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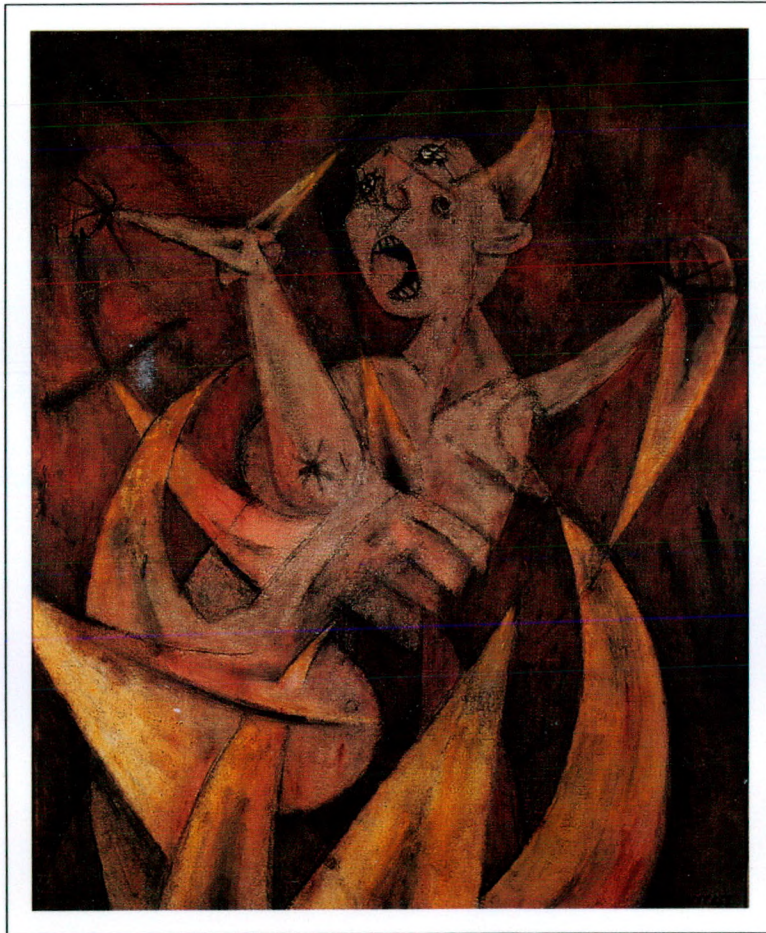
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HEALTH • FAITH • ETHICS



FOCUS ON VIOLENCE

Rape • Elie Wiesel Interview • Female Genital Mutilation • Inmates, Guns, and Power

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

COVER

El Atormentado (Tortured Being).
Oil on canvas by Rufino Tamayo, 1949.

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HEALTH • FAITH • ETHICS



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

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

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

SECOND OPINION

Volume 20, number 2* • October 1994

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

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CONTRIBUTORS

Marius L. Bressoud Jr. writes, paints, and volunteers in a parish ministry with the ill and elderly. He served in the Marines during World War II and the Korean War and worked for 36 years in corporate advertising and public affairs.

Susan J. Brison is assistant professor of philosophy at Dartmouth College, Hanover, New Hampshire. Following her recovery from a sexual assault and attempted murder, she has addressed the issue of violence against women as a teacher, speaker, and organizer.

David Cain is Distinguished Professor of Religion, Mary Washington College, Fredericksburg, Virginia, and an ordained minister in the United Church of Christ. He is completing a book on Kierkegaard to be published in 1996.

Marlyne Cain is an assistant professor at the Medical College of Virginia, Virginia Commonwealth University, Richmond, and an ordained minister in the United Church of Christ. She is an Association of Clinical Pastoral Education supervisor and a volunteer at Hospice Support Care, Fredericksburg.

Cheryl Mac Leod Darling is clinical research associate, Hematology/Oncology Division, Lutheran General Hospital, Park Ridge, Illinois. For five years she was clinical research associate with the Center for Clinical Ethics, also at Lutheran General.

Richard E. Koenig is a retired pastor of the Evangelical Lutheran Church in America.

Loretta M. Kopelman is professor and chair, Department of Medical Humanities, School of Medicine, East Carolina University, Greenville, North Carolina. She is one of the editors of the second edition of *The Encyclopedia of Bioethics*.

Drew Leder is associate professor of philosophy, Loyola College in Maryland, Baltimore, Maryland. For the past two years he has been teaching philosophy to inmates of the Maryland State Penitentiary, a maximum-security prison, as part of the federal Pell Grant Program. He and his inmate-students are working on a book together.

Al Miles is coordinator of hospital ministry for Interfaith Ministries of Hawaii at the Queen's Medical Center in Honolulu. He is an ordained Church of God minister and lectures widely on the subject of caring for families who suffer the critical illness or death of a loved one.

Richard L. Morgan is a retired minister of the Presbyterian Church (USA) and a volunteer chaplain at Caldwell Memorial Hospital, Lenoir, North Carolina. His most recent book, *From Grim to Green Pastures: Meditations for the Sick and Their Caregivers* (Upper Room Books, 1994), is based on the journal he kept during his illness and recovery.

Elie Wiesel is Andrew W. Mellon Professor in the Humanities, University Professor, and professor of religious studies, Boston University. He was interned—with his family—in Auschwitz, where his mother and youngest sister died. Three months after he was awarded the Nobel Peace Prize, he founded the Elie Wiesel Foundation for Humanity; its mission is to advance the cause of human rights and peace.

Ernlé W. D. Young is clinical professor of medicine and pediatrics (ethics), Stanford University School of Medicine, Stanford, and codirector of Stanford University Center for Biomedical Ethics, Palo Alto, California. He is currently working on a book, *Faith, Reason, and Bioethics*, to be published by Concordia Press.

INITIAL COMMENT

On Violence and on Listening

PHILOSOPHER PAUL RICOEUR once called violence “history’s dirty secret,” and any number of political thinkers have talked about the invention of politics as a means of reducing the overt violence that would otherwise characterize the human jungle, as it does when political order breaks down. If violence is so pervasive a theme in human affairs, a journal devoted to health, faith, and ethics would do an injustice *not* to inquire into the topic.

The interviewer of writer Elie Wiesel opens by announcing that in that conversation “we are going to focus not on the violence of groups—nation against nation, for example—but on the violence of individuals: physician against patient, husband against wife, parent against child, clergy against women or boys.” From an almost overpowering lead article on the experience of rape, a reader might gain the impression that the focus is to be the violence of men against women. Philosopher Susan J. Brison has a searing account in the form of autobiography (the genre she insists has been overlooked in studies of rape) that sharpens the focus, making it memorable if not simply unforgettable. For a moment, it would seem, the journal’s concentration on health, *faith*, and ethics seems to be slighted in her account: God shows up only negatively, in the chatter of fools who misheard her story or misread theistic traditions.

Immediately, however, having heard Brison, David and Marlyne Cain tease out as many biblical

and theological themes as one is likely to hear from a pulpit in a month or even a season of Sundays. Their comment on biblical texts involving Job and the foolish friends who would comfort him are only part of their succinct but rich treatment of spirituality. They define this in theologian Nancy Ramsey’s terms as “a sense of meaning and the possibility for life that is larger than one’s own efforts.” Writers C. S. Lewis and Elie Wiesel and ethicists Sharon Welch and Karen Lebacqz add contemporary flavor just as they adduce themes from Genesis and Jesus and from Paul’s “interim ethics.”

In another article the violence done to women gets the “health, faith, and ethics” treatment. This is Loretta M. Kopelman’s piece on female circumcision/genital mutilation. It is hard to think of many more urgent or basic ethics topics than hers on “ethical relativism” as it affects dehumanizing but religiously based practices in other cultures. The romantic notion that all other religious cultures should be appreciated and left alone, on one hand, and the imperialist notion that superior cultures should impose themselves on those they perceive to be inferior, on the other, collide and set up a tension. Kopelman finds that people from different parts of the world do share common goals like promoting health and stopping oppression and that these shared goals can be used to assess practices like female circumcision/genital mutilation.

The already mentioned interview with Elie Wiesel moves from the theme of violence done to women by including women in the world of those who have been victimized by modern totalitarianisms and perpetrators of genocide. The Nobel-prize author, like the Cains, begins with Job but soon brings up Jeremiah in an interplay that again presses the preoccupation with faith that distinguishes the Park Ridge Center and this, its journal. Note that Wiesel cannot be drawn into formal analysis of what demons or madresses drive the perpetrators. His whole vocation has been to treat the theme of violence by listening to the victims, the survivors, or by telling the stories of those who were killed.

In Case Stories, we listen in on three pastors or chaplains who, like Brison, speak autobiographically. They talk of the powerlessness they felt in the presence of disease and the violence that comes with certain aspects of modern medicine. They also wrestle with interpretations of their powerlessness in Scripture and from the mouths of other ministers, friends, visitors. Richard L. Morgan, Al Miles, and Richard E. Koenig eloquently demonstrate that being a member of the cloth does not mean that one is armed against the violence to body and spirit done when one is stripped of clothes and defenses and most explanations in the time of serious illness.

And to remind ourselves and readers that violence for most people is experienced at the end of a

gun barrel, we offer two articles on such violence. Marius L. Bressoud Jr. faces up to the ethical questions relating to "aggressive euthanasia" by reference to a wartime experience in which he was its agent. And Drew Leder lets us eavesdrop on the world of prisoners who confess that they have drawn power and identity from the possession and use of guns. There is no doubt about the implications for faith in their discussions; they bring it up explicitly.

But this issue of *Second Opinion* is not simply on violence, meaning violence of the sort that turns some of us squeamish folks away from the sight of blood and cruelty on television or movie screens. It is just as much about listening. Almost all the autobiographical authors complain that they were unheard. They met denial, willful misinterpretation, rejection, ignorance, and even acts of being simply ignored. Meanwhile our contributors who write about other people in several cases notice that little listening goes on, but that listening is a crucial act for those in therapy and for those who wish to keep alive the humanizing ventures that must be attended to in this violent world.

Martin E. Marty



Night in Spain.

Gouache painting by Marion Greenwood, 1940. 14 x 19 inches.

Collection of Madison Art Center, Madison, Wisconsin. Bequest of Dr. and Mrs. Rudolph Langer.

Surviving Sexual Violence

Susan J. Brison

ON JULY 4, 1990, AT 10:30 IN THE MORNING, I WENT for a walk along a peaceful-looking country road in a village outside Grenoble, France. It was a gorgeous day, and I didn't envy my husband, Tom, who had to stay inside and work on a manuscript with a French colleague of his. I sang to myself as I set out, stopping to pet a goat and pick a few wild strawberries along the way. About an hour and a half later, I was lying face down in a muddy creek bed at the bottom of a dark ravine, struggling to stay alive. I had been grabbed from behind, pulled into the bushes, beaten, and sexually assaulted. Feeling absolutely helpless and entirely at my assailant's mercy, I talked to him, calling him "sir." I tried to appeal to his humanity, and when that failed, I addressed myself to his self-interest. He called me a whore and told me to shut up. Although I had said I'd do whatever he wanted, as the sexual assault began I instinctively fought back, which so enraged my attacker that he strangled me until I lost con-

sciousness. When I awoke, I was being dragged by my feet down into the ravine. I had often, while dreaming, thought I was awake, but now I was awake and convinced I was having a nightmare. But it was no dream. After ordering me, in a gruff, gestapo-like voice, to get on my hands and knees, my assailant strangled me again. I wish I could convey the horror of losing consciousness while my animal instincts desperately fought the effects of strangulation. This time I was sure I was dying. But I revived, just in time to see him lunging toward me with a rock. He smashed it into my forehead, knocking me out, and eventually, after another strangulation attempt, he left me for dead.

After my assailant left, I managed to climb out of the ravine, and I was rescued by a farmer who called the police, a doctor, and an ambulance. I was taken to emergency at the Grenoble hospital, where I underwent neurological tests, X rays, blood tests, and a gynecological exam. Leaves and twigs were taken from my hair for evidence, my fingernails were scraped, and my mouth was swabbed for samples. I had multiple head injuries, my eyes were swollen shut, and I had a fractured trachea which made breathing difficult. I was not permitted to

Susan J. Brison is assistant professor of philosophy, Dartmouth College, Hanover, New Hampshire.

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drink or eat anything for the first 30 hours, though Tom, who never left my side, was allowed to dab my blood-encrusted lips with a wet towel. The next day, I was transferred out of emergency and into my own room. But I could not be left alone even for a few minutes. I was terrified that my assailant would find me and finish the job. When someone later brought in the local paper with a story about my attack, I was greatly relieved that it referred to me as *Mlle M.R.* and didn't mention that I was an American. Even by the time I left the hospital, 11 days later, I was so concerned my assailant might track me down that I put only my lawyer's address on the hospital records.

Although fears for my safety may have initially explained why I wanted to remain anonymous, by that time my assailant had been apprehended, indicted for rape and attempted murder, and incarcerated without possibility of bail. Still, I didn't want people to know that I had been sexually assaulted. I don't know whether this was because I could still hardly believe it myself, because keeping this information confidential was one of the few ways I could feel in control of my life, or because, in spite of my conviction that I had done nothing wrong, I felt ashamed.

When I started telling people about the attack, I said simply that I was the victim of an attempted murder. People typically asked, in horror, "What was the motivation? Were you mugged?" and when I replied "No, it started as a sexual assault," most inquirers were satisfied with that as an explanation of why some man wanted to murder me. I would

have thought that a murder attempt *plus* a sexual assault would require more, not less, of an explanation than a murder attempt by itself. (After all, there are *two* criminal acts to explain here.)

One reason sexual violence is taken for granted by many is that it is so very prevalent. The FBI, notorious for underestimating the frequency of sex

crimes, notes that a rape occurs in the U.S. on an average of every six minutes (FBI 1989:6). But this figure covers only the reported cases of rape, and some researchers claim that only about 10 percent of all rapes get reported.¹ Every 15 seconds, a woman is beaten.² The everydayness of sexual violence, as evidenced by these mind-numbing statistics, leads many to think that male violence against women is natural, a given, something not in need of explanation, and not amenable to change. And yet, through some extraordinary mental gymnastics, while most people take sexual violence for granted, they simultaneously manage to deny that it really exists—or,

rather, that it could happen to them. We continue to think that we—and the women we love—are immune to it, provided, that is, that we don't do anything "foolish." How many of us have swallowed the potentially lethal lie, "If you don't do anything wrong, if you're just careful enough, you'll be safe"? How many of us have believed its damaging, victim-blaming corollary: "If you are attacked, it's because *you* did something wrong"? These are lies, and in telling my story I hope to expose them, as well as to help bridge the gap between those of us who

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have been victimized and those who have not.

