor, and you have so much. You can't blame them for beating you up." "It could be worse. After all, it only happened to you once." "Don't worry, next time I see a dead guy in the ER, it will probably be one of them." "You can't leave the city because of this. If you do, you are letting them 'win.'"

But the emotional beating from health professionals distressed me the most because when I found the courage to stand up for myself, I was so harshly rebuked. In a follow-up visit, Dr. ENT accused me

of causing my own injuries by struggling with the assailants. He was shocked and angry at my firm response that I had been the victim, not the perpetrator. A nurse questioned me in a crowded elevator: "Were you raped? Or only beaten?" She berated me for my "defensiveness" when I asked her if she didn't think being beaten was enough. These interchanges were not medically necessary. These caregivers did not probe my psychic world in order to prescribe appropriate treatment. Instead, they

violated rules of simple civility and risked further harm to a patient for the sake of their own piece of mind.

There were, by comparison, few gestures of concern, caring, or interest, though I still remember each one. After the ER doctor released me, a nurse took

me aside secretly to apply antiseptic to my wounds. A classmate left a lecture with me when I became ill. Late in my treatment, a physician embraced me upon hearing of the cause of the injuries. And one brave nurse looked me in the eye and smiled whenever she said, "Good morning."

FOUR YEARS LATER, I TURN TO THE PARABLE OF the Good Samaritan hoping for news of the victim. But the victim hadn't spoken. I am left with a confusing dialogue between a man who wanted to pin down the identity of the neighbor he was commanded to love, and Jesus, who was intent upon instructing him on mercy and the kind of neighbor he ought to be. Who is our neighbor and how do we act as a neighbor? Whom do we love and how do we show it? What does it mean in the context of violence and fear?

The term *neighbor* describes a person in relation to others. It is not an aspect of some job or role a person carries out each day but the chosen character of one's juxtaposition to others. *Mercy*, too, is a term of mutuality, motivated by an understanding of our common vulnerability. Whether we are the neigh-

For the victim of violence, a neighbor is anyone who can embrace his or her own fear and listen to a story.

bor in need or the neighbor in giving, we are commanded to love each other and to show each other mercy. Love and mercy can also form an endless cycle.

It is easy to expect healing from medicine, but authentic mercy cannot be confined to or consistently demanded of people in a particular role. Although we are all commanded to love and to be merciful neighbors, encountering one's neighbor is always a wondrous gift. Yet more can be reasonably expected from the health care profession than is currently offered as treatment to victims of violence. From my own experience I can draw up a list of needs I had as a patient.

First, I needed the physicians to investigate all my physical injuries and to explain the treatment or the reasons they would not be treated. Thorough medical attention should not slip through the cracks for those who transfer between medical institutions. Second, I needed emotional trauma to be included among the injuries to be treated, if only through a routine referral to a psychologist. Third, I needed a measure of tolerance for the alternating moments of emotion and numbness I was experiencing, as well as some sensitivity toward my need for protection from the gross insensitivity of others. In practical terms, this means a private room where possible, reassurance about hospital security, and a commitment by the staff not to relate stories of crime and violence in the presence of the patient.

It is reasonable for people to expect the term *health care* to encompass meeting such needs for victims of violence. However, the medical community will require further education if this is to happen. Just as emotional trauma is now viewed as part of the medical fallout of war, it deserves the attention of health care providers in our embattled cities. And indigent-care facilities, which serve the victims of battle on the largest scale, should be the first focus of research and reeducation.

**People push away the victim,
make the crime her fault, draw
the lines of difference—class,
race, gender. We all do it.**

Beyond the above recommendations for the health care system, the parable of the Good Samaritan speaks to all of us about being a neighbor to the victim of violent crime. Four years ago I wanted to share my story with someone who was interested in more than a chronological accounting that would confirm his or her own safety, someone who could accept that life is not always in our control

and who could empathize with one whose life had to be reconstructed to accommodate that fact. I wanted the mercy that, according to Jesus, marks one as my neighbor. I looked for it in the expected places: the medical community, friendships, church. I didn't find it

because, although we are all called to be neighbors, being able to act mercifully is a unique gift and one that is particularly difficult to deliver in the context of violence.

For the victim of violence, a neighbor is anyone who can embrace his or her own fear and listen to a story. In seeking relief through self-disclosure, I waited to recognize my neighbor by some comforting words they alone would utter as the password of their trustworthiness. So long as I looked for such assurance, I waited silently, in vain. I now know that encountering a neighbor requires the victim to risk sharing her fear, with no apologies for feeling or expressing strong emotion nor for having been made a victim. I discovered this fact through therapy at a Samaritan Pastoral Counseling Center, long after my stay in indigent care. I am not sure if such bold self-revelation and self-acceptance are possible in the direct aftermath of violent assault. Yet in hindsight I see this message of mercy in the actions of my neighbors outside the grocery store, who first forced me to accept my plight and turned me toward others for care. And I hope for a future where the message of mercy is carried beyond the emergency room doors. ☸

ISSUES & CURRENTS

In the Name of God and Truth: The Catholic Ban on Sterilization

Ron Hamel

AFTER ALMOST 20 YEARS OF VIRTUAL NEGLECT (some would say ostracization), religion, theology, and spirituality are once again being perceived as having a legitimate role in medical ethics and even as having something valuable to contribute. Given this recent, ongoing rehabilitation, it might seem inappropriate for a person who welcomes this trend to raise for consideration an example of how religious thought and practice can have an adverse effect on human well-being. But religion can have a negative impact, and we should not lose sight of that. The harm done in the name of religion must be recognized and addressed.

Over the past two years, the Catholic church's condemnation of direct sterilization as intrinsically evil (that is, as evil in itself and therefore never justifiable for any reasons or circumstances) has become problematic (and an embarrassment) to me in ways it previously had not. I have long questioned this moral teaching and the theological and philosophical framework that supports it. But I had not realized acutely the conflict, anguish, and harm it inflicts on women and children, on providers of care, and on administrators of Catholic health care facilities. While the vignettes and discussion that follow concern poor women and children, the problem is by no means restricted to them. These cases exemplify severe harms brought about by church policy on sterilization, but in all cases in which tubal ligations would seem to be indicated, similar harms (of perhaps lesser degree) to women and possible future children are at issue.

LAURA IS A 22-YEAR-OLD WOMAN WHO, just ten months ago, delivered her fourth child in six years. Two additional pregnancies had been terminated. She has no address, has lost contact with her family, is known to be a heavy intravenous drug user, is HIV positive, and receives her mail and takes her meals at a homeless shelter.

All four of her children have been born HIV positive. Tox screens performed at birth on her last three children were positive for cocaine and opiates. The Department of Children and Family Services (DCFS) has custody of all her children.

The last child, Angela, was born at a Catholic hospital located in a predominantly African-American neighborhood of a large city. At the delivery, Laura told the obstetrician that at her one prenatal visit at the county hospital, they had scheduled her for a tubal ligation following delivery and had arranged for a private social agency to transport her there 48 hours after she gave birth. The procedure could not be performed in the hospital where she delivered because it was a Catholic hospital. Laura, however, was discharged before transportation arrived and never made it to the county hospital. Eleven months later, she presented to the emergency room of the Catholic hospital in labor with her fifth child.

SHEILA IS 30 YEARS OLD. She has six children ranging in age from 11 years to 2 weeks. She admits to drinking one gallon of alcoholic beverages per day. Her 16-month-old was born weighing 2 pounds, 6 ounces, and has fetal alcohol syndrome. Baby M, her two-week-old baby girl, weighed 2 pounds, 12 ounces, at birth and also has fetal alcohol syndrome. Sheila was

intoxicated at both deliveries; at the most recent birthing, her blood alcohol was recorded at .125. The baby's father was also intoxicated at the delivery. There has been some DCFS involvement, but the children reside with their mother.

FLOWER IS 29 YEARS OLD, mentally handicapped, and homeless. All of her four children are in DCFS custody and have been placed with relatives. A tox screen performed at birth on her youngest child, Melody, was positive for cocaine, congenital syphilis, and neonatal shigellosis (a bacteria that causes dysentery). Melody was critically ill and required a total colectomy. Her long-term medical prognosis is grim; she is in DCFS custody awaiting placement.¹

SITUATIONS LIKE THESE CONFRONT physicians, nurses, social workers, and chaplains in Catholic health care clinics and institutions almost daily. More often than not they find themselves virtually powerless to respond in ways they believe would be most beneficial for the mothers and their future children. Part of the problem lies in the failures of DCFS; part in the lack of sufficient drug rehab programs; and part in the moral teaching of the Catholic church on the matter of tubal ligations. It is the latter that is most strongly felt by many health care providers in Catholic facilities. Good medical care for these women and concern for the well-being of future children would point to tubal ligation. But the church condemns all sterilizations that aim to prevent conception. Any interference with the natural procreative process is viewed by the church as being against the design and, therefore, the will of the Creator. God ordered acts of sexual intercourse to be procreative. To frustrate this God-given purpose from being achieved is morally wrong. (The only exception to this is the rhythm method, which permits spouses to refrain from intercourse during the time the woman is fertile.)

Perhaps the best-known condemnation of sterilization is that found in the 1968 encyclical of Pope Paul VI, *Humanae vitae*. The document, which represents the pope's official teaching on the matter of artificial birth control, states that "equally to be excluded . . . is the direct sterilization, whether perpetual or temporary, whether of the man or of the woman."