In my efforts to tell the victim's story—my story, our story—I've been inspired and instructed not only by feminist philosophers who have refused to accept the dichotomy between the personal and the political but also by critical race theorists like Patricia Williams, Mari Matsuda, and Charles Lawrence, who have incorporated first-person narrative accounts into their discussions of the law. In writing about hate speech, they have argued persuasively that one cannot do justice to the issues involved in debates about restrictions on speech without listening to the victims' stories.³ In describing the effects of racial harassment on victims, they have departed from the academic convention of speaking in the impersonal, "universal" voice and related incidents they themselves experienced. In her groundbreaking book *The Alchemy of Race and Rights*, Williams describes how it felt to learn about her great-great-grandmother who was purchased at age 11 by a slaveowner who raped and impregnated her the following year (Williams 1991). And in describing instances of everyday racism she herself has lived through, she gives us imaginative access to what it's like to be the victim of racial discrimination. Some may consider such first-person accounts in academic writing to be self-indulgent, but I consider them a welcome antidote to the arrogance of those who write in a magisterial voice that in the guise of universality silences those who most need to be heard.

Philosophers are far behind legal theorists in acknowledging the need for a diversity of voices. We are trained to write in an abstract, universal voice and to shun first-person narratives as biased and inappropriate for academic discourse. Some topics, however, such as the impact of racial and sexual violence on victims, cannot even be broached unless those affected by such crimes can tell of their experiences in their own words.

One of the very few articles written by philosophers on violence against women is Ross Harrison's

(1986) "Rape: A Case Study in Political Philosophy."⁴ In this article Harrison argues that not only do utilitarians need to assess the harmfulness of rape in order to decide whether the harm to the victim outweighs the benefit to the rapist, but even using a rights-based approach to criminal justice we need to be able to assess the benefits and harms involved in criminalizing and punishing violent acts like rape. He points out the peculiar difficulty most of us have in imagining the pleasure a rapist gets out of an assault, but, he asserts confidently, "There is no problem imagining what it is like to be a victim" (Harrison 1986:51). To his credit, he acknowledges the importance of gaining imaginative access to others' experience. But imagining what it is like to be a rape victim is no simple matter, since much of what a victim goes through is unimaginable. Still, it is essential to try to convey it. Unwittingly further illustrating the need for the victim's perspective, Harrison writes, "What principally distinguishes rape from normal sexual activity is the consent of the raped woman" (Harrison 1986:52). There is no parallel to this in the case of other crimes, like theft or murder. Try "What principally distinguishes theft from normal gift-giving is the consent of the person stolen from." We don't think of theft as "gift-giving minus consent." We don't think of murder as "assisted suicide minus consent." Why not? In the latter case, it could be because assisted suicide is relatively rare (even compared with murder), and so it's odd to use it as the more familiar thing to which we are analogizing. But in the former case, gift-giving is presumably more prevalent than theft (at least in academic circles), and yet it still sounds odd to explicate theft in terms of gift-giving minus consent. In the cases of both theft and murder, the notion of violation seems built into our conceptions of the physical acts constituting the crimes, so it is inconceivable that one could consent to the act in question. Why is it so easy for a philosopher such as Harrison to think of rape, however, as "normal sexual activity minus consent"?

This may be because the nature of the violation in the case of rape hasn't been so obvious. Witness the phenomenon of rape jokes, the prevalence of pornography glorifying rape, the common attitude that, in the case of women, "no" means "yes," that women really want it.⁵

Since I was assaulted by a stranger, in a "safe" place, and was so visibly injured when I encountered the police and medical personnel, I was, throughout my hospitalization and my dealings with the police, spared the insult, suffered by so many rape victims, of not being believed or of being said to have asked for the attack. However, it became clear to me as I gave my deposition from my hospital bed that this would still be an issue in my assailant's trial. During my deposition, I recalled being on the verge of giving up my struggle to live when I was galvanized by a sudden, piercing image of Tom's future pain on finding my corpse in that ravine. At this point in my deposition, I paused, glanced over at the police officer who was typing the transcript, and asked whether it was appropriate to include this image of my husband in my recounting of the facts. The *gendarme* replied that it definitely was and that it was a very good thing I mentioned my husband, since my assailant, who had confessed to the sexual assault, was claiming I had provoked it. As serious as the occasion was, and as much as it hurt to laugh, I couldn't help it—the suggestion was so ludicrous. Could it have been those baggy Gap jeans I was wearing that morning? Or was it the heavy sweatshirt? My maddeningly seductive jogging shoes? Or was it simply my walking along minding my own business that had provoked his murderous rage?

After I completed my deposition, which lasted eight hours, the police officer asked me to read and sign the transcript he'd typed to certify that it was accurate. I was surprised to see that it began with the words "*Comme je suis sportive*"—"Since I am athletic"—added by the police to explain to the court just what had possessed me to go for a walk by myself that fine morning. I was too exhausted at this

point to protest "no, I'm not an athlete, I'm a philosophy professor," and I figured the officer knew what he was doing, so I let it stand. I retained a lawyer and met him along with the investigating magistrate when I gave my second deposition toward the end of my hospitalization. Although what had occurred was officially a crime against the state, not against me, I was advised to pursue a civil suit in order to recover unreimbursed medical expenses, and, in any case, I needed an advocate to explain the French legal system to me. I was told that since this was an "easy" case, the trial would occur within a year. In fact, the trial took place two and a half years after the assault because of the delaying tactics of my assailant's lawyer, who was trying to get him off on an insanity defense. According to Article 64 of the French criminal code, if the defendant is determined to have been insane at the time, then, legally, there was "*ni crime, ni délit*"—neither crime nor offense. The jury, however, did not accept the insanity plea and found my assailant guilty of rape and attempted murder, sentencing him to 10 years in prison.

As things turned out, my experience with the criminal justice system was better than that of most sexual assault victims. I did, however, occasionally get glimpses of the humiliating insensitivity victims routinely endure. Before I could be released from the hospital, for example, I had to undergo a second forensic examination at a different hospital. I was taken in a wheelchair out to a hospital van, driven to another hospital, taken to an office where there were no receptionists and where I was greeted by two male doctors I had never seen before. When they told me to take off my clothes and stand in the middle of the room, I refused. I had to ask for a hospital gown to put on. For about an hour the two of them went over me like a piece of meat, calling out measurements of bruises and other assessments of damage, as if they were performing an autopsy. This was just the first of many incidents in which I felt as if I was experiencing things posthumously. When

the inconceivable happens, one starts to doubt even the most mundane, realistic perceptions. Perhaps I'm not really here, I thought, perhaps I did die in that ravine. The line between life and death, once so clear and sustaining, now seemed carelessly drawn and easily erased.

For the first several months after my attack, I led a spectral existence, not quite sure whether I had died and the world was going on without me, or whether I was alive but in a totally alien world. Tom and I returned to the States, and I continued to convalesce, but I felt as though I'd somehow outlived myself. I sat in our apartment and stared outside for hours, through the blur of a detached vitreous, feeling like Robert Lowell's newly widowed mother, described in his poem "For Sale" as mooning in a window "as if she had stayed on a train / one stop past her destination" (Lowell 1977:82).

My sense of unreality was fed by the massive denial of those around me—a reaction I learned is an almost universal response to rape. Where the facts would appear to be incontrovertible, denial takes the shape of attempts to explain the assault in ways that leave the observers' worldview unscathed. Even those who are able to acknowledge the existence of violence try to protect themselves from the realization that the world in which it occurs is their world, and so they find it hard to identify with the victim. They cannot allow themselves to imagine the victim's shattered life, or else their illusions about their own safety and control over their lives might begin to crumble. The most well-meaning individuals, caught up in the

myth of their own immunity, can inadvertently add to the victim's suffering by suggesting that the attack was avoidable or somehow her fault. One victims' assistance coordinator, whom I had phoned for legal advice, stressed that she herself had never been a victim and said that I would benefit from the experience by learning not to be so trusting of people and to take basic safety precautions like not going out alone late at night. She didn't pause long enough during her lecture for me to point out that I was attacked suddenly, from behind, in broad daylight.

We are not taught to empathize with victims. In crime novels and detective films, it is the villain, or the one who solves the murder mystery, who attracts our attention; the victim, a merely passive pretext for our entertainment, is conveniently disposed of—and forgotten—early on. We identify with the agents' strength and skill, for good or evil, and join the victim, if at all, only in our nightmares. Though one might say, as did Clarence Thomas, looking at convicted criminals on their way to jail, "but for the grace of God, there go I,"⁶ a victim's fate

prompts an almost instinctive "it could never happen to me." This may explain why there is in our criminal justice system so little concern for justice for victims. Unlike their assailants, who have special constitutionally protected rights *qua* defendants, victims have no rights *qua* victims. They have no right to a speedy trial or to compensation for damages (though this has been changing in recent years) or to privacy (*vis à vis* the press). As a result of their

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victimization, they often lose their jobs, their homes, their spouses—in addition to losing a great deal of money, time, sleep, self-esteem, and peace of mind. The rights to “life, liberty, and the pursuit of happiness,” possessed in the abstract by all of us, are of little use to victims who can lose years of their lives, the freedom to move about in the world without debilitating fear, and any hope of returning to the pleasures of life as they once knew it.

People also fail to recognize that if a victim could not have anticipated an attack, she can have no assurance that she will be able to avoid one in the future. More to reassure themselves than to comfort the victim, some deny that such a thing could happen again. One friend, succumbing to the gambler’s fallacy, pointed out that my having had such extraordinary bad luck meant that the odds of my being attacked again were now quite slim (as if fate, though not completely benign, would surely give me a break now, perhaps in the interest of fairness). Others thought it would be most comforting to pretend nothing had happened. The first card I received from my mother, while I was still in the hospital, made no mention of the attack or of my pain and featured the “bluebird of happiness,” sent to keep me ever cheerful. The second had an illustration of a bright, summery scene with the greeting: “Isn’t the sun nice? Isn’t the wind nice? Isn’t everything nice?” Weeks passed before I learned what I should have been able to guess—that after she and my father received Tom’s first call from the hospital, they held each other and sobbed. They didn’t want to burden me with their

pain—a pain which I now realize must have been greater than my own.

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more than a blip on the graph of God’s benevolence—a necessary, fleeting evil, there to make possible an even greater show of good. An aunt with whom I have been close since childhood did not write or call at all until three months after the attack, and then sent a belated birthday card with a note saying that she was sorry to hear about my “horrible experience” but pleased to think that as a result I “will become stronger and will be able to help so many people. A real blessing from above for sure.” Such attempts at a theodicy discounted the horror I had to endure. But I learned that everyone needs to try to

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make sense, however inadequately, of such senseless violence. I watched my own seesawing attempts to find something for which to be grateful, something to redeem the unmitigated awfulness: I was glad I didn’t have to reproach myself (or endure others’ reproaches) for having done something careless, but I wished I had done something I could consider reckless so that I could simply refrain from doing it in the future. I was glad I did not yet have a child, who would have to grow up with the knowledge that even the protector could not be protected, but I felt an inexpressible loss when I recalled how much Tom and I had wanted a baby and how joyful were our attempts to conceive. For nearly three years after the assault, it was difficult to imagine getting preg-

nant, because it was so hard to let even my husband near me, and because I thought it would be harder still to let a child leave my side.

From this litany of complaints, it might be gathered that I was the recipient of constant, if misguided, attempts at consolation during the first few months of my recovery. This was not the case. It seemed to me that the half-life of most people's concern was less than that of the sleeping pills I took to ward off flashbacks and nightmares—just long enough to allow the construction of a comforting illusion that lulls the shock to sleep. During the first few months after my assault, most of the aunts, uncles, cousins, and friends of the family notified by my parents almost immediately after the attack didn't phone, write, or even send a get-well card, in spite of my extended hospital stay. These are all caring, decent people who would have sent wishes for a speedy recovery if I'd had, say, an appendectomy. Their early lack of response was so striking that I wondered whether it was the result of self-protective denial, a reluctance to mention something so unspeakable, or a symptom of our society's widespread emotional illiteracy that prevents most people from conveying any feeling that can't be expressed in a Hallmark card.

In the case of rape, the intersection of multiple taboos—against talking openly about trauma, about violence, about sex—causes conversational gridlock, paralyzing the would-be supporter. We lack the vocabulary for expressing appropriate concern, and we have no social conventions to ease the awkwardness. As the philosopher Ronald de Sousa has argued, it is important to grasp paradigm scenarios in early childhood in order to learn appropriate emotional responses to situations (1987). But we do not learn—early or later in life—how to react to a rape. What typically results from this ignorance is bewilderment on the part of victims and silence on the part of others, often the result of misguided caution. When, on entering the angry phase of my recovery period, I railed at my parents “Why haven't my rel-

atives called or written? Why hasn't my own brother phoned?” they replied, “They all expressed their concern to us, but they didn't want to remind you of what happened.” Didn't they realize I thought about the attack every minute of every day and that their inability to respond made me feel as though I had, in fact, died and no one had bothered to come to the funeral?

For the next several months, I felt angry, scared, and helpless, and I wished I could blame myself for what had happened so that I would feel less vulnerable, more in control of my life. Those who haven't been sexually violated may have difficulty understanding why women who survive assault often blame themselves, and may wrongly attribute it to a sex-linked trait of masochism or lack of self-esteem. They don't know that it can be less painful to believe that you did something blameworthy than it is to think that you live in a world where you can be attacked at any time, in any place, simply because you are a woman. It is hard to go on after an attack that is both random—and thus completely unpredictable—and not random, that is, a crime of hatred toward the group to which you happen to belong. If I hadn't been the one who was attacked on that road in France, it would have been the next woman to come along. But had my husband walked down that road instead, he would have been safe.

Although I didn't blame myself for the attack, neither could I blame my attacker. Tom wanted to kill him, but I, like other rape victims I came to know, found it almost impossible to get angry with my assailant. I think the terror I still felt precluded the appropriate angry response. It may be that experiencing anger toward an attacker requires imagining oneself in proximity to him, a prospect too frightening for a victim in the early stages of recovery to conjure up. As Aristotle observed in the *Rhetoric*, Book 1, “no one grows angry with a person on whom there is no prospect of taking vengeance, and we feel comparatively little anger, or none at all,

with those who are much our superiors in power" (Barnes 1984:2181–82).⁷ The anger was still there, but it got directed toward safer targets: my family and closest friends. My anger spread, giving me painful shooting signs that I was coming back to life. I could not accept what had happened to me. What was I supposed to do now? How could everyone else carry on with their lives when women were dying? How could Tom go on teaching his classes, seeing students, chatting with colleagues . . . and why should he be able to walk down the street when I couldn't?

The incompatibility of fear of my assailant and appropriate anger toward him became most apparent after I began taking a women's self-defense class. It became clear that the way to break out of the double bind of self-blame versus powerlessness was through empowerment—physical as well as political. Learning to fight back is a crucial part of this process, not only because it enables us to experience justified, healing rage, but also because, as philosopher Iris Young has observed in her essay "Throwing Like a Girl," "women in sexist society are physically handicapped," moving about hesitantly, fearfully, in a constricted living space, routinely underestimating what strength we actually have (Young 1990:153). We have to learn to feel entitled to occupy space, to defend ourselves. The hardest thing for most of the women in my self-defense class to do was simply to yell "No!" Women have been taught not to fight back when being attacked, to rely instead on placating or pleading with one's assailant—strategies that researchers have found to be least effective in resisting rape (Bart and O'Brien 1984).

The instructor of the class, a survivor herself, helped me through the difficult first sessions, through the flashbacks and the fear, and showed me I could be tougher than ever. As I was leaving after one session, I saw a student arrive for the next class—with a guide dog. I was furious that, in addition to everything else this woman had to struggle

with, she had to worry about being raped. I thought I understood something of her fear since I felt, for the first time in my life, like I had a perceptual deficit—not my blurred vision from a detached vitreous but rather the more hazardous lack of eyes in the back of my head. I tried to compensate for this on my walks by looking over my shoulder a lot and punctuating my purposeful, straight-ahead stride with an occasional pirouette, which must have made me look more whimsical than terrified.

The confidence I gained from learning how to fight back effectively not only enabled me to walk down the street again. It gave me back my life. But it was a changed life. A paradoxical life. I began to feel stronger than ever before but more vulnerable—more determined to fight to change the world but in need of several naps a day. News that friends found distressing in a less visceral way—the trials of the defendants in the Central Park jogger case, the controversy over *American Psycho*, the Gulf War, the Kennedy rape case, the Tyson trial, the fatal stabbing of law professor Mary Jo Frug near Harvard Square, the ax murders of two women graduate students at Dartmouth College—triggered debilitating flashbacks in me. Unlike survivors of wars or earthquakes, who inhabit a common shattered world, rape victims face the cataclysmic destruction of their world alone, surrounded by people who find it hard to understand what's so distressing. I realized that I exhibited every symptom of post-traumatic stress disorder—dissociation, flashbacks, hypervigilance, exaggerated startle response, sleep disorders, inability to concentrate, diminished interest in significant activities, and a sense of a foreshortened future.⁸ I could understand why children exposed to urban violence have such trouble envisioning their futures. Although I had always been career-oriented, always planning for my future, I could no longer imagine how I would get through each day, let alone what I might be doing in a year's time. I didn't think I would ever write or teach philosophy again.

The American Psychiatric Association's *Diag-*

nostic and Statistical Manual of Mental Disorders defines post-traumatic stress disorder, in part, as the result of “an event that is outside the range of usual human experience” (APA 1987:247). Because the trauma is, to most people, inconceivable, it’s also unspeakable. Even when I managed to find the words—and the strength—to describe my ordeal, it was hard for others to hear about it. They would have preferred me just to “buck up,” as one friend urged me to do. But it’s essential to talk about it, again and again. It’s a way of remastering the trauma, although it can be retraumatizing when people refuse to listen. In my case, each time someone failed to respond, I felt as though I were alone again in the ravine, dying, screaming. And still no one could hear me. Or, worse, they heard me but refused to help.

I now know that they were trying to help but that recovering from trauma takes time, patience, and, most of all, determination on the part of the survivor. After about six months, I began to be able to take more responsibility for my own recovery and stopped expecting others to pull me through. I entered the final stage of my recovery, a period of gradual acceptance and integration of what had happened. I joined a rape survivors’ support group, I got a great deal of therapy, and I became involved in political activities, such as promoting the Violence against Women Act, currently before Congress.⁹ Gradually, I was able to get back to work.

When I resumed teaching at Dartmouth in the fall of 1991, the first student who came to see me in my office during freshman orientation week told me that she had been raped. The following spring four Dartmouth students reported sexual assaults to the local police. In the aftermath of these reports, the women students on my campus have been told to use their heads, lock their doors, not go out after dark without a male escort. They have been advised: just don’t do anything stupid.

Although colleges are eager to “protect” women by limiting their freedom of movement or

providing them with male escorts, they continue to be reluctant to teach women to protect themselves. After months of lobbying the administration at my college, we were able to convince them to offer a women’s self-defense and rape prevention course. It was offered in the winter of 1992 as a physical education course, and nearly 100 students and employees signed up for it. Shortly after the course began, I was informed that the women students were not going to be allowed to get P.E. credit for it, since the administration had determined that it discriminated against men. I was told that granting credit for the course was in violation of Title IX, which prohibits sex discrimination in education programs receiving federal funding—even though granting credit to men for being on the football team was not, even though Title IX law makes an explicit exception for P.E. classes involving substantial bodily contact, and even though every term the college offers several martial arts courses, for credit, that are open to men, geared to men’s physiques and needs, and taken predominantly by men. I was told by an administrator that, even if Title IX permitted it, offering a women’s self-defense course for credit violated “the College’s non-discrimination clause—a clause which, I hope, all reasonable men and women support as good policy.” The implication that I was not a “reasonable woman” didn’t sit well with me as a philosopher, so I wrote a letter to the appropriate administrative committee criticizing my college’s position that single-sex sports, male-only fraternities, female-only sororities, and pregnancy leave policies are not discriminatory, in any invidious sense, while a women’s self-defense class is. The administration has finally agreed to grant P.E. credit for the course, but shortly after that battle was over, I read in the *New York Times* that “a rape prevention ride service offered to women in the city of Madison and on the University of Wisconsin campus may lose its university financing because it discriminates against men” (19 April 1992, p. 36). The dean of students at Wisconsin said that this group—

the Women's Transit Authority—which has been providing free nighttime rides to women students for 19 years—must change its policy to allow male drivers and passengers. These are, in my view, examples of the application of what legal scholar Catharine MacKinnon refers to as “the stupid theory of equality.”¹⁰ To argue that rape prevention policies for women discriminate against men is like arguing that money spent making university buildings more accessible to disabled persons discriminates against those able-bodied persons who do not benefit from these improvements.¹¹

Sexual violence victimizes not only those women who are directly attacked but *all* women. The fear of rape has long functioned to keep women in their place. Whether or not one agrees with the claims of those, like Susan Brownmiller (1975), who argue that rape is a means by which *all* men keep *all* women subordinate, the fact that all women's lives are restricted by sexual violence is indisputable. The authors of *The Female Fear*, Margaret Gordon and Stephanie Riger, cite studies substantiating what every woman already knows—that the fear of rape prevents women from enjoying what men consider their birthright. Fifty percent of women never use public transportation after dark because of fear of rape. Women are eight times more likely than men to avoid walking in their own neighborhoods after dark, for the same reason (Gordon and Riger 1991). In the seminar I taught at Dartmouth on violence against women, the men in the class were stunned by the extent to which the women in the class took precautions against assault

every day—locking doors and windows, checking the back seat of the car, not walking alone at night, looking in closets on returning home. And this is at a “safe,” rural New England campus.

Although women still have their work and leisure opportunities unfairly restricted by their relative lack of safety, paternalistic legislation excluding women from some of the “riskier” forms of employment (for example, bartending¹²) has, thankfully, disappeared, except, that is, in the military. We are still debating whether women should be permitted to engage in combat, and the latest rationale for keeping women out of battle is that they are more vulnerable than men to sexual violence. Those wanting to limit women's role in the military are now using the reported indecent assaults on the two female American prisoners of war in Iraq as evidence for women's unsuitability for combat.¹³ One might as well argue that the fact that women are much more likely than men to be sexually

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assaulted on college campuses is evidence that women are not suited to postsecondary education. No one, to my knowledge, has proposed returning Ivy League colleges to their former all-male status as a solution to the problem of campus rape. Some have, however, seriously proposed enacting after-dark curfews for women, in spite of the fact that men are the perpetrators of the assaults. This is yet another indication of how natural it still seems to many people to address the problem of sexual violence by curtailing women's lives. The absurdity of this approach becomes apparent once one realizes that a woman can be sexually assaulted anywhere, at

any time—in “safe” places, in broad daylight, even in her own home.

For months after my assault, I was afraid of people finding out about it—afraid of their reactions and of their inability to respond. I was afraid that my professional work would be discredited, that I would be viewed as “biased,” or, even worse, not properly “philosophical.” Now I am no longer afraid of what might happen if I speak out about sexual violence. I’m much more afraid of what *will* continue to happen if I don’t. Sexual violence is a problem of catastrophic proportions—a fact obscured by its mundanity, by its relentless occurrence, by the fact that so many of us have been victims of it. Imagine the moral outrage, the emergency response we would surely mobilize, if all of these everyday assaults occurred at the same time or were restricted to one geographical region? But why should the spatio-temporal coordinates of the vast numbers of sexual assaults be considered morally relevant? From the victim’s point of view, the fact that she is isolated in her rape and her recovery, combined with the ordinariness of the crime that leads to its trivialization, makes the assault and its aftermath even more traumatic.

As devastating as sexual violence is, however, I want to stress that it is possible to survive it, and even to flourish after it, although it doesn’t seem that way at the time. Whenever I see a survivor struggling with the overwhelming anger and sadness, I’m reminded of a sweet, motherly woman in my rape survivors’ support group who sat silently throughout the group’s first meeting. At the end of the hour she finally asked, softly, through tears: “Can anyone tell me if it ever stops hurting?” At the time I had the same question and wasn’t satisfied with any answer. Now I can say, yes, it does stop hurting, at least for longer periods of time. A year ago, I was pleased to discover that I could go for 15 minutes without thinking about my attack. Now I can go for hours at a stretch without a flashback. That’s on a good day. On a bad day, I may still take

to my bed with lead in my veins, unable to find one good reason to go on.

Our group facilitator, Ann Gaulin, told us at that first meeting: “You will never be the same. But you can be better.” I protested that I had lost so much: my security, my self-esteem, my love, and my work. I had been happy with the way things were. How could they ever be better now? As a survivor, she knew how I felt, but she also knew that, as she put it, “When your life is shattered, you’re forced to pick up the pieces, and you have a chance to stop and examine them. You can say ‘I don’t want this one anymore’ or ‘I think I’ll work on that one.’” I have had to give up more than I would ever have chosen to. But I have gained important skills and insights, and I no longer feel tainted by my victimization. Granted, those of us who live through sexual assault aren’t given ticker-tape parades or the keys to our cities, but it’s an honor to be a survivor. Although it’s not exactly the sort of thing I can put on my résumé, it’s the accomplishment of which I’m most proud.

Now, more than two years after the assault, I can acknowledge the good things that have come from the recovery process—the clarity, the confidence, the determination, the many supporters and survivors who have brought meaning back into my world. This is not to say that the attack and its aftermath were, on balance, a good thing or, as one aunt put it, “a real blessing from above.” I would rather not have gone down that road. It’s been hard for me, as a philosopher, to learn the lesson that knowledge isn’t always desirable, that the truth doesn’t always set you free. Sometimes it fills you with incapacitating terror and then uncontrollable rage. But I suppose you should embrace it anyway, for the reason Nietzsche exhorts you to love your enemies: if it doesn’t kill you, it makes you stronger.

People ask me if I’m recovered now, and I reply that it depends on what that means. If they mean “am I back to where I was before the attack?” I have to say, no, and I never will be. I am not the same per-

son who set off, singing, on that sunny Fourth of July in the French countryside. I left her—and her trust, her innocence, her joie de vivre—in a rocky creek bed at the bottom of a ravine. I had to in order to survive. I now understand what a friend described to me as the Jewish custom of giving those who've outlived a brush with death new names. The trauma has changed me forever, and if I insist too often that my friends and family acknowledge it, that's because I'm afraid they don't know who I am.

But if recovery means being able to incorporate this awful knowledge into my life and carry on, then, yes, I'm recovered. I don't wake each day with

a start, thinking "this can't have happened to me!" It happened. I have no guarantee that it won't happen again, although my self-defense classes have given me the confidence to move about in the world and to go for longer and longer walks—with my two dogs. Sometimes I even manage to enjoy myself. And I no longer cringe when I see a woman jogging alone on the country road where I live, though I may still have a slight urge to rush out and protect her, to tell her to come inside where she'll be safe. But I catch myself, like a mother learning to let go, and cheer her on, thinking, may she always be so carefree, so at home in her world. She has every right to be.

NOTES

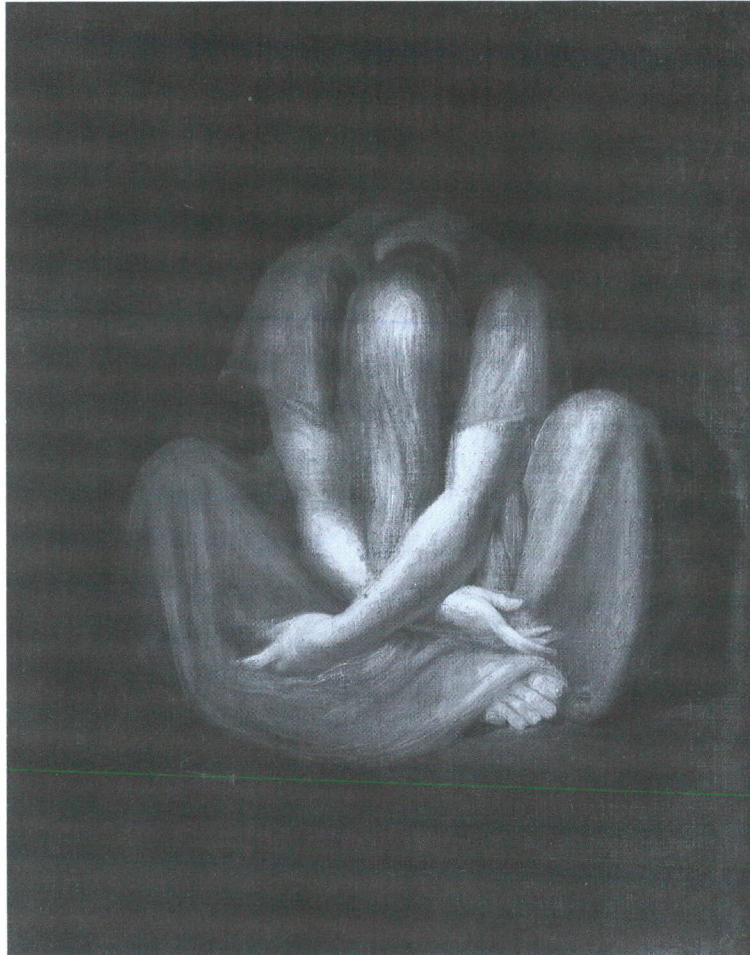
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1. Robin Warshaw notes that "government estimates find that anywhere from three to ten rapes are committed for every one rape reported. And while rapes by strangers are still underreported, rapes by acquaintances are virtually nonreported. Yet, based on intake observations made by staff at various rape counseling centers (where victims come for treatment, but do not have to file police reports), 70-80 percent of all rape crimes are acquaintance rapes" (Warshaw 1988:12).
2. National Coalition against Domestic Violence, fact sheet, in "Report on Proposed Legislation S.15: The Violence against Women Act," p. 9. On file with the Senate Judiciary Committee.
3. See especially Patricia Williams's discussion of the Ujaama House incident in *The Alchemy of Race and Rights* (Williams 1991:110–16), Mari Matsuda, "Public Response to Racist Speech: Considering the Victim's Story" (Matsuda 1989), and Charles Lawrence, "If He Hollers, Let Him Go: Regulating Racist Speech on Campus" (Lawrence 1990).
4. Another, much more perceptive, article is Lois Pineau's (1989) "Date Rape: A Feminist Analysis." In addition, an excellent book on the causes of male violence was written by a scholar trained as a philosopher, Myriam Miedzian (1991). Philosophical discussions of the problem of evil, even recent ones such as that in Nozick 1991, don't mention the massive problem of sexual violence. Even Nell Noddings's *Women and Evil* (1989), which is an "attempt to describe evil from the perspective of women's experience," mentions rape only twice, briefly, and in neither instance from the victim's point of view.
5. As the authors of *The Female Fear* note: "The requirement of proof of the victim's nonconsent is unique to the crime of forcible rape. A robbery victim, for example, is usually not considered as having 'consented' to the crime if he or she hands money over to an assailant (especially if there was use of force or threat of force)" (Gordon and Riger 1991:59).
6. Quoted in the *New York Times*, 13 September 1991, p. A18. Although Judge Thomas made this statement during his confirmation hearings, Justice Thomas's actions while on the Supreme Court have belied his professed empathy with criminal defendants.
7. I thank John Cooper for drawing my attention to this aspect of Aristotle's theory of the emotions.
8. For a clinical description of post-traumatic stress disorder (PTSD), see American Psychiatric Association 1987:247. Excellent discussions of the recovery process undergone by rape survivors can be found in Bard and Sangrey 1986, Benedict 1985, Herman 1992, and Janoff-Bulman 1992. I have also found it very therapeutic to read first-person accounts by rape survivors such as Susan Estrich (1987) and Nancy Ziegenmeyer (1992).
9. The Violence against Women Act, S.11, sponsored by Senator Joseph Biden, D-Delaware, was drafted largely by Victoria Nourse, Special Counsel for Criminal Law, Office of the Senate Judiciary Committee (the Senate passed the act as part of the crime bill, but as of July 1994 the Senate and House had not yet agreed on a compromise bill). I am particularly interested in Title III, which would reclassify gender-motivated assaults as bias crimes. From the victim's perspective this reconceptualization is important. What was most difficult for me to recover from was the knowledge that some man wanted to kill me simply because I am a woman.