The *Ethical and Religious Directives for Catholic Health Facilities* (1971), which serve as the moral basis for Catholic health care institutions in the United States, repeats this papal teaching. In the years immediately following the publication of the encyclical and the directives, there was variation in practice and even some confusion about policy among Catholic hospitals in the United States. Some hospitals asserted that they adhered to papal teaching and to the directives and for that reason performed tubal ligations only when they were medically indicated. In some cases, this was justified in terms of the woman's overall well-being (sometimes referred to as the principle of totality). Others said that they performed only "indirect" sterilizations (permitted by church teaching), but, in fact, they were mistakenly identifying tubal ligations performed for medical reasons as indirect sterilizations. (Removal of a cancerous uterus is one example of an indirect sterilization that the church would find acceptable.)

This confusion was short-lived, however. In 1974, the National Conference of Catholic Bishops sought clarification of the matter from the Sacred Congregation for the Doctrine of the Faith (an office of the Vatican responsible for maintaining orthodox doctrine). On March 13, 1975, the Congregation issued its response in a document titled "Sterilization in Catholic Hospitals."

Any sterilization whose sole, immediate effect, of itself, that is of its own nature and condition, is to render the generative faculty incapable of procreation is to be regarded as direct sterilization. . . . It is absolutely forbidden, therefore, according to the teaching of the Church, even when it is motivated by a subjectively right intention of curing or preventing a physical or psychological ill-effect which is foreseen or feared as a result of pregnancy. . . . Neither can one invoke the principle of totality in this case, the principle which would justify interference with organs for the greater good of the person. Sterility induced as such does not contribute to the person's integral good, properly understood, "keeping things and values in proper perspective." Rather does it damage a person's ethical good, since it deprives subsequently freely chosen acts of an essential element.

. . . The following is absolutely forbidden:

cooperation, officially approved or admitted, in actions which of themselves (that is of their own nature and condition) have a contraceptive purpose, the impeding of the natural effects of the deliberate sexual acts of the person sterilized. For the official approval of direct sterilization and, all the more so, its administration and execution according to hospital regulations is something of its nature—that is, intrinsically—objectively evil. Nothing can justify a Catholic hospital cooperating in it.

Two years later, on September 15, 1977, the National Conference of Catholic Bishops of the United States reaffirmed the Congregation's position:

As it was stated in the Roman document, the Catholic hospital can in no way approve the performance of any sterilization procedure that is directly contraceptive. Such contraceptive procedures include sterilizations performed as a means of preventing future pregnancy that one fears might aggravate a serious cardiac, renal, circulatory, or other disorder. Freely approving direct sterilization constitutes formal cooperation in evil and would be "totally unbecoming of the mission" of the hospital as well as "contrary to the necessary proclamation and defense of the moral order."

Catholic theologians have repeatedly challenged the thinking that underlies the church's condemnation of sterilization expressed in these documents, beginning with the papal encyclical. Even some bishops have had the courage to express their disagreement either publicly or privately. Catholics themselves have largely ignored it. Yet the teaching remains unchanged and binding on Catholic health care institutions. What impact has this had on Catholic hospitals and clinics, their staffs, and the patients they serve?

On the one hand, Catholic hospitals across the country perform tubal ligations when there are serious medical and psychosocial reasons to do so and when there are no better alternatives. In a few cases, they do so with the knowledge of local ecclesiastical authorities, who, for various reasons, choose not to interfere. In these instances, physicians who recommend tubal ligations, women who seek or agree to

them (many if not most of whom do not share the religious and moral convictions of Catholicism), and possible future children are fortunate. Physicians can practice what they conscientiously believe to be good medicine. Women are spared an unfortunate, even a catastrophic pregnancy. And children are spared the dire consequences of an adverse fetal or neonatal environment.

But these situations are the exception. Most Catholic hospitals that permit tubal ligations do so without the knowledge of local church authorities. Their practice is in some ways covert. These institutions are torn between loyalty to the teaching authority of the church and loyalty to patients and their welfare. While this approach meets the needs of many women and benefits future children, in the end, it is unsatisfactory. When institutions craft policies that appear to be consistent with the teaching of the church but are worded in such a way as to allow for exceptions or when they say one thing publicly and do another privately, that smacks of deception and is for many a source of scandal. Such practice is also a source of confusion for hospital staff, particularly for those involved in performing the tubal ligations. Many do not understand ecclesiastical politics or the distinctions in Catholic moral theology that might justify exceptions in concrete cases to the general prohibition. They don't understand how a policy can apparently say one thing while another is being done. Third, such an approach generates fear: the fear of being "found out" by the local bishop and being required to cease all tubal ligations or risk losing the designation "Catholic"; the fear of having to turn women away, of not providing them with the care they need, and, in some instances, of actually doing them harm; the fear of remaining powerless to spare future children physical and emotional injury. Finally, there is a sense in which this approach (as well as the previous one) is unjust. Women who by chance live near a Catholic hospital or clinic run by a courageous administrator or overseen by a compassionate bishop may have their needs met. Others who are not so fortunate will not and will suffer the consequences.

On the other hand, most Catholic hospitals and clinics probably observe the moral teaching of the church that prohibits sterilization. Their fidelity, however, carries a price. It forces many physicians to act against what they believe to be morally right and

to be good medical practice. It forces physicians (many of whom are not Catholic) to be untrue to themselves and to be unfaithful to their own professional commitments, responsibilities, and standards of practice. Beyond that it forces physicians and other providers to be accomplices in doing harm. Their refusal to perform a tubal ligation may permit a pregnancy harmful to the mother (for example, because of a preexisting cardiac, vascular, or renal condition) and possibly to the fetus, infant, or child (for example, because of HIV infection, drug and alcohol abuse, physical and sexual abuse).

Few Catholic moral theologians would hold that sterilization is a neutral matter. The loss of the physical capacity to procreate is precisely that, a loss—one that generally should be avoided. But that loss, that harm, that negativity is not the only one at issue. Other harms must be taken into account. To disregard the harm that a decision against sterilization will bring to women and their children is itself morally wrong. And that harm seems far greater than the evil of sterilization. A tubal ligation may do violence to the integrity of a biological process and to an important human capacity. But not performing a tubal ligation may do far greater violence to the physical and psychological well-being of women and children. The consequences of not doing tubal ligations in many cases are far more dire and tragic than the loss of a procreative capacity. While keeping in mind the real loss that sterilization represents and the dangers of coercion of and discrimination against women, especially minority women, it is also imperative to recog-

nize that the well-being of women and children is of far greater value than the preservation of a physical capacity for procreation; that some women should not bear children and that some individuals cannot and should not be parents; that infants and children are the ultimate victims of poverty, homelessness, drug and alcohol abuse, HIV infection, mental illness and retardation, and patterns of physical and sexual abuse.

To maintain the church's teaching about the moral worth of preserving the capacity for procreation has a price. It is a price, sadly, paid by women and children who have had no voice in shaping the teaching and who by and large do not hold to the tenets underlying the position. The price they pay gets lost in the claim to moral truth.

Several of the documents cited above caution against the scandal that might result from Catholic hospitals' performing tubal ligations. But the scandal really lies in the Catholic church's refusal to permit direct sterilizations in the face of human tragedy and suffering, in its failure to recognize the harm that is often inflicted upon women and their children because of this, and in the lack of various forms of tangible support for women who have been turned away or for their children who have been harmed. It also lies in the burdens that the church's teaching imposes on the consciences of physicians and other health professionals and in the way it compromises the mission of Catholic health care institutions to serve the "total good of the patient."² What makes all this the worse is that it is done in the name of God and truth.

NOTES

1. These vignettes are adaptations of cases provided by Diane Butterfield, M.D., Chicago, Illinois.
2. From the preamble to *Ethical and Religious Directives for Catholic Health Facilities*: "The total good of the patient, which includes his higher spiritual as well as his bodily welfare, is the primary concern of those entrusted with the management of a Catholic health facility. So important is this, in fact, that if an institution could not fulfill its basic mission in this regard, it would have no justification for continuing its existence as a Catholic health facility."

NOTEBOOK

New findings show that the placebo effect—in which patients given an inactive treatment believe it can cure them—is twice as powerful as was previously thought and most powerful when offered enthusiastically by a



trusted physician. In a study of more than 6,000 patients being given experimental treatments for asthma, duodenal ulcers, and herpes, two-thirds improved, at least temporarily, even though rigorous tests later found the treatments medically useless. It was formerly believed that only about one-third of patients will show some improvement when given a placebo.

To assess the potency of the placebo effect during the burst of enthusiasm for a new medical treatment, researchers reexamined data from initial clinical trials of five procedures that at first seemed highly promising and later were shown to be useless. Of 6,931 patients receiving one of the five treatments, 40 percent reportedly had excellent results, 30 percent had good results, and another 30 percent had poor results. Dr. Alan H. Roberts, a psychologist at the Scripps Clinic and Research Foundation in California who led the research, believes that the effects would not be nearly as strong for serious diseases such as AIDS or cancer. "In the more severe disorders," he said, "the placebo effects would be mainly in terms of patients' subjective complaints, not their physical symptoms." (*New York Times*, 17 August 1993)



News stories on religious issues are few, and reporters assigned to cover religious stories are seldom experts in the field, according to Terry Mattingly, author of "On Religion," a nationally syndicated religion column. Fewer than 50 of the 1,600 daily newspapers have full-time religious reporters on staff. "Journalists know less than many Americans about religion," says Mattingly. "This phenomenon affects how much space is given to religion and who covers this complicated subject." He believes the media suffer four biases where religion is concerned.

1. The bias of time and resources: Religious issues are simply not covered when resources are scarce.

2. The bias of knowledge: Most reporters are not well informed about religion. They may overlook key



facts and sources in their stories or, worse, overlook potential stories altogether.

3. The bias of worldview (the view that people are no longer as religious as they were in the past): A 1980 survey of journalists found that 86 percent rarely if ever attended religious meetings, and 50 percent claimed no religious affiliation. However, 40 percent of Americans regularly attend religious services, and 90 percent state some religious affiliation.

4. The bias of prejudice: "It's hard to produce balanced, fair coverage of people you dislike, distrust, or who you feel are irrelevant," says Mattingly. "Yet I am convinced that prejudice is a minor problem in news coverage of religion compared with apathy and ignorance."

(*The Quill*, July/August 1993)

"Nearly one of five Americans agreed with the statement in a Gallup Poll that the 'floods are God's judgment on the people of the United States for their sinful ways.'"

(*New York Times*, 24 July 1993)

Women may live longer than men, but they seldom live healthier lives, a comprehensive national survey shows. Many American women lack access to—or fail to take advantage of—basic preventive care, are dissatisfied with their health care providers, weigh too much, and exercise too little.

The survey, conducted by Louis Harris and Associates, found that 13 percent of American women failed to receive needed medical care at some point during the past year, compared with 9 percent of men. The figure rose to 20 percent among women whose annual family income is \$15,000 or below and to 36 percent among uninsured women. One-third of women did not have any of the following basic preventive services in the past year: a Pap smear, a clinical breast exam, a pelvic exam, and a complete physical exam. Forty-four percent of women over age 40 did not have a mammogram, and at least half of women age 65 and over did not have a Pap smear or a mammogram in the last year. Poor and minority women are generally less likely to have had clinical preventive services, though African-American women are more likely than white or Hispanic women to have had a Pap smear or clinical breast exam.

Many American women exhibit unhealthy behaviors: one in four smokes; nearly seven in ten are overweight; while 31 percent exercise vigorously three or more times a week (compared with 47 percent of men), another 31 percent of women never exercise.

(*Nation's Health*, August 1993)

Recently, Bishop Kenneth Untener, ordinary of the diocese of Saginaw, Michigan, reflected on people's response to Pope Paul VI's 1968 encyclical that reaffirmed the Catholic church's ban on the use of contraceptives.

"Most people haven't read *Humanae vitae*, although they know that in one section it reaffirmed the teaching against artificial birth control. They also know that the findings of the papal study commission on birth control—which recommended a change in the church's teaching—were not accepted, and they have watched how dissent has been handled. Their reactions are generally negative.

"The encyclical is certainly not the sole cause, but it appears to have contributed to an attitude among Catholics that authoritative teachings can be brushed aside, and that church discipline (e.g., Sunday mass attendance) is less binding. It has made it more difficult to defend our position on abortion, and exacerbated the negative attitude of many women toward the church. Those who teach and preach have felt less confident in attempting to provide guidance in sexual matters. Lay people are increasingly suspicious of the willingness of the hierarchy to listen to them on important matters. . . .



"When asked what he thought about the laity, Cardinal Newman said something like, 'Well, the church would look strange without them.' We are without them on *Humanae vitae*, and we look strange. We've got to do something about that."

(*Commonweal*, 18 June 1993)

For the first time since the AIDS epidemic began, more women in the United States have contracted the dis-

ease through heterosexual sex than through drug use. Although the vast majority of AIDS patients are still men, new cases among women are increasing almost four times faster than cases among men. New cases among females increased 9.8 percent in 1992, compared with 2.5 percent among males. About 47,095 new cases of AIDS were diagnosed in the U.S. last year, up from 45,499 in 1991.

(*American Medical News*, 9 August 1993)



Since the mid-1980s, the media have significantly increased their coverage of medical news stories. But too often, the public is not aware that the stories are based on single sources (which results in biased coverage), that the experts interviewed may be paid representatives of the company whose product is being discussed, or that the story was culled from a much longer news release created and sent to reporters by the company's public relations firm.

"In medical news, people are relying on the media to make judgments about their health, and it's a responsibility too great to be mishandled," said former CNN reporter Gary Schwitzer. Dr. Arthur Caplan, director of the Center for Biomedical Ethics at the University of Minnesota, cites some reasons for poor



medical reporting: difficulty distinguishing between research projects and genuine therapies; overdependence on "breakthrough" articles in the *New England Journal of Medicine* and the *Journal of the American Medical Association*; a disregard for the business concerns of medical news sources; and insufficient coverage of the structural, institutional, political, and financial side of medicine. "If it's not beeping, buzzing, or humming, no one's going to cover it," said Caplan.

Americans increasingly turn to the mainstream media for information on health and medicine. Journalists must strive to separate fact from fiction and to present their information in a useful, relevant way. Says Schwitzer, "Reporters may not need special skills to cover medical news but they need a strong dose of special judgment. Getting a second opinion can be as important for the medical reporter as for the medical patient."

(*The Quill*, November/December 1992)



A new program in New Hampshire will soon allow terminally ill patients to elect do-not-resuscitate orders outside of the hospital. Patients will wear orange bracelets that alert emergency medical people to let them die. New York, Connecticut, Virginia, and Colorado already have such programs.

(*American Medical News*, 26 July 1993)



"Natural Family Planning [N.F.P.] has a dark side," says Mitch Finley, coauthor with his wife, Kathy, of *Christian Families in the Real World*, "and I do not find the N.F.P. crowd, in general, open to discussing this, nor do N.F.P. instructors often admit to inquiring couples the existence of this dark side. On the contrary, for Natural Family Planning enthusiasts N.F.P. sometimes becomes an ideology that brooks no rivals.

"In talking with Catholic married couples in various parts of the United States, I find that many have a serious difficulty with N.F.P. Such couples believe, often based on their own experience, that N.F.P. can actually undermine a healthy marriage and a healthy marital spirituality. . . .

"To put this another way, the bodily way husband and wife nourish their love is also the most spiritual way. Thus, for Catholic spouses to welcome opportunities *not* to make love sounds self-defeating. This is compatible, however, with a distorted Catholic piety that views celibacy and—verging on the spiritually spectacular—celibate marriages as superior in the eyes of God. . . . Ordinarily, couples should no more welcome the chance to avoid loving sexual intercourse than they would rejoice at the opportunity to miss Mass on Sunday. . . .

NOTEBOOK

"I wish Natural Family Planning could be all it's advertised to be. But it isn't. Maybe one day research will lead to a form of N.F.P. that will be both more effective and less stressful in a marriage. When and if that day arrives, I will celebrate along with the most avid Natural Family Planning enthusiasts. Until then, however, let buyers beware."

(*America*, 23 February 1991)



"The new face of AIDS worldwide is the face of teenaged girls," says Karen Hein, director of the Adolescent AIDS Program, Montefiore Medical Center, New York. At a recent conference, Hein pointed out that the number of 13- to 21-year-olds infected with HIV has risen by 77 percent in the last two years. She also pointed out that among teenagers in the Job Corps (a U.S. program for disadvantaged and out-of-school youth) not only has there been a recent increase in HIV infection but the increase was greater among girls than among boys. Moreover, the largest increase was in corps entrants from smaller communities in the southeastern United States. "Is there a problem when only less than one percent of U.S. teenagers—3,058—are infected?" Hein asked colleagues at a recent American Medical Association-sponsored conference. She responded to her own question by noting that teenagers have the highest rate of sexually transmitted diseases of any age group in America and wondering "Why is that people don't see that [this] will soon be true for HIV?"

During the past year at Montefiore Medical Center, Hein learned that all of the HIV-infected girls in her program were totally unaware of their risk of contracting the virus and could realize what had put them at risk only in retrospect: the major risk factor was not injecting drugs but so-called survival sex—trading sex for food, shelter, or crack cocaine. Finally, and "most disturbingly," not one of the young women in the program was able to convince her partner to use a condom on a regular basis.

Many teenagers living with HIV are doing the best they can, Hein says, without being able to disclose that they have the disease to their boyfriends or girlfriends, work colleagues, college roommates, or even their parents. She asked colleagues to try to remove barriers—consent, confidentiality, and payment—that

keep teenagers from seeking help. She also asked for medical and prevention services to join forces "and look at prevention in light of the fact that HIV is well established in the teen community."

(*Journal of the American Medical Association*,
7 July 1993)



Seventy-eight percent of medically underserved Americans live in metropolitan areas.

(*American Hospital Association News*, 19 July 1993)



An estimated 20,000 children and adolescents will die this year in the United States as a result of injuries, and another 30,000 will be permanently disabled by brain injuries, says a panel convened by the Institute of Medicine to study the effectiveness of emergency services for young people. The panel recommends that Congress appropriate \$30 million a year for five years to improve emergency services for children nationwide. It reported that although some emergency equipment designed for adults could be adapted for children, other items, such as cervical collars used for neck injuries, are simply too large. Children with life-threatening conditions sometimes need special facilities that many otherwise excellent hospitals may not have. "Until very recently, emergency-care curricula have included little information on children," said Dr. Donald N. Medearis, Jr., of the children's services at Massachusetts General Hospital, adding that "pediatrics curricula have paid little attention to emergency care."

(*American Medical News*, 19 July 1993)



That Catholic bishops are politically active against abortion is commonly known, but, as Denise Shannon notes, they have also played a less publicized role in trying to limit access to contraception.

"The bishops—individually and through their political arm, the United States Catholic Conference (USCC)—have attacked contraceptive programs from the pulpit, testified at legislative hearings, written letters to legislators, and engaged in behind-the-

scenes lobbying in their effort to suppress the availability of effective methods of birth control in the United States and abroad. . . .

" . . . All along the path to legality and public acceptance of contraception, the Catholic hierarchy has sought to obstruct it, and their efforts continue. They actively oppose, for instance, government funding of contraception research, coverage of family planning in proposed national health insurance (family planning is covered in every country that has national health insurance), the distribution of contraception and information on birth control at school-based clinics, and the dissemination of condoms even in prevention programs for AIDS and sexually transmitted diseases. The hierarchy has successfully supported increased emphasis on periodic abstinence (natural family planning)—one of the least effective methods of birth control, but the only one with Vatican approval—in government-sponsored family planning programs."