10. She characterized a certain theory of equality in this way during the discussion after a Gauss seminar she gave at Princeton University on 9 April 1992.
11. For an illuminating discussion of the ways in which we need to treat different people differently in order to achieve genuine equality see Minow 1990.
12. As recently as 1948, the U.S. Supreme Court upheld a state law prohibiting the licensing of any woman as a bartender (unless she was the wife or daughter of the owner of the establishment where she was applying to work). *Goesaert v. Cleary*, 335 U.S. 464 (1948).
13. *New York Times*, 19 June 1992, p. 1, A13.

REFERENCES

- American Psychiatric Association. 1987. *Diagnostic and Statistical Manual of Mental Disorders*. 3d ed., rev. Washington, D.C.: American Psychiatric Association.
- Bard, Morton, and Dawn Sangrey. 1986. *The Crime Victim's Book*. New York: Brunner/Mazel.
- Barnes, Jonathan, ed. 1984. *The Complete Works of Aristotle*, vol. 2. Princeton: Princeton University Press.
- Bart, Pauline B., and Patricia H. O'Brien. 1984. "Stopping Rape: Effective Avoidance Strategies." *Signs: Journal of Women in Culture and Society* 10, no. 1: 83–101.
- Benedict, Helen. 1985. *Recovery: How to Survive Sexual Assault—for Women, Men, Teenagers, Their Friends and Families*. Garden City, N.Y.: Doubleday.
- Brownmiller, Susan. 1975. *Against Our Will: Men, Women, and Rape*. New York: Bantam.
- de Sousa, Ronald. 1987. *The Rationality of Emotion*. Cambridge, Mass.: MIT Press.
- Estrich, Susan. 1987. *Real Rape*. Cambridge, Mass.: Harvard University Press.
- Federal Bureau of Investigation. 1989. *Uniform Crime Reports for the United States*. Washington, D.C.: U.S. Government Printing Office.
- Gordon, Margaret T., and Stephanie Riger. 1991. *The Female Fear: The Social Cost of Rape*. Chicago: University of Illinois Press.
- Harrison, Ross. 1986. "Rape: A Case Study in Political Philosophy." In *Rape: An Historical and Cultural Enquiry*, ed. Sylvana Tomaselli and Roy Porter, 41–56. New York: Basil Blackwell.
- Herman, Judith Lewis. 1992. *Trauma and Recovery*. New York: Basic Books.
- Janoff-Bulman, Ronnie. 1992. *Shattered Assumptions: Towards a New Psychology of Trauma*. New York: Free Press.
- Lawrence, Charles R., III. 1990. "If He Hollers, Let Him Go: Regulating Racist Speech on Campus." *Duke Law Journal*, 431–83.
- Lowell, Robert. 1977. *Selected Poems*. New York: Farrar, Straus and Giroux.
- Matsuda, Mari. 1989. "Public Response to Racist Speech: Considering the Victim's Story." *Michigan Law Review* 87, no. 8: 2320–81.
- Miedzian, Myriam. 1991. *Boys Will Be Boys: Breaking the Link between Masculinity and Violence*. New York: Doubleday.
- Minow, Martha. 1990. *Making All the Difference: Inclusion, Exclusion, and American Law*. Ithaca, N.Y.: Cornell University Press.
- Noddings, Nell. 1989. *Women and Evil*. Berkeley and Los Angeles: University of California Press.
- Nozick, Robert. 1989. *The Examined Life: Philosophical Meditations*. New York: Touchstone Books.
- Pineau, Lois. 1989. "Date Rape: A Feminist Analysis." *Law and Philosophy* 8:217–43.
- Warshaw, Robin. 1988. *I Never Called It Rape*. New York: Harper and Row.
- Williams, Patricia J. 1991. *The Alchemy of Race and Rights*. Cambridge, Mass.: Harvard University Press.
- Young, Iris Marion. 1990. *Throwing Like a Girl and Other Essays in Feminist Philosophy and Social Theory*. Indianapolis: Indiana University Press.
- Ziegenmeyer, Nancy. 1992. *Taking Back My Life*. New York: Summit Books.



The Silence.

Oil on canvas by Henry Fuseli, ca. 1799–1801.

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The Risk of Hearing Death and Life in a Survivor's Story

Marlyne Cain and David Cain

I. The Risk of Hearing Death

*... worthless physicians are you all. Oh that you would
keep silent, and it would be your wisdom!*

—Job 13:4b–5

FOUR YEARS HAVE PASSED. NOT LONG AT ALL. NOT long in a process of grief. This grief is over death, the death of a loved one, oneself. Susan Brison was left “for dead” in this daylight nightmare. She *was* dead or, rather, was to begin a long, agonizing process of dying and grieving and “movement toward living death.”¹

Brison knows what she is doing and the cost of doing it. She praises writers who have ventured first-person narratives, giving “imaginative access to

Marlyne Cain is an assistant professor at the Medical College of Virginia, Virginia Commonwealth University, Richmond, Virginia, and an ordained minister in the United Church of Christ.

David Cain is Distinguished Professor of Religion, Mary Washington College, Fredericksburg, Virginia, and an ordained minister in the United Church of Christ.

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what it’s like to be the victim.” Her brave account offers some imaginative access to the horrors of sexual assault and attempted murder, helping us realize ways in which they are unimaginable.

This is a testimony of fear injected into the heart of existence, of the ugly irony that gestures capable of expressing love, tenderness, and intimate affirmation of identity are poisoned. Presbyterian minister and teacher of pastoral theology Nancy J. Ramsey articulates this same irony: “The alienation and estrangement of sexual violence are all the more poignant because what is intended as the context for intimacy and care becomes the context of violation, domination and betrayal” (1991:117). Sexuality (however “constructed”) is central to identity; rape is a fundamental attack upon one’s sense of self.²

Nothing emerges more forcefully from Brison’s pages than the death which rape is; and rape, like death, meets dis-ease and avoidance. If rape is a form of death, death is (or is readily perceived as) ultimate loss of control. Brison insightfully identifies the pervasiveness of control. Control keeps reentering her reflections, as when she considers the attitude of many toward “sexual violence”—that “it could [not] happen to them.” As she makes searingly clear,

desire to remain in control contributes to the lie that “[i]f you don’t do anything wrong, if you’re just careful enough, you’ll be safe.” This is analogous to a biblical formulation proffered, modified, denied, and proffered again: If you do what is well-pleasing to the Lord, you will prosper. As Eliphaz, the first of Job’s would-be comforting friends, counsels, “Think now, who that was innocent ever perished? [We do not have to think for long.] Or where were the upright cut off? As I have seen, those who plow iniquity and sow trouble reap the same” (Job 4:7–8).³ Why does this offensive formulation die so hard and come to life again and again? Why, if not because it allows one the illusion of *control*?

Rabbi Harold Kushner makes this point as he recalls the first words spoken to him by parents of a young woman who died suddenly: “You know, Rabbi, we didn’t fast last Yom Kippur” (1981:8). As helpless and hopeless as they are, these words nevertheless bespeak some groping for control, even if in accepting this form of control the parents must assume guilt for their daughter’s death.

A similar sacrifice for the sake of control surfaces in theologian Arthur McGill’s masterful treatment of the parable of “the good Samaritan” (Luke 10:25–37; McGill 1968:94–106). “Who is my neighbor?” (Luke 10:29). Not “anyone in need,” as the parable preached upon so easily admonishes: Shame on that priest and Levite for passing by “on the other side” of the road (Luke 10:31–32), for not stopping to help their needy neighbor who was attacked by thieves. No, for McGill the priest and Levite are essentially as needy as the injured, helpless victim. In Luke, the only *noncandidate* for

“neighbor” is the injured man. The candidates are priest, Levite, Samaritan. Clearly the “neighbor” is the one who performs “excessive love” (1968:98). The neighbor is the Samaritan, and the Samaritan, McGill suggests, is Jesus (1968:105). Only as our utter neediness is met by *this* Samaritan are we capacitated to “Go and do likewise” (Luke 10:37).

Between gratefully going and doing likewise, responsively loving out of one’s neediness because first loved by God (1 John 4:19), and loving out of one’s supposed strength in order to measure up or to court divine favor—between these alternatives, the Christian faith hangs in the balance. But so does control. Would we rather be guilty of walking by with priest and Levite (the implication being that we have the capacity to help) than guilty

of seeing ourselves as essentially needy, lifeless at the side of the road or “in a rocky creek bed at the bottom of a ravine” in need of the ultimate Neighbor?⁴ This would mean admission of the loss or lack of control.

The loss of control in rape is recalled, even repeated, in Brison’s ordeal of forensic examination:

For about an hour the two of them [male doctors] went over me like a piece of meat, calling out measurements of bruises and other assessments of damage, *as if they were performing an autopsy*. (Emphasis added)

Again, loss of control is death. Brison notes, “This was just the first of many incidents in which I felt as if I was experiencing things posthumously.” She reflects, “I didn’t want people to know that I had

Brison experiences vulnerability socially as well as personally. She has been existentially sensitized to worldwide suffering. Every headline is a personal affront. The shift from “my recovery period” to “women” and “we” is healing.

been sexually assaulted.” Both “sexually” and “assaulted” are operative words. “Sexually” exacerbates “assaulted” with ambiguities of intimacy and identity, but assault alone is enough.⁵

Brison wonders why she did not want people to know:

. . . because I could still hardly believe it myself, because keeping this information confidential was one of the few ways I could feel in control of my life, or because, in spite of my conviction that I had done nothing wrong, I felt ashamed.

Underlying all three of these possibilities—shock, silence, shame—is the death of feeling “in control of my life.”⁶ Brison confides:

I wished I had done something I could consider reckless so that I could simply refrain from doing it in the future [and so remain in or, rather, reclaim control].

. . . I wished I could blame myself for what had happened so that I would feel less vulnerable, more in control of my life. . . . it can be less painful to believe that you did something blameworthy than it is to think that you live in a world where you can be attacked at any time, in any place, simply because you are a woman.

Brison shows how the unimaginability of the violence she suffered is attested by avoidance, which effects the additional violence of isolation. Denial on the part of victim or of family and friends may be construed as negative control: “denial takes the shape of attempts to explain the assault in ways that leave the observers’ worldview unscathed”—that is, in ways that leave observers still in apparent control. Observers “cannot allow themselves to imagine the victim’s shattered life, or else their illusions about their own safety and control over their lives might begin to crumble.” They are “caught up in the myth of their own immunity.” To suggest that “the attack

was avoidable or somehow [the victim’s] . . . fault” is the controlling presupposition of Job’s “friends.” Eliphaz claims, “Agree with God, and be at peace; thereby good will come to you. . . . [God] delivers the innocent man; you will be delivered through the cleanness of your hands” (Job 22:21, 30). Control is alive and well, even when reduced to “odds” of recurrence:

[S]ome deny that such a thing could happen again. One friend, succumbing to the gambler’s fallacy, pointed out that my having had such extraordinary bad luck meant that the odds of my being attacked again were now quite slim. . . .

The isolation of adversity haunts the account and its author. One does not know “what to say.” A sincere “I’m sorry” is not so bad. Simply being there in silence, in compassion, isn’t either. Brison wonders if the lack of response of “caring, decent people”

was the result of self-protective denial, a reluctance to mention something so unspeakable, or a symptom of our society’s widespread emotional illiteracy that prevents most people from conveying any feeling that can’t be expressed in a Hallmark card.

We answer, “All of the above.” But reasons one and two may be referred to reason three, articulated acutely by Brison: our society’s widespread emotional illiteracy. The reference to cards is aptly ironic, for what do cards say? “There are no words to tell you how much . . .” “No words can begin to express . . .” “Words cannot convey . . .” Are words at fault—or word-users? Inability to communicate concern reinforces a sense of death: “[relatives’] inability to respond made me feel as though I had, in fact, died and no one had bothered to come to the funeral.” “My kinsfolk and my close friends have failed me . . .” complains Job (Job 19:14).

What Brison says of attempts to comfort reminds us that honesty, openness, and a certain

candor are appropriate, except where other signals are given. Ethicist William F. May calls for *discretio*. In the context of truth telling between physician and patient, May moves not away from but out from “telling the truth” to include consideration of something called “being-true” (1983:142), which means willingness to invest—to risk—oneself in the promise of fidelity: “I’m here with you. No matter what, I’ll be with you; I won’t abandon you.” This is a powerful step toward overcoming “emotional illiteracy.” There is a “how” of speaking as well as a “what.” The former can decisively affect the latter. May draws on J. L. Austin’s influential distinction between “descriptive” and “performative” utterances. If the former *describe* the world, the latter *change* it, as with a performative promise of fidelity: “The fidelity of others will not eliminate the disease [the rape, the attempted murder, the loss of control and identity], but it affects mightily the human context in which the disease runs its course” (1983:143). Or *makes the context human*.