(*Conscience*, Winter 1992/93)



The number of people in nursing homes in the United States jumped by 24 percent between 1980 and 1990, rising from 1.43 million to 1.77 million.

(*American Hospital Association News*, 5 July 1993)



A growing population of foster children with serious emotional problems and a dwindling pool of foster parents have prompted the Missouri Department of Social Services to recruit career foster parents, "paying them professional wages provided they devote themselves full-time to the children's care." The career foster parents receive 39 hours of training initially and an additional 16 hours of training each year. For their services, parents receive \$16,000 a year, plus \$614 a



month for each child—up to nine times more than traditional foster parents receive. Missouri expects the program to save money. The state pays \$127,000 a year to keep a child in a psychiatric hospital and \$33,675 for a child to stay in a children's home; a career foster parent caring for one child will be paid \$23,368 a year.

Jeannie Palladino, from the Missouri Division of Family Services, points out that the state makes it clear to prospective career foster parents that they are taking on a challenge. "We tell them it's going to be difficult," she said. "We're talking about some very troubled and troubling children. It takes a lot of one-on-one work. . . ."

(*Health Progress*, July/August 1993)



Nearly 3 million low-income elderly and disabled Americans failed to take advantage of a government program that pays some of their out-of-pocket medical expenses, an advocacy group says. The study, conducted by Families USA, found complex application forms keep some seniors from seeking benefits.

(*American Medical Association News*, 12 April 1993)



A study charting the pay raises of the chief executive officers of 26 top health care corporations found their median pay—2.9 million annually—to be 85 times higher than that of nurses, up from 54 times higher in 1985. Salaries of the CEOs ranged from \$696,000 for the chief of Beverly Hills Enterprises, David R. Banks, to \$8.8 million for the chief of Merck, Dr. Roy P. Vagelos. If the value of cashed-in stock options is included, the highest pay was \$127 million to the chief executive of the Hospital Corporation of America, Thomas F. Frist, Jr.

Graef Crystal, a professor at the University of California at Berkeley who compiled the report, noted that although these pay scales are not unlike those in other American industries, they far exceed those of companies in Japan, Britain, France, and Germany. There, the ratio of executive pay to that of other workers was in the range of 20 to 1 to perhaps 33 to 1.

(*New York Times*, 23 June 1993)

BOOKS

Ethics: Three Views from the Shop Floor

Arthur W. Frank

Charles L. Bosk. *All God's Mistakes: Genetic Counseling in a Pediatric Hospital*. Chicago: University of Chicago Press, 1992.

Timothy Diamond. *Making Gray Gold: Narratives of Nursing Home Care*. Chicago: University of Chicago Press, 1992.

Robert Zussman. *Intensive Care: Medical Ethics and the Medical Profession*. Chicago: University of Chicago Press, 1992.

"WHAT YOU HAVE TO DO IS THIS," a physician tells Charles Bosk, who has asked him how he "came to grips with all the 'accidents' or 'mistakes' that he saw." "When you get up in the morning, pretend your car is a spaceship. Tell yourself you are going to visit another planet. You say, 'On that planet terrible things happen, but they don't happen on my planet. They only happen on that planet I take my spaceship to each morning'" (p. 171). This quotation not only stands as an epigram for an aspect of physicians' attitudes toward their work, it also introduces the idea of ethnography. To read ethnography is to take a spaceship to some strange and often disturbing place.

Bosk closes his book reminding readers that "one does not use ethnography merely to produce a literal

record of who said what to whom. Rather, one uses ethnography to produce a focused, analytic account about how some recurrent dilemma of social life is managed" (p. 182). These three books focus on the recurrent dilemma of how health care workers act in ways that at least they themselves can understand as ethical.

Bosk likes to refer to hospital settings as a shop floor, suggesting the commonality of workplaces. However distinctive the content of medical work may be, the hospital is a shop floor where workers take their places in a hierarchy, perform tasks that may be routine or problematic, sustain relationships with outsider clients and insider colleagues, and try to account for what they do as the right thing given the circumstances. This latter task is what ethics means, as a practice, on the shop floor.

These books put us on three shop floors that provide a good cross section of contemporary medical work. Nursing homes think of themselves as "the firing line of health care" (Diamond, p. 13), but from a sociological perspective they are the periphery of medical practice. Physicians are seldom seen there (p. 181). After completing his doctorate in sociology, Timothy Diamond became certified as a nursing assistant; *Making Gray Gold* is the story of his experiences working on the "firing line." When Diamond would tell his co-workers that he really was a sociologist writing a book, they seem to have regarded it as a benign delusion of grandeur. His employers were more interested in his punctuality.

If nursing homes are the medical periphery, intensive care units are the center, specializing in what Bosk tells us physicians value most, the technical

Arthur W. Frank is professor of sociology at the University of Calgary, Calgary, Alberta, Canada.

ability to accomplish “dramatic ‘saves’” (p. 58). Among the three authors, Robert Zussman is most explicitly interested in medical ethics, but as a sociologist his interest is in ethical practice rather than principle. Physicians are aware of principles but are less than constrained by them; principles set terms of accountability more than they determine courses of action.

Charles Bosk’s field is genetic counseling. *All God’s Mistakes* is a haunted work because as Bosk identifies ethical problems in the work of counselors, he realizes that his ethnographic practices have their own ethical dilemmas. Bosk paraphrases theologian Stanley Hauerwas to name the ethical issue common to ethnography and genetic counseling: Professionals in both fields are concerned not with “What should we do?” but rather with “How do we know we are describing the situation correctly?” (p. 102). Genetic counselors, like ethnographers, describe situations; when Bosk studied them, that was about the limit of their practice. The problem of both ethnography and genetic counseling is that describing “correctly” is an impossible ideal. Any description is always partial, always involves taking a perspective, and can never simply provide neutral “facts.” Description is itself a moral act, and both social scientists and medical scientists are troubled by engaging in moral acts.

Terrible things do take place on the planets observed by Bosk, Diamond, and Zussman. Oppressed by his inability to make what he counts as a difference in what he has seen, Bosk dismisses himself as “more a shadow than a witness” (p. 179). Whatever that disclaimer is worth, the value of each book, and their greater cumulative value, is to tell us a good deal about problems shop floor workers have describing their own situations correctly to themselves and thus clearing the way for ethical action.

Textually Mediated Care

THE SINGLE FACT THAT BEST ORIENTS READERS to the reality of the nursing homes where Diamond worked is that the ratio of residents to nursing assistants, who provide the primary care, is 30 to 1 (p. 125). Both staff and residents are caught between two interests: a for-profit system¹ and state regulation. In this unholy alliance the state regulations become the ra-

tionales for the imposition of daily routines that parody the intent of legislated standards while adhering to their letter.² The net effect is that staff can no longer speak the truth about the setting they work in. Describing a nurse responding to a resident’s complaint, Diamond writes, “All she could say was what she had been instructed to say” (p. 106).

Diamond organizes his ethnography around the idea formulated by the social theorist Dorothy Smith that much of social reality is “textually mediated.” Anecdotes describe this process better than formal definitions. A charge nurse who was filling out the nursing monthly summary asked Diamond how a resident had been eating. He thinks of her comments on the food, what she eats, and what she dislikes. The nurse cuts off these musings and tells him to choose one of the following: “independent, requires assistance, dependent on staff, or a tube feeder” (p. 120). These options have little to do with the reality of residents’ lives, but they define institutional truth. Diamond concludes, “these terms and categories and codes came to be viewed by many staff and outsiders as the ultimate reality itself, rather than a small part of it” (p. 126).

The specific texts that most significantly mediate nursing home life are the patients’ charts and state regulatory standards. Diamond summarizes the chart best when he writes that “words like *impoverished*, *insulted*, *powerless* or *angry* did not appear anywhere in the writing” (p. 123). The instruction to nursing assistants that becomes a chapter title is “If it’s not charted, it didn’t happen.” Nursing assistants are not being told to cover up incidents by not charting them. The lesson is that for purposes of accountability the chart is proof that all responsibilities were carried out. The converse is perhaps truer: whatever *is* in the chart did happen.

Meals are thus reduced to “precise quantities of nutrition” (p. 174). How much was eaten is noted on cards that come on each tray; the cards are filled out by nursing assistants and then become the texts that the home uses to document its adequate practices. The reality of why food was or was not eaten is lost in these documents. “If the mashed potatoes had become chunky or the eggs solid and cold and almost everyone left them on their plates, or if no one ate the pancakes, which had had syrup ladled on them down in the kitchen and were now saturated like wet sponges,

there was no place to record that no one ate the potatoes or eggs or pancakes. There were only records for the behaviors of separate cases, each in a file" (pp. 110–11).

State health officials consider only the texts, not the realities. "Inspectors claimed to have inspected the food," Diamond writes, "but what they looked at were socially constructed measures of it" (p. 192). The concept of "textually mediated reality" means that what counts as real is a text recording formal terms of compliance. The production of these texts prescribes what actually happens: collecting the cards on each tray is more important than serving the food in edible condition, showers must be given and charted whether the water is warm or cold, and so forth. On the medical periphery, the document is the reality.

How then do nursing assistants do their work? Diamond is convincing in his praise for his co-workers, mostly women of color, many immigrants, working at minimum wage and needing double shifts to get by, who still find ways to express caring to their patients. "The lesson we struggled most to comprehend during the training was how to overcome the fears, embarrassment, and nausea through building the work into a relational context" (p. 217). Despite employers whose attitudes vary from cold to contemptuous, nursing assistants do build relationships with their patients. Care, Diamond encourages us to believe, can persist despite institutional attempts to suppress it. Shop floor workers may no longer be able to speak the truth or enter it in official records, but they continue to know it and, when they are able, to act on it.

Medical Solidarity in the ICU

FROM THE NURSING HOME TO THE ICU is a transition from the lowest level of health care work to a shop floor that is among the most prestigious. One sociological measure of how privileged intensive care physicians are is their comparative disregard for the chart. A resident responds to a do-not-resuscitate order by saying that the "note itself is not written for the other housestaff. I don't think housestaff really care what is in your note." The note is written instead for "anyone who may review the chart . . . a lawyer or a medical

review board" (Zussman, p. 163). Here the worker is attentive to the potential force of documents, but her work is not mediated by them to anything like the degree that lower-status work is.

Medical ethics has a good deal to say about DNR orders, and the resident's comment also illustrates the difference between ethics as proclaimed by ethicists and as practiced by workers. Zussman concludes: "there is no evidence that the development of formal policies has in any way changed decision-making processes" (p. 162). This news is just as heavy as Diamond's observation of the futility of legislating standards for nursing home care and even more complex to sort out.

Zussman argues that physicians would have a hard time conducting themselves strictly according to medical ethics even if they wanted to, because the realities of decision making on the shop floor differ from how decisions are talked about in the ethics literature. Ethicists often postulate a moment of decision making; but Zussman finds that for physicians, "Decisions were not an event but a process" (p. 159). What is finally done is not so much decided at that point in time as it is made inevitable by numerous smaller decisions that have preceded it. In the ritual of recording decisions there is, as in the resident's comments quoted above, an orientation to ethics, but it's a show.

Physicians orient their work to the demands of ethics by explaining their decisions on the basis of technique rather than values, thus making "principles appear to rest on exclusively technical judgments" (p. 124; see also p. 141). Zussman argues that "the boundaries between the technical and the ethical are, at least in part, social constructions. They are social constructions because technical judgments . . . are inherently probabilistic" (p. 151). It is a social judgment what percentage possibility of success justifies some action. Technique can fill in the percentages, but we need values to evaluate what these numbers mean.³ Values, in turn, take on meaning only in the context of lives.

Here we get to the central rub in ICU work: the people whose lives the numbers represent, the patients, have in Zussman's metaphor "vanished" (p. 43). If most ICU patients are not actually beyond competent communication, the many who are incompetent set staff expectations for all communication.

ICU patients are transients in crisis: action must often be taken without time for discussion. All these factors, plus the physical isolation of ICUs, creates what Zussman calls "a moral universe of limited liability" for ICU staff (p. 43).

This limited liability cuts both ways, meaning that patients, such as drug users, who might be judged responsible for their condition receive the same measure of effort in their treatment as other, less culpable, patients. Here again we have the reality of ICUs as a shop floor: "The physicians in intensive care are not—and do not imagine themselves—as priests or cops, as ministers to the soul or guardians of decency. If anything, they are most like repairmen" (p. 42). Repairmen certainly have an *ethos* of good repair, but this may be some distance from medical *ethics*.

Triage and limitations on treatment involve, respectively, decisions about whom to repair and how much to repair. The primary value guiding these decisions seems to be solidarity with co-workers, a finding replicated in all three ethnographies. Triage thus works as a "system of reciprocity" among physicians. Bosk continues: "Obligations to patients become a matter not of the relationship of individual physicians to individual patients but of the housestaff to each other or the housestaff as a whole to a patient population as a whole. In this sense, the commitment to individual patients does not compete with commitment to abstract, potential patients but with commitments to other physicians who are friends and colleagues as well as indispensable allies in managing the stresses of training in internal medicine" (p. 215).

These stresses in training reinforce the ethos of solidarity as well as the value placed on heroic treatment. Zussman discusses the limits set by some states on the number of hours that house staff can work; he concludes that "whatever the eventual balance of benefits and costs" of such legislation, "something will have been lost" (p. 60). As I follow Zussman's argument, what will be lost is the premium on heroic medical action: "It is the genius of medical training that it turns such banal concerns to such lofty ends" (p. 61).

But "lofty" for whom? One answer is lofty within a collegial solidarity that defines heroic as lofty. Zussman tells of a patient who had not been definitely diagnosed but was presumed to have AIDS (p. 84). He was charted on a standard hospital mental status exam

as "oriented x3 and appropriate" and thus judged competent. After discussion with the resident, he was clear in his refusal of intubation should he require it. Later he did require it, the chart was brought forward, and the attendings overruled his request.⁴ Zussman quotes one physician, "In effect, lie to him. . . . We have to save his life." Acceding to the attending's demand was collegial and saving the life was heroic, but was overriding this patient's self-determination a lofty end?

Zussman documents how few ICU patients leave the unit and how few of those leave the hospital. He hardly minimizes the cost of ICU treatment, but like most physicians he gives cost a secondary priority. Physicians' "appetite for intensive care is insatiable," he notes, in a phrase that should give health care planners the chills (p. 204). One resident does express concern about ICU costs and how many lives could be saved by applying those resources to preventive and public health measures (p. 195), but the shop floor ethos is to proceed without regard to cost. This ethos is certainly heroic; whether it's lofty is a matter of perspective.

Within this limited moral universe of physicians, ethics take a back seat to other values, mainly collegiality. In their relations with patients physicians are generally able to use technical expertise to frame questions in a way that produces the "ethical" outcome they desire (p. 220). If ethical accountability has required physicians to place the rights of patients among "the values of medicine," these inclusions "may represent the triumph of form over substance." Zussman adds that "substance does not always matter more than form" (p. 171). The most singular effect of the "institutionalization of [ethical] procedures" has been to make "existing distrust and disagreement [between patients and physicians] more consequential" (p. 160). Certainly informed consent procedures can elicit distrust, and ethics reviews can be venues for disagreement. But I interpret these problems as a mixed blessing. Medical work requires trust, but the institutional dominance of physicians requires checks that are consequential. The problem is whether patients are finding viable treatment options when they do distrust and disagree.

Ethics has an impact on medical practice, but that impact is mediated by realities of practice and the particular ethos of the shop floor. That ethicists sel-

dom acknowledge that ethos or seek to affect its structural causes is a central limitation of ethics.

The Ethics of Value Neutrality

GENETIC COUNSELORS LIVE their professional lives in the hospital, which is the center of the medical action, but they are on the margin of this center. In a profession that values action, genetic counselors have “nothing special to offer save talk and elective abortion, and . . . are at the bottom of the medical status hierarchy” (p. 58).⁵ The issue then is how genetic counselors sustain their own sense of the value of their work.

Genetic counselors trade in predictions about why a birth went badly, what the risks are for a future birth, or what the damage is to a newborn. The explicit aspect of their work ethos requires observing strict value neutrality toward parents’ decision making. The more implicit and noncomplementary aspect is to give equally strict support to their medical colleagues, even when counselors perceive mistakes being made.

Typical parental decisions include whether to undertake another pregnancy after problems with a previous one or whether to authorize surgical intervention, and at what level, for an impaired infant. Value neutrality means counselors pride themselves on giving parents complete and accurate technical information and making sure that patients, who are often distressed, understand what is being told them.

Like the ICU physicians described by Zussman, genetic counselors try to frame questions of value in technical terms. “Despite their commitment to non-directive, neutral, information-based counseling, invariably the counselors shape the way that information is presented to prospective parents in ways that are geared to influence private risk assessment and decision making. This arises from the way the risk statements that genetics counselors use to frame alternatives are constructed,” Bosk writes (p. 28; see also p. 34) and then goes on to detail those constructions and their influence.

The other side of the counselors’ ethos is support for those colleagues who have primary care responsibility for patients. If counselors often seem unreflective about how their nondirective counseling actually directs, they do anguish when they are convinced that parents are not being told the whole story. “You have

this situation where nature is ready to take its course,” a counselor tells Bosk, “but, if you go ahead and intervene, who knows? You may save the baby, which is the last thing anybody really wants in this situation. Here, the father was saying, ‘I’ve got to think of my family. I don’t know if we can really handle it,’ and [the neonatologist] says, ‘Sure, we want what you want.’ And all the time he’s planning to save the baby. I don’t think he played very straight with that family” (pp. 76–77).

But invariably counselors do support other physicians: “How are the claims of these parents whom I deal with but once matched against the claims of colleagues I need to work with day in and day out?” is their rhetorical complaint (p. 104). Whatever their moral reservations, counselors’ actions are governed by what Bosk calls a “consultant ethos” that means “providing colleagues with whatever it is they want” (p. 79), even if that offends counselors’ own values.

The situation is even more troubling because the outcome is not even a “communal consensus, which echoes a shared normative order” among physicians (p. 104). “Rather,” Bosk continues, “it might just as well be the case that when all the physicians gather together in one room, colleagues bow to those physicians involved with the strongest feelings about what should be done.” This takes me back to Zussman’s quotation (p. 120) of an ICU resident describing termination-of-treatment decisions: “Anybody can say yes to keep going.” In both the ICU and neonatology, practice reflects not a collective consensus based on values established through communal experience but rather an ethos of solidarity expressed as yielding to anyone who cares to push the point, in anticipation of some reciprocal courtesy.

Does Ethics Count?

ARE ETHICISTS SIMPLY SPINNING THEIR WHEELS? Worse yet, are they providing a literary cover for clinical practice to continue on its own way, not exactly oblivious to ethics but not substantially affected either? These books certainly raise this question, and it would be too much to expect them to answer it. The strongest statement of ethnography’s limitation may be Diamond’s: “This research . . . does not seek to find or generate abstract concepts” (p. 253).

Perhaps this is the ethnographic lesson for ethics: abstraction has little force; what can make a difference is to inform thinking with as much lived complexity as the mind, or one book, can encompass.

Bosk complains that when physicians try to act as ethicists, "a great deal of the world's complexity is washed out" by their reduction of issues of biography and family to technical and legal questions. "There are simply some fault lines where professional and lay criteria do not meet," he concludes (p. 109). Ethnography displays these fault lines to any who care to see them. What they do with this knowledge is another issue.