Our concern thus far has been to risk hearing the death which, we have contended, Brison’s experience is. The risk is real yet accompanied by hope that a kind of hearing can contribute to healing. This is what Ramsey has in mind when she employs feminist theologian Nelle Morton’s phrase, “hearing into speech”: “Such hearing evokes life, new life, more authentic life. ‘Hearing into speech’ is an act of nurture authenticating the life of the woman whose victimization robbed her of a sense of self” (1991:116). This is an active, creative hearing, which speaks of caring and is witness to hope.⁷

Brison delineates the plight of the victim. Attempts at comfort often produce more pain, as we have noted and as we stand warned. A quality of hearing has been signaled. Anything less invites Job’s indictment: “worthless physicians are you all.” Those who would maintain control dare not look too unflinchingly upon one who has lost it. Meanwhile, a victim is (can be, ought to be, must be) more than a victim. To hear Brison is to hear death, but in

hearing into speech one hopes to hear more. Brison is determined to find herself anew, to find a new self, to define herself as more than “victim,” to claim control, some control, again.

II. The Risk of Hearing Life

Oh, that I had one to hear me!

—Job 31:35

GRIEF GOES SOMEWHERE. IT FEELS STATIC BUT IS NOT. C. S. Lewis wonders if his grief is going in circles or a spiral and, if a spiral, whether up or down (1961:46).⁸ Lewis reflects:

I thought I could describe a *state*; make a map of sorrow. Sorrow, however, turns out to be not a state but a process. It needs not a map but a history. . . . Grief is like a long valley, a winding valley where any bend may reveal a totally new landscape . . . not every bend does. (1961:47)

Grief “gives life a permanently provisional feeling. . . . What’s wrong with the world to make it so flat, shabby, worn-out looking? Then I remember” (1961:29, 30). This is “the nightmare unreality” (1961:46). Grief goes somewhere, but it does not go away. Grief changes, ceasing to be utterly debilitating; but it abides in the unyielding truth of “never again.”

Susan Brison does not cheat the difference: “I am not the same person who set off, singing.” Her words sting and smart and burn. Perhaps she warrants a new name. She writes that confidence “gained from learning how to fight back effectively . . . gave me back my life.” She speaks of “integration of what had happened.” How does one integrate death into life?⁹ By turning indignation into action. Brison calls her life “changed” and “paradoxical”: changed, for any kind of life on the other side of

death is a different life; paradoxical, because she begins to feel both “stronger” and “more vulnerable.”¹⁰ She experiences this vulnerability socially as well as personally. She has been existentially sensitized to worldwide suffering. Every headline is a personal affront. The shift from “my recovery period” to “women” and “we” is healing.¹¹

This “we” begins to fulfill one of the requirements for what Ramsey calls “spirituality”: “a sense of meaning and the possibility for life that is larger than one’s own efforts” (1991:113). Brison fights for “empowerment—physical as well as political.” She enrolls in a women’s self-defense class. Eventually, she is able to teach a seminar on violence against women. She has found a cause, for a cause has found her. The well-meaning but reality-evading words of a relative—that she “will become stronger and will be able to help so many people”—ironically receive a kind of truth from her determination “to find something for which to be grateful, something to redeem the unmitigated awfulness.” Not so much to *find* as to *do*. The crucial shift is from passive to active. The shift is from passively seeking to find some sense in senseless violence to actively bestowing some sense upon senselessness, from striving to detect meaning already “there,” resident in the suffering, to bringing some meaning *to* (and not out of) the abyss of meaninglessness. Reenter: control.

Is control ever and always enemy? The point must be not to denigrate struggle for empowerment, “remastering the trauma,” taking self-defense classes, owning two dogs. The point must be to commend a kind of control that is humble and open, that knows that priest and Levite are in truth on the same side of the road as the one in evident need. *Open control* is controlling in something like the sense of Paul’s “as though not” (*hos me*):

I mean, brethren, the appointed time has grown very short; from now on, let those who have wives live as though they had none, and those who mourn as though they were not

mourning, and those who rejoice as though they were not rejoicing, and those who buy as though they had no goods, and those who deal with the world as though they had no dealings with it. For the form of this world is passing away. (1 Corinthians 7:29–31)

And let those who can manage some little control in their lives do so “as though not.”¹² Paul’s eye is on the imminence of the end of this age. Our eyes are on our essential neediness and hence on our need to be open to sources of new life, possibility, and sustenance beyond the self, sources that a tightly controlling self can shut out.

Different ways of being in and out of control must be discerned. Identity may depend on one’s ability to be in control of the way or ways in which one is out of control. One can be out of control and in the power of that which is life-destroying. Brison knows. Can one be out of control in the power of the life-enhancing? Are there ways to beware of the former without closing oneself off to the latter? Is open control livable?

There are no ways around death; we have no choice but to risk death, which is, finally, no “risk” at all. Perhaps death is not ultimate estate. Meanwhile, we do seem to be able to choose whether or not to risk life. To risk life is to relax one’s grip on control in at least two ways. One is by way of what child-abuse survivor Heather Ann Ackley Bean (1993:4) calls a “theodicy of lamentation,” speaking death, telling the truth. Another is by way of attentiveness, openness to possibility, hearing life.

Theodicy of lamentation: the phrase is suggestive. *Theology of lamentation* is suggestive enough, but *theodicy* invites a sense that lament itself may be justifying, salutary. Articulation of honest anger, outrage, belongs to lament and leads to a theology (theodicy?) of “protest.” Biblically, lament, anger, and protest are part of the discipline of the life of faith, of beginning to know God and of beginning to know oneself. Job, Psalms, and Lamentations are

among biblical resources for expression of anger and protest, ultimately to God. Talmudic amazement is appropriate: "Were it not written in Scripture, it would be impossible to say it" (quoted in Cain 1993:156; see also 241).

On the authority of his own experience of Holocaust horror, including the horror of divine absence or silence, Elie Wiesel gives these words of outrage and implied protest to Eliezer, a character suffocating, death-walking, between loyalty to the past as betrayal of the present and life in the present as betrayal of the past:

Whoever sees God must die. It is written in the Bible. I had never quite understood that: why should God be allied with death? Why should He want to kill a man who succeeded in seeing Him? Now, everything became clear. God was ashamed. God likes to sleep with twelve-year-old girls. . . . Death is only the guard who protects God, the doorkeeper of the immense brothel that we call the universe. (1962:92-93)

Does talk of protest to, even against, God have any meaning? In wondering about her inability to direct anger toward her assailant, Brison draws on Aristotle: "No one grows angry with a person on whom there is no prospect of taking vengeance, and we feel comparatively little anger, or none at all, with those who are much our superiors in power." Aristotle may be onto something, but healing may entail moving beyond that something. Cain takes his anger at God out on Abel, even though God had invited protest (Genesis 4:6-8). Job defies prudence—and deity. A "theology of protest" aimed at God may be basic to any living life of faith. Rabbi and professor of Judaic studies David Blumenthal soberly and painfully affirms just this in his important work, *Facing the Abusing God: A Theology of Protest*:

In view of the facts of historical and personal abuse, how can one live in faithfulness to

God? . . . Facing God, without flinching, is the task of theology. . . .

Is abusiveness, then, an attribute of God? Is abusiveness a quality without which we cannot understand the ultimate reality that we call God? Yes. . . . (1993:247)

Blumenthal's honesty and courage are vital, not least in relation to an evasion Brison spots: "Some devout relatives were quick to give God all the credit for my survival but none of the blame for what I had to endure."

Job is sensitive to Aristotle's point. He knows he is going for broke. His God is so superior in power that his protest takes form in a certain desperate freedom:

But I would speak to the Almighty, and I desire to argue my case with God. . . . [To his "comforters":] Your maxims are proverbs of ashes, your defenses are defenses of clay. Let me have silence, and I will speak, and let come on me what may. I will take my flesh in my teeth, and put my life in my hand. Behold, he will slay me; I have no hope; yet I will defend my ways to his face. (Job 13:3, 12-15)

Job knows what he is about with the insight of agony. "Let come on me what may," the truth as Job sees and breathes it must be risked. There is hope in God in spite of God. In spite of what appears to be God's way with him, Job braves stirring up divine wrath in hope of engaging divine compassion. To the same point, Blumenthal writes, "One undertakes such a confrontation, I think, only because of the need to speak—independent of how the hearer will hear. Do we need to do that with God? to protest, steadfastly, independent of whether He hears or not? independent of whether He reacts or not? My answer is yes" (1993:201).¹³

What of hearing life as a second way of open control? In response to rape and to external forces

that would cancel life, external forces of donation as well as of domination deserve recognition (May 1983:127). Life is gift as well as burden and task. This is why self-imprisoning control is death and why the death of such control is openness to life.

Sharon D. Welch, who teaches women's studies and religious studies, has authored *A Feminist Ethic of Risk*. One of the many strengths of the book is Welch's sensitivity on different levels to fear of loss of control (1990:29). Another is direct attack on understandings of love as "self-sacrifice," not least in a Christian context. Welch wants "a dance with life," recognition of "the web of life," "work for justice," "solidarity," "social transformation," and "communities of resistance" (1990:159, 160, 162, 179, 180). All of this means a loss of control which is yet not self-sacrifice: "To work with others is not to lose oneself, but first and foremost, it is to find a larger self." Welch affirms that we are "foundationally social beings," relational. Words such as *empowered*, *energizing*, and *enlargement* govern her discussion (1990:162, 164). Welch contends:

The love that heals is far from the spirit of self-sacrifice. . . . People are empowered to work for justice by their love for others and by the love they receive from others. . . . The concept of self-sacrifice is faulty in two fundamental ways. First, the term "sacrifice" is "reviewer-language." . . . Second, what is lost in resistance is precisely *not* the self. (1990:161, 165)

Welch advocates "the relational self"¹⁴ and "empowering interaction." In-coming power as well as out-going power belongs to the dialectical vitality of self.¹⁵ Quest for the wrong kind of control, which we can now call *closed control*, isolating "protection," can stifle it.

We know no recipe for distinguishing between open and closed control. Discernment is requisite but no guarantee. The other side of risking life is risking death. One might speak, with Christian

ethicist Karen Lebacqz, of "appropriate vulnerability." In her striking essay "Appropriate Vulnerability: A Sexual Ethic for Singles," she writes in the context of Genesis creation stories:

The very last line in the creation story in Genesis 2 reads: "And the man and his wife were both naked, and they felt no shame" (Gen. 2:25). In ancient Hebrew, "nakedness" was a metaphor for vulnerability, and "feeling no shame" was a metaphor for appropriateness. . . . We can therefore retranslate the passage as follows: "And the man and his wife experienced appropriate vulnerability." (1993:58)

The word *appropriate* gestures toward the difference between open and closed control.

Suppose someone insightfully observes, "The notion of 'appropriate' and 'inappropriate' vulnerability is somewhat problematic with regard to violent attacks and *could* tend toward shifting some blame to the victim." Yes. And no. Yes: what, then, shall we do? Strive (futilely) to eradicate all vulnerability or recognize that *violent attacks are problematic* with regard to both appropriate and inappropriate vulnerability? No: inappropriate vulnerability means not—say—carelessness but rather closed control; inappropriate vulnerability is quest for invulnerability. This inappropriate vulnerability is the enemy, is death. Appropriate vulnerability is life—sexual, relational, and human.¹⁶

Walker Percy's Will Barrett reflects on what he bluntly calls "the great suck of self" (1980:14). Think of an infant's energetic effort to swallow everything in sight. Rescue from this centrifugal swirl is *decentering*. Decentering is liberating, lightening. May articulates this Christianly in relation to "covenant," wherein not the reality but the ultimacy of suffering and death is denied, where God's power is not "destructive" but "the power of donative love," and where the "covenantal setting frees us from the need to avoid ties to the perishing" (*we*, of

course, are “the perishing,” as May makes explicit [1983:127–28])—or to victims of rape. In light of this covenantal setting, May prescribes “a truly serious-light-hearted medical practice” (1983:128). The phrase is precisely, dialectically right also as a prescription for those who would risk hearing death and life.

Christianly, an inevitable text in this context is a saying attributed to Jesus: “He who finds his life will lose it, and he who loses his life *for my sake* will find it” (Matthew 10:39; emphasis added). “For my sake” relates to our qualification of control as open or closed. Have we earned the right to say, “He or she who seeks closed control of his or her life will lose it, and he or she who opens himself or herself to true life will find it”?

Susan Brison is a survivor of two of the unkindest cuts of all: “it’s an honor to be a survivor. Although it’s not exactly the sort of thing I can put on my résumé, it’s the accomplishment of which I’m most proud.” We think of a colleague who is just now enduring the death to cancer of his beloved wife. At the memorial service, he concluded personal remarks by noting that (and this must be understood in relation to the many honors he has received) “being her husband is what I am most proud of.” Blessed are those whose résumés do not contain their proudest accomplishments, who are not exposed by the realization of another Percy character, Allie: “I made straight A’s and flunked ordinary living” (1980:93).

III. A Survivor’s Story

*Therefore I will not restrain my mouth;
I will speak in the anguish of my spirit;
I will complain in bitterness of my soul.*

—Job 7:11

God made man because he loves stories.

—Elie Wiesel

Story is a potentially rich and evaluative word. *Survivor* is actually both. In some sense, all stories are of survivors; and all survivors have stories. Stories are achievements, little victories of enduring—or reborn—agency.

A survivor’s story may be told in different languages. Do religious languages and imageries seek to make palpable and more human vast and inexorable processes of the cosmos, or are these processes held in place by inexorable intentionality that religious languages and imageries seek to celebrate? Professor of religious studies John Bowker seems to imply the compatibility of these apparent alternatives. He writes in the context of different attempts to understand death:

If you ask, “Why is death happening to me (or to anyone)?” the answer is: because the universe is happening to you; you are an event, a happening, of the universe; you are a child of the stars, as well as of your parents. . . . it is not possible to arrive at life except via the route of death. That means, in turn, that the price which has to be paid for any organization of energy in a universe of this kind is very high indeed. (1991:215–16)

Bowker speaks of “the absolute necessity for death, if there is to be life” and even of “the good services of death” (1991:219, 221). But the language of inexorable process—“there is not death without the consequence of life”—is suddenly also the language

of resurrection, of resurrection which “is not particularly surprising” (1991:229). This is “the way things are.” Yet there is also more personal language: “we who owe God a death are nevertheless enabled to enter into the joy of our Lord” (1991:229). Perhaps religious language, if not privileged and given primary force, will be reductively spent, spilled in the soaking sands of impervious process. Do we have a gracious God to learn to love or loveless forces to learn to live with? Bowker maintains a subtle balance.

The issue is, if one is to risk living an “appropriate vulnerability,” to *what* (*whom?*) is one ultimately vulnerable? Welch risks that “grace is not the manifestation of the divine in our lives, the gift of a separate or foundational being; but . . . grace is all there is or need be of the divine” (1990:175). We choose another risk: the wonder of a God responsible for and suffering the consequences of this kind of world in which all hell can break loose and wastes little time in so doing, a world nonetheless headed for a wedding banquet, headed for this banquet somehow freely, nonmanipulatively, without domination, violence, or rape, through inexorable love.