These three spaceship rides to different shop floors of medical work convince me that the gap between ethical theory and medical work is bridged only nominally by the current practice of ethics. On what is wrong let me quote Bosk at some length. He writes about neonatology but speaks equally of those who regulate nursing homes and those who decide on the extent of treatment in ICUs. What Bosk describes is how health care has turned in on itself and how dangerous this insularity is to those it serves:

None of the key medical decision makers have to live with any of the consequences of their decisions. There are no economic costs that fall upon providers from salvaging infants that are better left unsalvaged. Because in the American system there is no fixed sum allocated for health-care, there is no pressure on any individual physician to consider the costs of a treatment, or the resource implications of salvaging a particular child, or even what it might mean to the emotional life of the family. This is not to say that individual physicians never consider these issues, but that there is very little incentive for them to do so. This reinforces whatever tendencies exist to divorce clinical action from individual responsibility. (P. 105)⁶

The practical task for medical ethics is to reconnect clinical action to individual responsibility and to corporate responsibility. Until that reconnection is made, until physicians realize that their shop floor is not another planet but the one we all share, the world of health care will remain, in Zussman's troubling phrase, a moral universe of limited liability.

NOTES

1. The title *Making Gray Gold* was derived from an article in *Forbes* that described investment opportunities in nursing homes; its nonironic title was "Gray Gold" (Diamond, p. 245).
2. Church-supported homes are not exempt from this critique. Diamond writes that "nonprofit homes operate with the same administrative mandates to produce balance sheets and bottom lines, demonstrating productivity and efficiency. They provide services with similar staff ratios and wage rates . . . within the larger context of caretaking as a business" (p. 198). These observations were gathered after Diamond had concluded his participant observations and received funding for a systematic study of nursing homes, including site visits in several countries.
3. Technique does fill in percentages, but what these mean even as statistics is often questionable. Bosk reports an exchange between two genetic counselors when one criticizes the other after a session: "I don't know where you got that number from. It's clear they have an increased risk, but it's impossible to place a precise number on it" (p. 120). A response from the first colleague might be that technique requires him to speak in the language of numbers.
4. This case and several others contradict Zussman's overall assessment that "physicians most often use their discretion—albeit with occasional exceptions—to limit treatment" (p. 101). Perhaps it is inevitable in ethnographies that the "occasional exceptions" are the most interesting and receive disproportionate attention. Or perhaps physicians talk more about the need to limit treatment but in actual cases feel compelled to continue. Both Zussman and Bosk describe instances where stated principles do not match observed action.
5. Bosk's fieldwork took place in the early 1980s, and he notes that since then much genetic counseling has been taken over by nonphysicians. What's interesting about Bosk's ethnography is how little this change matters to the relevance of what he is saying about medical work.
6. A complementary discussion of the nonresponsibility of physicians for the consequences of their clinical actions is made by William F. May, *The Patient's Ordeal* (Bloomington: Indiana University Press, 1991).

BOOK NOTES

Donald Hall, *Life Work* (Boston: Beacon Press, 1993), 124 pp.

"ONE UNDERTAKES CHEMOTHERAPY, but the cure rate for this disease is negligible. If I cannot be operated on, I will die fairly soon. A year? Eighteen months? Six months? I speculate; I cannot stop speculating." Thus poet Donald Hall opens the second half of a book divided simply into parts 1 and 2. The shadow of his colon cancer provides background for Part 1, in which he has set out to describe the meaning and role of work in a life well lived. Living with the cancer metastasized to the liver is the context for Part 2: "The nature of this book alters. Shall I change the title from *Life Work* to *Work and Death*? Box office, he said sneering."

Donald Hall resists "box office" and thus will not know best-seller status. This work is not a clinically detailed log, a depressing account of what he endures, or a superficial essay in denial designed to cheer. "If all goes well, as it were, I will by inches recover the morning *Globe*, the coffee, work on poems and work on prose, walking the dog, love with Jane [poet Jane Kenyon, his spouse, who also has had cancer], and the continual and recurrent dread . . . that a black cell multiplies." Millions experience what Hall does; he serves them and others by integrating the story of his disease into the story of his life.

Life Work is only part of Hall's recent production. He completes *The Museum of Clear Ideas*, a worthy book of poetry. We hear how he revises "Another Elegy" more than 60 times, makes love, *does* get to read the *Globe*, *does* experience dread. Never in the second half is the metastasized cancer offstage, far into the wings; never does it fully interrupt *Life Work*. Because Hall mingles realism with hope, singleness of purpose with double preoccupation, doubt with faith, he is able to minister to the afflicted and afflict those who go about their life work unmindful of all that threatens life and work.

He has written one of the better contemporary essays on work, calling, vocation, admittedly as one of the fortunate. "I've never worked a day in my life," the opening line of it all, promises an exuberance one would find harder to express for drudge work, hewing of wood and drawing of water. Yet, without sounding

teacherly, he teaches anyone who cares to read something about work and its role in life.

And faith. Hall had seen his faith quickened some years before he wrote this book; now it gets tested. That faith is not obtrusive: "Why, when I write about my work and my day, do I not speak of the spirit?" He cites discreditable reasons: "I am afraid of ridicule; most of my friends are embarrassed by my Christianity, my Deaconhood at the South Danbury Church, and explain it away." And "I *am* skeptical," as people of deep faith also are. But "at times my skepticism is overwhelmed by a spiritual light, strobe more than nightlight." And he hopes.

Jack, the minister who modeled life and work for Hall, makes several appearances. "Jack Jensen discovered the figure of Jesus for me," and Jesus joins Jack as exemplar. When the cancer cells multiply, fear of ridicule about Jesus and faith disappears, though skepticism and hope do not. People of Jesus-faith, deacon-faith, other-faith, and no-faith are likely to be more able to interpret their life and work, their benign experiences and their malignancies, after tracking Hall's. His is an exercise in narrative ethics and theology, one that will last.

—Martin E. Marty

Howard Waskow and Arthur Waskow, *Becoming Brothers* (New York: Free Press, 1993), 218 pp.

WHAT CAUSES THE EMOTIONAL SEPARATION that often occurs between brothers (and some sisters) at adolescence? Arthur Waskow, a Jewish writer and teacher, and his brother, Howard, a psychotherapist, both now in their late fifties, attempt to answer this question in what becomes a five-year correspondence. These letters, compiled and edited, make up *Becoming Brothers*. The conversation moves from tenuous beginnings—"a question here, a thoughtful gesture there, a confidence revealed" (p. 6)—to eventual reconciliation upon the death of their mother.

The catalyst for the book actually occurs 20 years prior to its conception. On a quiet retreat with their wives in a cabin on the Oregon coast, the brothers argue. Arthur curses Howard, who quietly responds that he may have to kill his brother some day "after all" (p. 3). Later, talking calmly, they discover that

each has feared the other brother would try to destroy him. "How did we come to this murderous place?" they ask. "We are two right-thinking liberal men, two workers for harmony and peace, but in us, between us, rage and hatred burn. . . . We are Cain and Abel, Jacob and Esau, Joseph and his brothers—we have murder in our hearts" (p. 4).

In writing (they take alternating chapters to ensure a book "big enough for both our voices" [p. 9]), the brothers are surprised to find they experienced their childhood, and their mother and father, quite differently. Arthur, the older brother, remembers being instructed by his father not to show any signs of fear around their mother during her four-year struggle with tuberculosis (she later recovers); spoken fears could depress her and cause her to lose the will to live. Arthur recalls the burden of responsibility—"I myself could kill her" (p. 121). Howard, who enjoyed a much closer relationship with his parents than did Arthur, comments, "Never was I warned this way" (p. 126). Howard's memories of the local synagogue include feelings of humiliation at being unable to comprehend the Hebrew prayers or to purchase seats for the High Holidays. Arthur does not dispute the facts of Howard's account, but he does not share the feelings. "Did I feel differently back then," he asks, "or am I feeling defensive now because my life has taken such a Jewish turn?" (p. 53).

Naturally, both brothers' remembrance of the forces that shaped their lives and their relationship are influenced by their present worldviews. Howard the therapist takes a psychological and literary approach to describing his childhood, "weaving a narrative about the family, creating an explanatory tale, a map that I can use to place myself" (p. 111). Arthur draws

on a faith in Judaism gained in adulthood to enlighten his understanding of his place in the family. His "wrestling" with Howard over the years—for their mother's love, for intellectual superiority, for mutual understanding—gains religious significance when compared with the "Godwrestling" from which Israel gets its name. Seeing himself as the family outsider, Arthur names himself Ishmael, cast out because of the younger brother—who only later in life seeks reconciliation. (In an interview after completion of the book, Arthur said that writing it gave him a better understanding of the Torah: "It's not just that different chunks of text were put together to make the Torah. The Torah is different parts of the Jewish family telling the story. The genius . . . was in using both accounts.")

The brothers achieve reconciliation when they cooperate to help their aging mother die, working against hospital regulations that would keep her on a respirator indefinitely. Later, for the funeral, Howard bestows on Arthur a special affirmation by asking him to give the eulogy.

Is any reconciliation ever final or complete? Arthur points out that "one wrestle may lead to reconciliation, and then the new relationship will somehow spark again that flash of murder. And we find ourselves in still a different wrestle" (p. 166). In the final chapters, one senses the brothers embarking on another wrestle, this one concerning Arthur's acceptance of the Jewish faith and Howard's rejection of it. Feelings rise, but they agree to play, to try to understand the language each has adopted. This time, however, they have already laid the groundwork.

—Stephen Hudson

LITERATURE DIGEST

Religious rites in refugee trauma therapy

Judith Shepherd and Shotsy Faust, "Refugee Health Care and the Problem of Suffering," *Bioethics Forum* 9, no. 3 (Summer 1993): 3–7.

SHEPHERD AND FAUST BEGIN with the informed understatement: "Providing health care to refugees who have been tortured and weakened by war is no easy task" (p. 3). This article documents the authors' experiences in the Refugee Clinic at San Francisco General Hospital with Cambodian women who suffer from post-traumatic stress disorder (PTSD). Not only do they validate the largely accepted notion that for such women "medical care alone is insufficient to positively affect overall health" (p. 3) and advocate therapeutic support-group interventions that promote healing by "rebuilding culture"; they also discover that the effectiveness of support groups can be limited if they overlook the significance of clients' religious beliefs. They illustrate with one woman's story how medical practice, support groups, and religious communities can work together to alleviate suffering and promote healing.

The authors recount in brief some of the traumas experienced by these women (for example, extensive torture, starvation, forced labor, rape, the witnessing of grossly inhumane acts, and separation from family and community through murder, abduction, and forced conscription) and the symptoms and disabilities they continue to experience (from severe headache, back pain, and abdominal pain to blindness brought on by psychological trauma). They note that

in many cases standard medical tests revealed no underlying pathology, and therefore no remedies were indicated for the women's often persistent and unrelieved pain; in fact "intrusive medical testing" (p. 3) sometimes contributed to these patients' suffering.

Finding no relief in Western medicine, refugees often seek care from traditional healers in their communities. The authors seem to dismiss the potential efficacy of these therapies: "since they cause no harm we do not discourage their use. In fact, we often encourage such practices in an effort to support the patient's cultural values while introducing Western concepts of health and treatment" (p. 4).

Shepherd and Faust note that recent mental health literature correlates many of the symptoms of these women with post-traumatic stress disorder, but they also note that accepted treatment protocols needed "to be less disease focused and less ethnocentric in order to address the underlying needs of this group" (p. 4). In 1991, with the goal of reducing "social isolation and emotional numbing that had plagued our patients for over ten years" (p. 5), the authors began a weekly support group with a number of Cambodian women who scored high on tests measuring PTSD.

Though the activities of the group reduced the women's symptoms, new trauma sometimes caused the symptoms to recur; therapy in these situations often released repressed, unremembered, and unresolved grief. The experience of one of the Cambodian women, T., helped the authors see not only that symptoms were caused by loss of loved ones or memories of atrocities (T. had witnessed the dismemberment and burning to death of her sister-in-law by soldiers) but that the lack of opportunities "to mourn

the death of . . . family members in ways appropriate to Cambodian religion and culture" (p. 6) also contributed to symptoms.

As the authors note, in Cambodian culture

illness is frequently viewed as the result of karma [the notion that past and present actions can influence present and future lives] on an individual or collective basis, or as an imbalance in the world of nature or spirits, community and family (Aronson 1987). Abatement of suffering and resolution of disease can occur only if balance is restored in some or all of these areas, or by bearing one's suffering as fate. . . .

. . . Religious upbringing may also cause patients to believe they will suffer emotionally if they are unable to participate in appropriate religious rites for ensuring the proper transmigration of relatives' souls from this world to the next. (P. 6)

This recognition of the need for religious rites led the authors to arrange for a Buddhist ceremony at a local temple to commemorate T.'s dead relatives. Members of the support group also joined in the ceremony.

Enjoining other clinicians who work with ethnic minorities to have "the courage to look beyond the usual limits of clinical care," the authors conclude: "We realized that suffering that results from severe trauma may not be managed successfully unless health care providers examine a patient's beliefs and values about dying and death and honor appropriate cultural and religious rituals. . . . A support group format can foster partnership with the religious community to facilitate healing" (p. 7).

—M. Therese Lysaught

On the psychological aftermath of an abortion

Douglas Brown, Thomas E. Elkins, and David B. Larson, "Prolonged Grieving after Abortion: A Descriptive Study," *Journal of Clinical Ethics* 4, no. 2 (Summer 1993): 118–23.

Jo Ann Rosenfeld and Tom Townsend, "Doesn't Everyone Grieve in the Abortion Choice?" *Journal of Clinical Ethics* 4, no. 2 (Summer 1993): 175–77.

Nada L. Stotland, "Realistic Reflections on an Emotional Subject," *Journal of Clinical Ethics* 4, no. 2 (Summer 1993): 177–78.

Philip G. Ney, "Some Real Issues Surrounding Abortion, or, the Current Practice of Abortion Is Unscientific," *Journal of Clinical Ethics* 4, no. 2 (Summer 1993): 179–80.

BROWN, ELKINS, AND LARSON HAVE FANNED the flames of the politically charged debate surrounding the alleged potential negative psychological consequences of having an abortion. They contend that the research indicating that, on the whole, women do not experience debilitating psychological conditions as a result of abortion is significantly limited. While not disputing the validity of such a generalization, they seek to document cases in which women have experienced prolonged suffering as a result of having had abortions.

Three reactions to the article appear in the same issue of the *Journal of Clinical Ethics*. These articles take Brown et al. to task for poor scientific methodology, inappropriate moralizing, and failure to address the basic medical and social appropriateness of abortion as a procedure.

Brown et al. gathered evidence of abortion-related psychological suffering from letters submitted in response to the request of the pastor of a large, predominantly white, urban, middle- to upper-class, anti-abortion Protestant congregation in Florida. Following a suggestion from the surgeon general in 1987, the pastor solicited descriptive letters from women who had "had negative experiences that they perceived to be linked with past abortion." The request elicited extensive personal letters from 45 women. From these letters the authors tabulated the reported incidences of masking ("hiding inner feelings beneath an apparently stable and peaceful outward manner"), anger, feelings of loss, depression, regret, shame, fantasizing about the infant, suicidal ideation, and guilt. In addition, they calculated the percentage of respondents who reported experiencing negative feelings immediately following the procedure and during the 0–5

years, 5–10 years, and 10 years and more after the procedure.

Seventy-three percent of the women reported feelings of guilt, and 58 percent fantasized about the aborted fetus. Other commonly experienced negative emotions included depression (44 percent), regret (44 percent), and masking (36 percent). Interestingly, all of the women who reported having had the procedure voiced discontent with the lack of counseling offered and with the doctors involved. The authors note that women who felt coerced into the decision to have an abortion tended to report negative emotions more frequently than others.

Brown et al. believe that their case presentation serves four major purposes in the current debate over the possible negative psychological consequences of having an abortion. First, it strengthens the anecdotal evidence that such consequences do occur. Second, it indicates that although women may not struggle publicly with their negative feelings, many may be suffering privately. Third, it encourages clinicians to be sensitive to the reasons a woman is seeking an abortion and to be vigilantly alert for signs of coercion. Fourth, it raises questions about the belief that religious fervor may cause or intensify psychological consequences following an abortion. Forty-two percent of the respondents stated that they were not practicing Christians at the time of the abortion, yet their responses did not differ significantly from those of the group as a whole. Religious involvement appears to have deepened the psychological pain for some while helping to reduce feelings of guilt and despair in others.

The authors defend their nonscientific methodology by upholding their simple wish to document the occurrence of negative psychological consequences, highlight the need for further studies of delayed grief reactions and of factors that may predict such complications, and encourage an expansion of clinical counseling and informed consent procedures.

In the first response article, Rosenfeld and Townsend do attack Brown et al. for their lack of scientific rigor but focus on the fact that the negative emotions experienced by these women do not constitute evidence that the women now believe having an abortion is or was an immoral and regrettable act. They state that the article implicitly equates emotions with morals, when such an equation is not altogether

valid. Rosenfeld and Townsend maintain that the decision to abort or not is a difficult one and that negative emotions are likely to be associated with either decision. They do support the conclusion of Brown et al. that the medical community must recognize that abortion can and sometimes does have significant negative psychological consequences and that care providers must be prepared to offer supportive counseling both before and after all abortions.

Stotland, the author of the second response article, responds to Brown et al. from a clearly prochoice position. Hers is less a critique of the article than a diatribe against those who oppose abortion. She accuses “anti-choice” groups of distorting and falsifying facts and states that “those who oppose reproductive choice believe that women’s main role is to bear and nurture children within traditional family structures.” In direct response to Brown et al., Stotland criticizes the prejudicial nature of the data used and, like Rosenfeld and Townsend, stresses that abortion-related decisions are difficult regardless of the outcome. She concludes that “we must try to minimize human suffering by informing, accepting, understanding, and supporting women as they make and live with reproductive choices in the context of their own circumstances.”

Ney’s response to Brown et al. is the yin to Stotland’s yang. He clearly speaks from an anti-abortion standpoint and criticizes the authors for not boldly confronting the medical assertion that abortion is “therapeutic”; he mocks their cowardice. He maintains that “there are no proven medical, psychological, or social benefits” to abortion and that, if examined by common standards of medical scrutiny with regard to its safety and therapeutic effectiveness, abortion would be “taken off the market.” He proposes a randomized clinical trial of pregnant rats as a rational and relatively objective way to evaluate the medical and psychological sequelae associated with abortion. At the end of his article, Ney moves from the medical and political to the philosophical; he concludes by asserting that because one cannot truly benefit at the expense of others, what is bad for the fetus must be bad for the mother.

This series of short articles indicates the nature of the abortion “debate” in the United States. Each author enters the debate with a clear personal agenda and allows this to color his or her conclusions about the same information. Clearly, the study by Brown,

Elkins, and Larson lacks scientific rigor, but it raises important points. On the positive side, all the authors seem to agree that society must recognize the difficult personal issues unwanted pregnancies present for those involved and that emotional support and appropriate medical information should be made available to those faced with such a painful decision.

—Deborah Harris-Abbott
Research Assistant

Does the sex of the physician matter?