Job risks speaking and complaining to God. Susan Brison’s quarrel is not with God. Not theodicy, the justification of a loving and generally com-

petent deity given our experience of egregious injustice, suffering, and evil, but what might be called *anthropodicy*, the justification of human beings given that same experience, is at stake for her. She arrives at the burden of anthropodicy on a mid-morning

walk along a French country road. But anthropodicy, if pressed, may lead to the threshold of theodicy. Theodicy is in the background of this attempt to hear but not to answer Susan Brison, who, with courage and determination, has moved beyond an incapacitating quest for answers and has written with her death and life a survivor’s

story. She might say with Job, “Behold, I cry out, ‘Violence!’ but I am not answered; I call aloud, but there is no justice” (Job 19:7).

Bowker wryly reminds us:

. . . all our languages are approximate, corrigible and frequently wrong. Yet . . . it may be that they are approximately wrong about what is nevertheless truly the case. (1991:225)

In various languages, a persistent hope is that vulnerability and engagement in a dialectic of open control will encompass demonic distortions of rape and destruction within health and healing. That hope is sometimes experience.

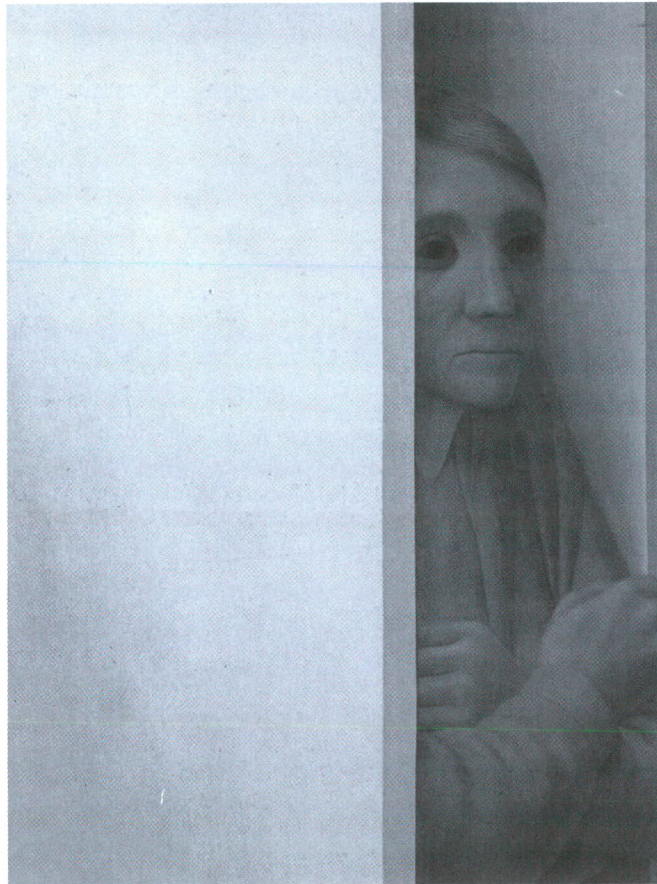
**Nothing emerges more
forcefully from Brison’s
pages than the death
which rape is; and rape,
like death, meets dis-ease
and avoidance.**

NOTES

1. In her close and powerful "feminist hermeneutic" reading of the biblical story of the rape of Tamar, Phyllis Tribble describes Tamar's "movement toward living death. . . . She lives in death" (1984:50, 52).
2. In a litany of loss in the context of "all experiences of sexual violence," Liz Kelly, a research fellow studying child abuse, lists "loss of safety, loss of independence or autonomy, loss of control, loss of confidence and self-esteem, loss of memories, loss of status . . . loss of trust, loss of a positive attitude to sexuality, loss of housing and property, loss of jobs, children and educational opportunities, loss of support networks including relatives and friends, loss of health and, in the most extreme cases, loss of life itself" (1988:189). Not surprisingly, Brison sounds the theme of loss: "I had lost so much: my security, my self-esteem, my love, and my work." Among symptoms of post-traumatic stress disorder, she includes the loss of a future: a sense of a "fore-shortened," compromised future. Job mourns, "Are not the days of my life few?" (Job 10:20).
3. All Scripture references are to the Revised Standard Version.
4. McGill writes, "It is very easy for Christians to forget their condition of need and, in a subtle concession to the satanic world, to imagine that in *their loving* they are completely strong" (1968:95).
5. Once David stepped off a bus at New York's Port Authority to be assaulted moments later; his ribs were broken and his vocal cords sprained. In retrospect, he decided that the choking was not intended to strangle but to prevent his calling out. This was ironic. He discovered with surprise that, so far was he from wishing to call out, he was embarrassed, instinctively did not wish to call attention to his helplessness, and, if he could have spoken, might have said to his assailants something like, "Shhhh! Quiet. Please don't make a scene."
6. The ambiguity here is instructive. Death is the end of feeling in control, yes; but feeling in control is also a kind of death.
7. "Hearing into speech" is richer still. Not only does the hearer encounter the challenge of hearing into speech; the *speaker* can be *heard into speech*, heard in such a way that trusting speech is called forth.
8. Nancy J. Ramsey also employs the image of a spiral: "The experience of recovery does not proceed in a linear progression but rather in a spiral process" (1991:115).
9. See the interpretation of "repetition" as "discontinuous continuity" in Cain 1993:335–58, esp. 351–52, 358.
This question—how does one integrate death into life?—is an invitation to appreciate something of the *achievement* of the unity of the Christian God as Trinity. The life of the triune God is severely shaken as the "first" and "third" *personae* suffer the death of the "second." Trinity enables one to speak seriously of the "death of God" without losing God to death and to speak of the possibility of creaturely unity-in-diversity, the zestful harmony in genuine otherness of creatures created in the *imago Dei*, in the image of a triune God in whom oneness is dynamic victory over possible discord.
10. Our concern is to indicate also a *nonparadoxical* relationship between strength and vulnerability. See below.
11. Wilfred Cantwell Smith, professor of comparative history of religion, observes, "One of the most deeply significant facts about any person is, whom he means when he says 'we'" (1982:178).
12. Self-deception haunts such a formulation. We can tell ourselves that we are prepared to do without relative control even as the striving for such control controls us absolutely.
13. At a recent conference, David asked David Blumenthal if there was a teleology to his protest against God. Blumenthal responded, "If God has something to say on the subject, he should make me an offer."
14. Several of the insights Welch presents in treating relational selfhood may be approached and some of the dangers she identifies as belonging to a transcendent deity may be avoided by rethinking talk of God as Trinity. Arthur McGill, Elizabeth A. Johnson, Jürgen Moltmann, Juan Luis Segundo, and Eberhard Jüngel, among others, have been working here. Welch is decidedly not tempted. But suppose relational selfhood is the *imago Dei* of a triune deity.
15. For a sensitive discussion of "a reciprocity of giving and receiving" in the context of physician-patient relationships (though not limited to this context), see May 1983:115–21.
16. Perhaps appropriate vulnerability is all this because *vulnerability*, beyond our attempt to speak of appropriate and inappropriate vulnerability, belongs to the life of God. See note 9 above.

REFERENCES

- Ackley Bean, Heather Ann. 1993. "A Process of Survival: A Feminist Theodicy of Sexual Abuse." *Creative Transformation: The Journal of Process and Faith* 3, no. 1 (Autumn): 3–4.
- Blumenthal, David R. 1993. *Facing the Abusing God: A Theology of Protest*. Louisville: Westminster/John Knox.
- Bowker, John. 1991. *The Meanings of Death*. Cambridge: Cambridge University Press.
- Cain, David. 1978. "A Way of God's Theodicy: Honesty, Presence, Adventure." *Journal of Pastoral Care* 22, no. 4 (December): 239–50.
- _____. 1993. "Notes on a Coach Horn: 'Going Further,' 'Revocation,' and *Repetition*." In *Fear and Trembling and Repetition*, 335–58. Vol. 6 of International Kierkegaard Commentary, ed. Robert Perkins. Macon, Ga.: Mercer University Press.
- Kelly, Liz. 1988. *Surviving Sexual Violence*. Minneapolis: University of Minnesota Press.
- Kushner, Harold S. 1981. *When Bad Things Happen to Good People*. New York: Schocken Books.
- Lebacqz, Karen. 1993. "Appropriate Vulnerability: A Sexual Ethic for Singles." In *Moral Issues and Christian Response*, ed. Paul T. Jersild and Dale A. Johnson, 55–59. Fort Worth: Harcourt Brace Jovanovich.
- Lewis, C. S. 1961. *A Grief Observed*. London: Faber and Faber.
- May, William F. 1983. *The Physician's Covenant: Images of the Healer in Medical Ethics*. Philadelphia: Westminster.
- McGill, Arthur C. 1968. *Suffering: A Test of Theological Method*. Philadelphia: Geneva.
- Percy, Walker. 1980. *The Second Coming*. New York: Farrar, Straus and Giroux.
- Ramsey, Nancy J. 1991. "Sexual Abuse and Shame: The Travail of Recovery." In *Women in Travail and Transition: A New Pastoral Care*, ed. Maxine Glaz and Jeanne Stevenson Moessner, 109–25. Minneapolis: Fortress.
- Smith, Wilfred Cantwell. 1982. *Religious Diversity*. New York: Crossroad.
- Trible, Phyllis. 1984. *Texts of Terror: Literary-Feminist Readings of Biblical Narratives*. Philadelphia: Fortress.
- Welch, Sharon D. 1990. *A Feminist Ethic of Risk*. Minneapolis: Fortress.
- Wiesel, Elie. 1962. *The Accident*, trans. Anne Borchardt. New York: Hill and Wang.



White Wall.

Egg tempera on gesso panel by George Tooker, 1964–65.

Collection of the Delaware Art Museum, Wilmington. Photo courtesy of Marisa del Re Gallery, New York. All rights reserved.

*Fourth in a series edited by
Arthur W. Frank*

The Case Confessions of a Pastoral Visitor

Richard L. Morgan

I STOOD IN REVERENT SILENCE OUTSIDE ROOM 509 AT Grace Hospital. While visiting a friend on that same floor, I suddenly found myself returning to the room where I had been a patient one year ago to the day. Bustling nurses scurried around, seeming in a quandary about attending to the needs of a patient recovering from prostate surgery. The present scene rekindled memories of the horrendous days and nights when I struggled with post-op complications from that same surgery. The past became vividly present. I had not been just a patient in that hospital; I had become its victim. I left the scene of my downfall and walked back to my car. I paused to take one final look at the place. Its gray walls seemed to protect outsiders from what happened within. From the outside it appeared silent and serene. On the inside it housed issues of life . . . and death, as I well knew.

I still cannot remember much about those seven days and nights. For a while my illness seemed

only a blur, its trauma obscured by medication and the grace of God. What happened to me sent me into a strange world that remains a ghostly figment of my mind. I remember looking up and seeing that I was being given blood transfusions and wondering if I was dying. I do recall a never-to-be-forgotten dream in which I had driven all night and suddenly saw the most incredible sunrise I had ever seen; I had no desire to leave that experience. I will always wonder how close I came to that other shore.

My wife later told me that on the third day after surgery she found me in complete disarray. I was strapped in a Posey jacket, surrounded by soiled linen, with blood everywhere. No one seemed available to explain my situation or apologize for such negligence. Later a pastor told me that she had been prevented from visiting me by a nurse who told her I was "in critical condition."

Now voices returned that spoke of pain, life and death, and muddled procedures. Nurses seemed like ghostly figures who probed and prodded private parts. The surgeon appeared as some invincible Rambo who was bewildered because he could effect no quick fix. A few visitors came and went, but my sense was that they hurried to leave, wanting some-

Richard L. Morgan is a retired Presbyterian minister and a volunteer chaplain at Caldwell Memorial Hospital, Lenoir, North Carolina.

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one to reassure *them* that I was OK. No one explained what happened or related to my anxiety.

My surgery (transurethral prostatectomy) was successful, with “unremarkable results.” The biopsy indicated no evidence of cancer. The problems began on the second post-op day when nurses removed the catheter too soon and their attempts to recatheterize me were unsuccessful. According to the surgeon’s report, “They managed to blow up the 30 cc. balloon in the prostatic urethra, which resulted in excessive bleeding from the prostate.” Hemorrhagic anemia ensued, which necessitated several transfusions and multiple medications. Two days later a second attempt by nurses at recatheterization failed, more bleeding occurred, and I suffered minimal mental confusion, compounded by my own anxiety. These complications caused severe weakness and prolonged my recovery by several weeks. I returned home feeling like a wounded old dog who had suffered a resounding defeat at the hands of a younger foe and crawled home to lick his wounds. Never in all my life had I felt such weakness and utter dismay.

When I felt like seeing visitors, they were few and far between. Some called with mixed messages. They said, “We won’t come to see you because we know you want to be alone.” How did they know? What they meant was, “We’d rather not deal with your pain.” The few who came seemed ill at ease, and I never knew whether they would discuss their problems or the pennant races. None asked anything specific about how I felt.

Visitors tried to cheer me up, but their well-intentioned remarks actually brought me further

down. Some shared macabre war stories of similar surgeries. Others spoke of men who had “breezed through this with *no* problems.” One minister seemed to take delight in telling me about a parishioner who had had the same surgery and “was chopping wood in two weeks.” The one who came to comfort me had become my accuser. I wanted to ask his forgiveness for my pain. I did receive some encouraging get-well cards, but one devout lady not only sent me a card with Scripture verses but cited Exodus (15:26) as well, writing “I am praying that the Lord will not put any more disease on you.”

The visits prompted me to recall my own pastoral visits. For more than 40 years as a parish pastor and hospital chaplain I had visited more people in hospitals and sickrooms than I could remember. Sometimes I was a helpful presence,

but more often than I like to admit, I was not. I recall reciting the usual Gospel platitudes or leaving sugar-coated Bible verses as I made a hasty exit from the place of sickness. How many times I offered canned prayers that had nothing to say to the real pain of the person.

With dismay I recalled how often I managed to distract people when they wanted to tell me about their illness or found some excuse to get out of the room when their sickness was more than I could bear. “Let me talk to your nurse about this” or “Perhaps I need to call your pastor” or “You need to talk to your doctor about this.” Such were the tactics I used to avoid hearing about patients’ feelings or risk being engulfed by their suffering.

One visit I recall with particular regret. A former parishioner who had had prostate surgery tried

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to mask his anxieties with humor. “Well, Dick, I hope I’m not ready for the pump yet,” he said. Instead of allowing him to discuss his sexual fears, I responded with some inane remark and light banter. Yes, I confess I was no different from those ancient healers of whom the prophet spoke: “They had healed the hurt of my people slightly” (Jeremiah 6:14).

My sickness and long days and nights of recovery hurled me into a “dark night of the soul,” that agonizing time when one seeks contact with God and finds only empty isolation. The religious beliefs that had sustained me when I was healthy and that promised smooth sailing through surgery were no longer working. I prayed, but the heavens seemed like brass. The words of the Bible were a blur. I had taken several spiritual books to the hospital to read but never opened them. I tried keeping a journal of some of my experience, but all I managed were half-scribbled sentences left on a hospital bed.

My anguish made me bombard the heavens with questions that had no answers: “Why me?” “Why did these complications happen to me?” “Why didn’t I sail through this surgery as other men had done?” I had served God, like the elder brother, “all these many years,” and *this* was my reward? I had just settled down to enjoy a well-deserved retirement, and it seemed as if I would never recover.