Nicole Lurie, Jonathan Slater, Paul McGovern, Jacqueline Ekstrum, Lois Quam, and Karen Margolis, "Preventive Care for Women: Does the Sex of the Physician Matter?" *New England Journal of Medicine* 329, no. 7 (12 August 1993): 478–82.

ARE THE RATES OF CANCER SCREENING for women—specifically, of Pap smears and mammography—affected by demographic differences between physicians like sex, age, and specialty? Researchers investigated this question by using the 1990 population of a large Midwestern health plan (the Medica health plan in Minneapolis–St. Paul, Minnesota). They concluded that "women are more likely to undergo screening with Pap smears and mammograms if they see female rather than male physicians, particularly if the physician is an internist or family practitioner" (p. 478).

The physician sample comprised 680 physicians, categorized according to sex (543 males, 137 females), age (358 physicians over 43, 147 between 38 and 42, 175 under 38), and specialty (550 internal medicine and family practice, 130 obstetrics-gynecology). The patient sample comprised 97,962 women, 18 to 75 years of age. A subgroup of 24,713 patients who visited only one physician for the year was also identified. Because the results of this subgroup differed little from the results of the entire sample, the authors report the findings from the subgroup.

The frequency of mammography and Pap tests ordered or performed by each physician was calculated, and the mean rates of screening by Pap smear and mammography were computed for physicians

according to sex, age, and specialty. The authors found the following:

1. "Rates of Pap smears and mammography were consistently higher for female physicians than for male physicians, with the exception of physicians around 50 years of age. . . . The largest difference in rates between male and female physicians was found for screening with Pap smears in the youngest group of physicians" (p. 497).
2. After adjustments for patient age and physician age and specialty, female physicians were twice as likely as male physicians to perform Pap tests and 41 percent more likely than male physicians to order mammograms for women 40 years and older.
3. After adjustments for patient age and physician age and sex, obstetricians-gynecologists were more than eight times as likely to perform Pap tests and two-and-one-half times as likely to order mammograms as were internists and family practitioners.
4. After adjustments for patient age and physician age, female internists and family practitioners were more than twice as likely as their male counterparts to secure Pap smears and 50 percent more likely to order mammograms. Female obstetricians-gynecologists were 40 percent more likely than their male counterparts to secure Pap smears; rates of mammography were about the same.

The authors found the low screening rates for young physicians "particularly disturbing": in light of increased attention to preventive care in medical education over the past decade, they are not optimistic that cancer-screening rates will be improved further through that means. They suggest that administrative changes may help increase screening, particularly changes that "bypass the physician and rely on nurses or other medical staff" (p. 481).

They draw only tentative conclusions from the data on sex differences but do suggest a number of possible implications and interpretations:

Women physicians may be more likely to offer screening tests, or they may exercise greater diligence in repeatedly offering screening or may communicate the risk of cancer more effec-

tively to their patients. Women patients may also be more likely to follow through in obtaining tests suggested by women physicians because they are more comfortable discussing issues of concern with female physicians or being examined by them. Female physicians may be more comfortable than males in discussing or performing breast examinations or Pap smears. In particular, young male physicians may be uncomfortable examining women's reproductive organs or discussing issues related to sexuality. . . . This discomfort may lessen as physicians mature with age and gain practice experience. (Pp. 481-82)

The authors note that certain aspects of the care provided by female physicians may be more effective than that provided by male physicians, at least for women patients, and they counsel further study: "it will be beneficial to identify the factors responsible for the differences, particularly if they can be incorporated into the practice of all physicians, regardless of sex" (p. 482).

—M. Therese Lysaught

Physician supply

Marc L. Rivo and David Satcher, "Improving Access to Health Care through Physician Workforce Reform: Directions for the 21st Century," *Journal of the American Medical Association* 270, no. 9 (1 September 1993): 1074-78.

IN 1986, CONGRESS AUTHORIZED the Council on Graduate Medical Education (COGME) to "provide [the Department of Health and Human Services with] an ongoing assessment of physician supply trends and to recommend appropriate federal and private sector efforts to address identified needs" (p. 1074). Rivo and Satcher here summarize the findings, goals, and recommendations of the Third Report of the COGME, which was released in October 1992.

In compiling the report, the COGME asked the following questions:

If Congress passed legislation tomorrow that provided health care access at reasonable cost,

would an adequate supply of appropriately trained physicians be available? Is our nation's medical education system producing a supply and mix of physicians that meet the population's needs? Is there a national plan and appropriate financing and reimbursement incentives to address physician resource needs in the 21st century? (P. 1074)

The COGME found that efforts at health care reform will be hindered by seven deficiencies in the physician workforce, in the medical education system, and in our public policy:

1. The nation has too few generalists and too many specialists.
2. Problems of access to medical care persist in rural and inner-city areas despite substantial increases in the physician supply.
3. The racial/ethnic composition of the physician workforce does not reflect the general population and contributes to access problems for minorities.
4. Shortages exist in general surgery, adult and child psychiatry, preventive medicine, and among generalist physicians with additional geriatrics training.
5. The nation's current physician-to-population ratio is adequate; further increases in this ratio will do little to enhance the public's health or to address access problems and will hinder efforts to control costs.
6. The nation's medical education system can be more responsive to public needs for more generalist and minority physicians, fewer specialists, and more physicians for medically underserved inner-city and rural areas.
7. The absence of a national physician workforce plan, combined with financial and other disincentives, is a barrier to health care reform.

Based on these findings, the COGME recommends five specific goals for a national physician workforce plan and financing strategy. These goals encourage the U.S. government and appropriate agencies to redress the problems named in findings 1-5. Specific recommendations include the following:

LITERATURE DIGEST

at least 50% of residency graduates should complete a 3-year training program in [family medicine, general internal medicine, or general pediatrics] and begin generalist practice. . . . The number of entering minority medical students should be doubled from 1500 to 3000 by the year 2000 (a goal of the Association of American Medical Colleges). . . . Allopathic and osteopathic medical schools [should] maintain or reduce enrollment and . . . residency positions [should] be capped at 10% more than the number of U.S. medical school graduates. (P. 1077)

The COGME proposes the development of a National Physician Work Force Commission that would work with state or regional commissions to monitor progress toward these goals. The role of this commission could range from direct oversight (determining the "number and mix of residency positions") to indirect influence (recommending "substantial multifaceted incentives and disincentives" in education and practice). The COGME also recommends a public funding strategy for medical education that would help in the realization of its five goals.

The COGME envisions that residency positions and medical education funding could be allocated through local, state, or regional academic "consortia" that might include medical schools, teaching and community hospitals, HMOs, community health centers, health departments, and other community sites. These consortia could provide broad training opportunities, simplify financing and administration, and assist in matching production with need.

As a general principle, the COGME recommends that all payers should contribute to an explicit graduate medical education pool, including not only Medicare funding, but also private insurers, self-insured employee plans, and managed care systems. Funds from this education pool should be more carefully accounted for and targeted to meet national physician workforce needs. (P. 1077)

The report encourages medical schools and residency training institutions to rethink their policies with these goals in mind.

—M. Therese Lysaught



Second Opinion Guidelines for Authors

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.
3. Authors are urged to use nonsexist language.
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.
5. We welcome suggestions for illustrations. Our criteria for selecting illustrations are relevance to the article and visual interest.
6. Articles should be aimed at a diverse but educated public. Do not write for the six specialists in your field, but rather for the general reader.
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.
8. In a separate section entitled "References" list alphabetically by author (and, within author, by year of publication) all items that are cited in the text. Give complete bibliographical information, including author's first name, publisher, and place of publication. If there is more than one reference to the same author and year, distinguish them by the use of letters (a,b) attached to year of publication, e.g., Smith 1978a.

Examples

Tillich, Paul. 1946. "The Relation of Religion and Health: Historical Considerations and Theoretical Questions." *Review of Religion* 10 (May): 348–84.

———. 1967. "The Meaning of Health." In *Religion and Medicine: Essays on Meaning, Values, and Health*, ed. David Belgum, 3–12. Ames: Iowa State University Press.

Witten, Robert W. 1978. "What Is a Healthy Personality?" *Counseling Psychologist* 9:17–29.

Second Opinion (ISSN #0890-1570) is published four times a year in January, April, July, and October for \$40 per year by the Park Ridge Center for the Study of Health, Faith, and Ethics, 211 E. Ontario, Suite 800, Chicago, Illinois 60611. Application to mail at second-class postage rates is paid at Chicago, Illinois, and additional mailing offices. POSTMASTER: Send address changes to *Second Opinion*, 211 E. Ontario, Suite 800, Chicago, Illinois 60611, attention subscription fulfillment.

Articles are indexed in the following: *Abstracts of Research in Pastoral Care and Counseling*; *Bibliography of Bioethics*; BIOETHICSLINE; *Christian Periodical Index*; *Cumulative Index to Nursing and Allied Health Literature*; *Hospital Literature Index*; *Index to Book Reviews in Religion (IBRR)*; *Religion Index One: Periodicals (RIO)*.

SECOND OPINION

Volume 19, number 3

January 1994

A Calling

Frederick J. Frese III

11

Mandatory HIV Testing and the Character of Medicine

Keith Berndtson

27

Does "No" Mean "Yes"? Jehovah's Witnesses and Refusal of Blood Products

Dena S. Davis

35

CASE STORIES

Editor's Introduction: Case Stories and the Ethics of Voice

Arthur W. Frank

44

The Case: An Eloquent Region

James Fitchette

49

Commentary: A Neurologist's Perspective

Harold L. Klawans

57

Overview: Hearing and Editing Good Stories

Arthur W. Frank

61

Holistic Healing in the New Age

Mary Farrell Bednarowski

65

A Voice from the Roadside

Beth C. Junker

87

ISSUES & CURRENTS • NOTEBOOK • BOOKS • LITERATURE DIGEST

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