One interminable autumn day I began to wonder if I would ever get well, and I fantasized that I would spend my final days like this—confined at home, unable to drive, dependent on others for bare necessities, staring outside the window at a world that had suddenly come to a screeching halt. Becoming an old, disabled man no longer seemed a future possibility; it had become a present reality.

What helped turn me around were the Psalms, which emerge out of experiences of being overwhelmed, nearly destroyed, and surprisingly given life and hope. They speak about life as it really is, especially when sickness or crisis makes us aware that life is always precarious. In their honest record

of the struggle for faith, I found in them my own story. The Bible “came alive,” as my experience mirrored theirs.

Most people expected me to say the usual words about my sickness. The raw edges of my illness had to be denied or suppressed to protect the well. Not so the Psalms. There is no cover-up of feelings in the Psalms. The psalmists’ expressions of pain, anger, and dismay that life is *not* always good helped me accept my own feelings. And, despite their anguish, they held out hope that life could be better, as did I.

I resonated with their experiences:

A fatal sickness has a grip on him; now that he is down, he will never get up again. (Psalm 41:8 NJB)

Have pity on me, Yahweh, for I am fading away. Heal me, Yahweh, my bones are shaken, my spirit is shaken to its very depths. But you, Yahweh . . . how long? (Psalm 6:2–3 NJB)

My heart beats fast, my strength has ebbed away. . . . My friends and my companions shun me in my sickness. (Psalm 38:10–11 NEB)

For my soul is full of trouble, and my life draws near the grave. . . . I am like a man without strength, . . . I am confined and cannot escape. (Psalm 88:3–4b NIV)

If they could be honest about their fear, so could I. If they had to suffer and find no quick fix, then my experience was not some punishment for sin. If they found God in the darkness, so could I. I realized that it was in the dark night of the soul that they found the presence of God. No wonder the writer of the Twenty-third Psalm finds God most personal (“Thou art with me”) in the valley of grim shadows, not in green pastures.

I remembered a parable from the Muslims.

"What are you searching for, Mullah?"

"My key."

Both men got to their knees to search. After a while the neighbor said, "Where did you lose it?"

"At home."

"Good Lord! Then why are you searching here?"

"Because it's brighter here."

I didn't find the key in the brightness of health but in the darkness of illness. I knew that whatever happened, whether I recovered or not, all was well. I began to experience a strange new Presence in my life. Faith had found a gentle beginning. Another word from the Psalms became the watchword of my convalescence. "I am confident of this; I will see the *goodness of the Lord* in the land of the living" (Psalm 27:13 NIV, emphasis added).

I have learned that every sick person is blessed if she or he has one real caregiver. Family members called from a distance offering support, but they could not be there in the lonely night watches or moments of quiet desperation.

My wife, Alice Ann, was there. She had nursed her first husband through horror-filled days and nights until he died from cancer. I knew it must have been doubly painful for her to have a second husband in such dire straits. Yet she was a nonanxious presence. There were times when I wondered how she kept her sanity. My endless impatience, catastrophic fears, and compulsive need to talk about my illness would have driven Mother Teresa to despair. But Alice Ann was always present, and her constancy was a major factor in my healing.

What I have learned from this experience is how to be a caring presence to others. Although I may have to descend into the abyss with others, I need not lose my own identity. To suffer with another person does not mean to drown oneself in the other's suffering; that would be as foolish as jumping into a pool to save a sinking swimmer only to drown oneself. I am there not to effect cure but to be friend in whatever way possible.

Recently, a friend of mine had prostate surgery that involved a malignancy. Radical surgery saved

his life but left him with lingering problems and angry questions. I became his confidant as we struggled through his anguish about an unknown future. Before my own illness, I might have tried to soothe him with assurances that "everything is fine." I would have made the perfunctory call at the hospital and sent some inane get-well card. Now, I have entered into an ongoing relationship, helping him express anger and deal with his unknown future and offering my constant friendship.

Before my experience as a patient, the reality of his relentless questions might

have put me off, his anger could have made me run for cover. He was angry at his surgeon for not preparing him for the aftermath of this surgery and for his reluctance to give any guidelines for the future, except to offer that timeworn phrase, "This will take time." He was angry at some of the X-ray technicians, whose inane banter and seeming indifference to his justifiable anxiety over these tests left him without emotional support. I had processed my own anger at the bungling of procedures and lack of constant care in my case, so now I could listen to

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Tom's anger with clarity and compassion. When one is a *healed* victim, he or she becomes a *wounded* healer for others.

Discussing his cancer was an obsession, and I could listen to him without feeling engulfed by my own cancerphobia. When he said, "We are given no guarantees of how long we have," I could be there for him and not let my own fears thwart his need to confront death. Having just been spared, I had become a member of the "order of Epaphroditus," of whom Paul wrote, "He was ill and almost died" (Philippians 3:27). Because I had stared my own finiteness in the face, I could hear his uncertainties without flinching. As our friendship continues to grow, it is deepened by the bond of our common experience with illness.

A further positive result of my illness grew out of journals I kept during eight weeks of convalescence. Although I received helpful medical advice for those days, I found a real gap in spiritual books intended for those recovering from illness. Other

than the Psalms and the healing stories of the Gospels, I found little that "spoke to my condition." I began to write a book of meditations (which was later published). I found the only way to grace for those who enter the kingdom of the sick *is* through grim pastures.

Those days and nights when life came to the edge of the precipice will always be a part of me. I try not to overdramatize my experience, for many others have suffered far worse ordeals, ones that would have devastated me. I marvel in silence at their raw courage and genuine faith. But I have learned that even when some semblance of order returns after illness, we never forget the time when life got out of focus.

I know now that sometimes we have to experience how bad things can be before we find the real presence of God. Like Jonah, I have crawled out of the belly of despair to be given a second chance at life . . . by the grace of God.



Walt Whitman as Nurse. By L. Daniel.

From *Selections from Leaves of Grass by Walt Whitman*, Crown Publishers Inc., New York, 1961.

Commentary

The Pastor as Patient

Richard E. Koenig

*“—Night is drawing nigh—”
For all that has been—Thanks!
To all that shall be—Yes!
—Dag Hammarskjöld*

THERE WAS A TIME WHEN WE WERE TOLD MORE OFTEN than we are today that “confession is good for the soul.” As a spiritual directive that is still true, but being entrusted with someone’s confession is dangerous. Hearing confession can remind one of certain failings or shortcomings of one’s own. If not that, one might be compelled to unexpected feelings of sympathy, even embarrassment, by the other person’s story. We will not be left unmoved.

Richard L. Morgan’s “Confessions of a Pastoral Visitor” brought recollections of moments in my ministry that I would just as soon have left in memory’s attic. He tells us frankly that there were times he lapsed into superficiality or pious cant on his rounds. Although I didn’t want to admit it, there were times when I did the same. Caregiving that is

genuinely beneficial for those who suffer illness demands an exquisite combination of skills along with a considerable store of physical energy. Given our human frailties, and in spite of our best intentions and the powerful resources of our faith traditions, we ministers do not always succeed.

After having made hundreds of hospital and sickroom visits as a parish pastor for more than 33 years of my 42 years of ordained ministry, I, like Pastor Morgan, one day found myself on the receiving end of such ministrations. For several years, at the time of my annual physicals, the doctor had noted that there was something abnormal in the shape of my prostate gland. Soon after turning 60, I was advised to undergo a biopsy of the prostate, an unpleasant experience that revealed nothing alarming. Four years later, acting on what I can only say was an intuition, I asked my internist for another examination. This time the abnormality that had been noted before caused the internist to refer me to the urologist, who used a new tool now at his dis-

Richard E. Koenig is a retired Evangelical Lutheran Church in America pastor.

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posals—the prostate-specific antigen (PSA) test—plus some advanced ultrasound techniques and the performance of the biopsy.

“Reverend Koenig, your test results came back. You will have to tell me what your choice is in the way of treatment,” he said over the telephone as I was eating dinner. “Treatment for what?” I asked naively, having forgotten (suppressed) the reason I had made the trips to the hospital a month before. Somehow I imagined that having undergone the inconveniences involved in the biopsy, the problem had been dealt with. There was no problem. There could be no problem. But there was. “You have cancer, Reverend Koenig,” the doctor said in the faintly weary tone that people use when speaking to those who don’t get it. “Let’s talk things over in the office on Monday.” “Thank you, doctor,” I replied, already adopting the submissive posture of the patient anxious to please the (imagined) omnipotent and omniscient individual who from that moment on would carry my life in his hands.

My hand shook as I signed the consent form for a radical prostatectomy, “the most thorough choice,” I was told, to “cure” me of cancer. It seemed that I was one of the fortunate 15 or 20 percent of men diagnosed with cancer of the prostate who were able to make surgery their therapy of choice. The cancer was encapsulated, only a nodule poking up in a location that would make it a good bet that the surgeon would “get” everything. “If you are going to get cancer, this is the best type to get,” so one of the doctors said gaily at one point. I was momentarily relieved. Even so, the possibility of urinary incontinence and permanent impotence from the surgery was tough to face. At the same time, the prospect of the cancer “racing through my body,” as I envisioned it would, was equally tough. All I could think of was to have the damn thing out and out fast. I’d deal with whatever other problems turned up once my feet were firmly planted on the road of life again.

There are several ways a radical prostatectomy can be performed, all of them barbaric, it seems to me. Drastic measures are necessary because of the inconvenient location of the gland. The day before the scheduled surgery, I packed my bag and took the commuter line to the Boston hospital where the operation was to be performed. I had told my wife not to accompany me since the things I had to do pre-op were best done in private. Alone in my room on the seventh floor of the hospital, between trips to the bathroom to clean out my insides, as I had been instructed, I watched the city’s lights come on. The dullness of the overcast day that was ending made them seem even brighter than usual. Each light signaled happy human activity of one kind or another—someone going out to dinner, another working late at the office, people shopping, others heading to the symphony or theater, everyone enjoying casual good health. Already I had started to feel the isolation of the ill from the rest of humanity.

The surgeon entered my room accompanied by his young nurse, whose friendliness and encouragement I had come to value as I prepared myself for the operation. I was pleased, in a crazy way even proud, to be able to report that I was expelling only clear liquid by that time. No sign of the approbation I was looking for from the surgeon at the beginning of our adventure together, but the achievement was noted. He left without saying anything that sticks in my mind as encouraging, although I am sure his parting words were meant to convey something of that sort. It was just that my feeling of isolation, sadness, self-pity, and a silent, pervasive fear made it hard for me to hear anything.

Then my chaplain arrived. In the three months since I’d received the test results (the operation was, maddeningly, twice postponed), I had constantly sought information on what I had, what I would undergo, and what might eventuate. Looking back, I fought “as one who beateth the air,” in the King James voice of St. Paul describing one who engages in a futile struggle against a spiritual foe. But one

decision I did make that turned out to be of enormous help to me was to choose a personal chaplain.

Who the pastor's pastor should be has long been a subject of debate in the profession. The individual I asked to be my pastor in *angustiis*, the "narrow straits" I was to pass through, was a trusted friend and colleague who served as pastor of a neighboring congregation. Fastidiously dressed, as usual, in black clerical garb that accented the whiteness of his carefully trimmed goatee, his arrival immediately dispelled my feelings of isolation. After some cheerful exchanges, he arranged the vessels for Holy Communion on the table beside the bed and read the service for me. I received the bread and the tiny sip of wine gratefully. At the end of the Liturgy, my friend put his hand on my forehead and pronounced the blessing.

The feeling of peace that enveloped me is as real today as the memory of the operation itself. I felt whole once again, connected with fellow human beings, fellow believers. I felt like a person, someone with a name, an identity that had been all but lost in the bewilderment attending the diagnosis, the process of admittance, the pre-op procedures, the emptying of my bowels, the loneliness of the solitary room where I was to spend the night, the formidable journey on which I was to embark the next morning. It was a gift that I would have to reclaim and deepen in meeting what lay ahead.

I do not know what Pastor Dan Carlson was feeling as he read the service. Perhaps he was tired. Perhaps he wanted to be at home with his family. Perhaps he had five other people he had to visit after me. But whatever his feelings, his ministrations lifted my soul and enabled me to endure what turned out to be as trying an ordeal as others had predicted and I had speculated that it would be.

I dare to believe that my experience might afford encouragement and comfort to all who offer spiritual and emotional care to those who are ill. We might judge our gestures inadequate and superficial. Our words might sound in our ears like cant at

times. But the ill, while not lacking in critical discernment, are not put off by our shortcomings. Loving intentions allow them to take words, gestures, and rites that are larger than their bearers at face value. Spirits are lifted. When the traditional words of the Lutheran Liturgy were read, they possessed a life and power of their own. The texts and the rites spoke to me in ways that I now realized I had only vaguely comprehended when administering them to others. The love both human and divine that met me in my distress proved as important as any of the antibiotics I was given for my healing. (At this point I must acknowledge that my wife, Elaine, was and continues to be a principal source of that love.)

Pastor Morgan reports that he was close to death from hemorrhaging following prostate surgery. The experience bred some disillusionment with the medical profession and became a time of soul searching and spiritual testing. To our joy and relief, his story ends on a triumphant note. The "darkness of illness" became the venue in which a "strange new Presence" appeared. The pastoral visitor was perfected in his calling as a result of his experience. He learned, he said, "how to be a caring presence to others."

In a broadcast over National Public Radio recently, an interviewer remarked that after talking with people who have passed through some medical ordeal, the statement "illness can make you a better person" sounded to her almost like a cliché. To which I would answer, it may sound that way, but for those of us who have endured a major procedure for some life-threatening condition, it is anything but that.

While "illness *can* make you a better person," that outcome is not a foregone conclusion. A moment's reflection on the experiences of friends and relatives who have fallen seriously ill would, I think, reveal any number of cases where the afflicted person was not made "better" morally or spiritually, where life became embittered, even despairing,

or where the ill person simply scrambled to put the experience behind him or her as far and as quickly as possible.

That certain people feel that they have been made better persons after an encounter with life-threatening illness some would say is a tribute to the human spirit, others, a signal instance of the grace of God. Whatever its source, the mere frequency with which a beneficent outcome is reported following such an event is a phenomenon worthy of appraisal. In Pastor Morgan's case the spiritual advance that came about by virtue of his passage through the "dark night of the soul" was so pronounced as to lead him, as we have seen, to regard his previous ministrations as a pastoral visitor woefully inadequate, an exaggeration, I am sure. But his story evidences the life-transforming effect that often issues from the encounter with life-threatening illness.

I, too, have come to a different place in my spiritual journey in the wake of the surgery and what followed. I underwent the operation convinced, as I had been told, that I would be "cured" of cancer. The issue seemed quite simple: have the operation and then get on with life free from the specter of an unpleasant and early death. Looking at the actuarial tables, I figured, like a gambler at the blackjack table, that I would be adding about 10 years to my life with this move. Of course there would be sacrifices, but I would take them in stride. The main thing was to live.

I underestimated the sacrifices. Nothing that had been told me about a radical prostatectomy prepared me for the discomfort I would experience in getting my bowels to move again, or having to use a catheter for ten days after surgery to drain my bladder, or suffering from hemorrhoids brought on by an infection from *clostridium difficile* (a "hospital bug" known as "c-dif" by the staff) that leaves one weak from diarrhea. Most serious of all, however, was coming to terms with an impotence that would prove permanent.

Judging from what has been determined regarding the sexual activity of married couples, I suppose that my wife and I enjoyed a normally active sex life. While we never considered it *sine qua non*, our sexual life was an enjoyable and precious bond between us. Even at our stage in life, when the frequency of sexual intercourse is much less than at first, the loss of the ability to engage in normal sexual activity created a void. Something has gone from our life together than cannot be replaced.

Cancer is a formidable foe. Even with highly sophisticated equipment and advanced techniques, it can elude eradication—quite literally. A year after the prostatectomy, measurable amounts of PSA began to show up on my screening tests, meaning that some of the tumor tissue was still active. "They tried for the home run, but they missed," a doctor friend told me. "But we are 85 to 90 percent sure we can catch this by radiation," so the radiologist said. Six months after 35 treatments in the bomb-shelter-type quarters where radiation is administered, my PSA ominously began to rise again. So much for predictions, so much for percentages.

The turning point in Pastor Morgan's story comes at his discovery of "a strange new Presence" in his time of abandonment. Mine came in a fresh realization that I was not a statistic, but a person, that my destiny was not in the hands of some kind of blind physiological process that will work its way out one way or another, but in the keeping of Someone to whom I mattered and to whom I could entrust myself in confidence—and with whom I could argue, if need be. The shattering of my reliance on the physicians' prognosis opened the way for me to claim and deepen what Pastor Carlson's blessing before the surgery had given me, a sense of personhood growing out of an awareness of the divine presence and care that transcended whatever was happening to my body.

The bird of mortality, as someone put it, had come to sit on my shoulder. It has not left. It never will. But instead of inducing depression or despair,

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the bird's presence has generated a new appreciation of life, "sweet life" as Homer calls it all the time in the *Iliad*. The possibilities that each new day presents seem to stand out in bold relief before my imagination. At the close of each day, whether I have been engaged in recreation or creation, activities trivial or more substantial, I feel a deep sense of satisfaction for just having been. The uncertain future that, humanly speaking, seems to be what I am facing has engendered new energies for the various opportunities for ministry that come my way even as a retired pastor.

If I ask myself why this happened, I think it is that accepting mortality clears the mental eye to discern the grace with which one's life has been crammed. Careening forward compulsively in our careers and professions, we simply do not have the capacity to appreciate the pattern and texture of our lives. Nor is it easy, despite the accomplishments we register, to see life as much more than a Sisyphean effort. Its ultimate meaning remains a mystery. The bird of mortality on the shoulder makes one look at things from a different angle. The feeling, whatever has been, is of completeness. The illusions created by the futile attempt to quantify life are blown away. One is liberated from preoccupation with the self and its accomplishments (so necessary for our feelings of worth) to love.

The realization that omnipotence and omniscience remain attributes of God and not of physicians actually made me appreciate doctors in a new way. Highly trained and dedicated to helping the ill, they are limited by their sciences, not to mention their own personal temperaments and abilities. In addition, they operate under intense pressures imposed upon them by their patients' anxieties and oftentimes absurd expectations. Then there are so many of us. Where does the doctor find the resources to deal with the sea of emotions as well as the serious medical problems that we bring? If it is asked who is the pastor for the pastor, I wonder

who is the "pastor" to the physician in his or her calling?

Falling ill with a serious disease is a vortex that can pull one into the self while all others disappear from sight. The suction is anxiety, but amazingly, as I have recounted, when what one considers the worst happens, the waters grow more calm. Having fended off the symptoms of advanced prostate cancer at least for a time by means of the best treatments known to medical science, I felt like a Holocaust survivor, bewildered by the magnitude and the cost of the efforts to extend my life and wondering why I was spared. I began musing about what happens to people who are the main breadwinners for their families or fill other important roles but go untreated simply because they aren't covered—as I was—by private medical insurance. Even before President Clinton was elected and put forth his proposal, I had become committed for moral reasons to the principle of universal health coverage. As one writer put it, I did not want the treatments that I had and continue to have "to be a privilege based on my occupation or income. If cancer occurs without prejudice, its treatment should be available without prejudice as well."

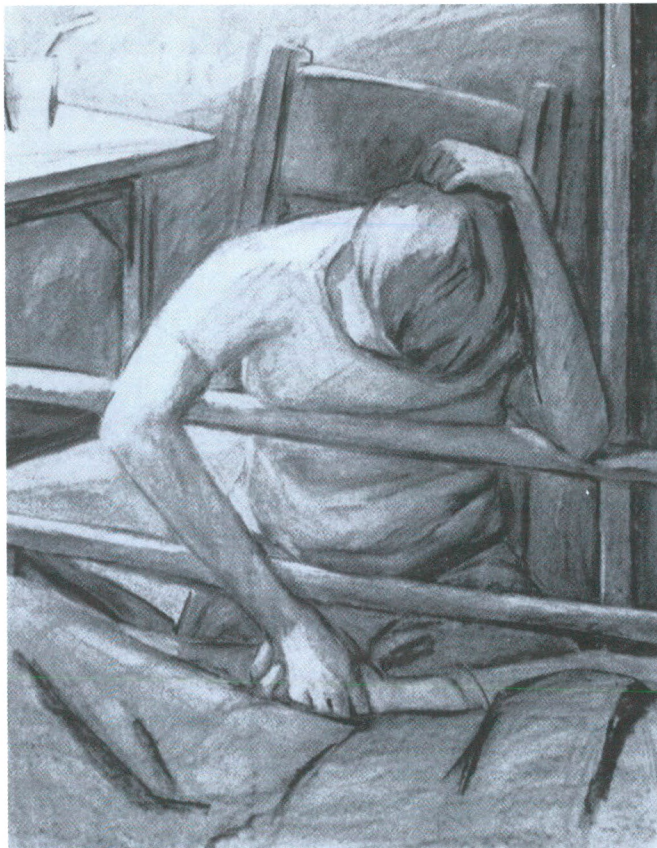
In 1956 Dag Hammarskjöld wrote in *Markings*, in his usual oblique style, this:

Beyond obedience, its attention fixed on
the goal—freedom from fear.

Beyond fear—openness to life.

And beyond that—love.

Surely it is possible to discover this for oneself in ways other than coming face to face with death through an illness, some grave condition, or medical procedure. It probably was so for Hammarskjöld. For me, however, that was the way my journey led and continues. I think I can say, like Pastor Morgan, yes, the experience has made me a better believer and a better human being. And as the others have said, too, in a paradoxical way I am grateful for it.



Visitor I. Charcoal on paper by Michael David, 1987.
From the series *Bearing Witness*.

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Commentary

Mid-Life Confessions

Al Miles

IN THE WOMAN'S ARMS LAY THE PRECIOUS BODY OF her only child. A casual onlooker might have thought the boy was in a peaceful sleep. The mother knew all too well that her son was dead. Tears raced down her face. A young chaplain resident entered the room. He had been summoned at the request of the mother. The resident had learned from a nurse that shortly before delivery a section of the umbilical cord had prolapsed from the uterus during labor, cutting off the supply of blood and oxygen to the baby.

Nothing in the chaplain's seminary training had prepared him for that moment. Not systematic theology, homiletics, world religion, introduction to the New Testament, or any of the other courses he had endured the previous three years. Suddenly these were meaningless. Reality was embodied in the young mother sitting before him holding her

dead son. The resident was overwhelmed. The woman's silence added to his discomfort. He opened his mouth and began to ramble. "I am very sorry your son died," he said. "He now lives with God in Heaven." To the chaplain's surprise, the mother found comfort in his words. She nodded affirmatively as her tears continued to flow.

Talking had certainly eased the resident's anxiety, so he continued. "At this very moment," he offered, "as your son lies in the ever-loving arms of our Lord, God is smiling down upon you." The mother's look of comfort turned quickly to one of rage. She asked, "Chaplain, why would a loving God be smiling at a woman who is in so much pain?"

The resident quickly found some excuse to leave the room. Deeply ashamed, he went directly to the office of the professor in charge of hospital ministry. In a quivering voice, attempting (unsuccessfully) to hold in his tears, the young man confessed. He realized that saying God was smiling down upon the mother was trite. He had felt overwhelmed and, as a result, had talked too much. The resident hoped he would soon eliminate such anxiety from his visits and offer only words of wisdom.

The professor silently studied his student.

Al Miles is coordinator of hospital ministry for Interfaith Ministries of Hawaii, at the Queen's Medical Center, Honolulu. He is an ordained minister in the Church of God.

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Then he said, “Young man, you showed a lot of wisdom by recognizing the reason for responding in the manner you did. Never reach a point in your ministry where situations such as the one you just described are not overwhelming. And never get to a place in life where you know exactly what to say when such tragedies occur. If you do, choose another line of work because this would indicate how self-serving your ministry had become.” The wise professor concluded, “Caring for the sick or dying person and their family is overwhelming. It is also one of the most rewarding professions known to humanity. Chaplaincy won’t make you a wealthy man, but with God’s spiritual guidance it will offer you riches beyond your wildest dreams.”

I BEAR WITNESS TO THE STORY JUST TOLD—I am that chaplain. This conversation occurred 16 years ago, when I was 27 and in my final year of seminary. Since then, I have been given the privilege of meeting hundreds of ill persons and their loved ones. They have ministered to me far more deeply than I could ever minister to them. In the midst of their pain and suffering, they have bravely challenged me to give more than just trite statements to hurting people. I now use the knowledge gained from their vast experience to educate clergy, laity, health care workers, and professionals from many other disciplines. I am appreciative and humbled. Unfortunately, I spent years providing mostly platitudes. I ask forgiveness from all whom I cared for so superficially.

I suddenly find myself in the middle years of my life and career. God has blessed both with the riches my professor predicted long ago. In the midst of these blessings, Richard Morgan’s moving story challenges me all the more.

How could Pastor Morgan know so much about my ministry? Did he videotape several of my pastoral visits and edit them into scenes from his own history? I felt as though he was writing about me when he said, “I managed to distract people

when they wanted to tell me about their illness or found some excuse to get out of the room when their sickness was more than I could bear. ‘Let me talk to your nurse about this’ or ‘Perhaps I need to call your pastor’ or ‘You need to talk to your doctor about this.’ Such were the tactics I used to avoid hearing about patients’ feelings or risk being engulfed by their suffering.”

Fortunately Pastor Morgan’s words will not leave me alone. They were especially present recently when I was called by one of the social workers at our hospital. She asked that I visit David, a 28-year-old man dying from complications brought on by AIDS. David had told both his longtime partner, Victor, and the social worker that he had had a vision that showed that God was going to heal him physically. Both hoped that I could help David see his situation more realistically. Many times during my career I have wished I had chosen some line of work that I could easily forget after putting in my eight-hour days, five times a week. This was certainly one of those moments.

I entered David’s dimly lit room with the same overwhelming feelings I had had at age 27. I still did not know what I was going to say. I wondered what wisdom I had actually acquired in the previous 16 years. As I came closer to David’s bed, I noticed a mask over his nose. He was receiving oxygen. A huge purple glob of tissue covered half his face. One eye had disappeared underneath this horrid-looking mess. The lesion is called Kaposi’s sarcoma. It is a form of cancer that persons with HIV disease often contract. The hair on David’s head was the length of peach fuzz. He could not have weighed much more than the sheet covering him. A stench filled the air. I felt like vomiting.

I wanted to fall back on the platitudes that had helped to distance me from the pain of ill persons during the earlier years of my career, statements that could be offered to anyone, anywhere—“God be with you” or “May God’s love fill your heart now and always,” followed by a quick recitation of the

Twenty-third Psalm or the Lord's Prayer. Then I would hurry away, unscathed and unhelpful.

At 43, I no longer can take this approach. I owe much more to God, to my wife, Kathy, and to friends, mentors, supervisors, peers, and students. And especially I owe more to patients like David, from whom I have learned so much.

David's words were muffled by the oxygen mask. Every syllable attempted seemed to cause excruciating pain throughout his body. I placed my hand in his to offer him, and me, support. I felt overwhelmed and sick.

"Pastor, I want God to physically heal me before I die," he said. "I don't want Victor to spend the rest of his life having this image of me. I want him to remember me like this." David reached for a picture on his nightstand. He was too weak to lift the five-by-seven frame, so I assisted him. The photograph showed Victor and a healthy David with their arms around one another. They were wearing tuxedos. He explained that it was taken at a fancy restaurant in Seattle. The occasion was their tenth anniversary. In the photo David and Victor were both beautiful. They looked really happy. Now Victor was grieving the imminent loss of his partner, and David was literally on his deathbed. My feelings of being overwhelmed began to subside. But I still felt sick and was filled with sadness.

I wondered where God's mercy was in this situation. My rage toward God was building. I was saying to myself, "This man's suffering is both cruel and sadistic, God! Where is your love?" At the same

time I asked God to empower me, because I desperately wanted to run away. David's skeletal appearance and the smell from the sores covering his body were intensifying my nausea. By the power of God I somehow stayed, remained silent, and continued to hold David's hand. And I did not throw up.

"Maybe Victor doesn't care how I look, Pastor," David said after pondering a few moments. "Perhaps it's just me. Would you please ask him to come in

here? I want you to stay with us." I stuck my head out of David's door and asked the social worker to bring Victor into the room. Moments later he entered. The two men embraced. Victor began to cry. David looked at me. His breathing seemed more labored. His voice was barely audible. "Pastor," he whispered, "Please ask God to take me and to take care of Victor."

I placed my hand on David and Victor. At first I could not speak. I felt overwhelmed. Tears flowed from my eyes. Finally I prayed, "God, you have heard the request of your child David.

Welcome him into Heaven. Take care of Victor as he grieves the death of his lovely partner. Bless their undying love. Amen."

David died less than an hour later.

An eight-hour-a-day, five-day-a-week job would be less taxing. I probably would not take my work home with me, but I would miss sacred moments I have shared with people like David and Victor.

PASTOR MORGAN'S STORY CHALLENGES ME personally as well. The struggles he faced after his illness force

"Never reach a point in your ministry where situations such as the one you just described are not overwhelming. And never get to a place in life where you know exactly what to say when such tragedies occur. If you do, choose another line of work because this would indicate how self-serving your ministry had become."

me to look closer at my own mortality. Although throughout my career I have been with persons who were facing death, I am not afforded any deeper insights or special dispensations. Fear consumed me when I read what Pastor Morgan wrote.

My sickness and long days and nights of recovery hurled me into a “dark night of the soul,” that agonizing time when one seeks contact with God and finds only empty isolation. The religious beliefs that had sustained me when I was healthy and that promised smooth sailing through surgery were no longer working. I prayed, but the heavens seemed like brass. The words of the Bible were a blur. I had taken several spiritual books to the hospital to read but never opened them. I tried keeping a journal of some of my experience, but all I managed were half-scribbled sentences left on a hospital bed.

I wonder how I will face my own dark night of the soul. Will the Psalms comfort me as they do Pastor Morgan, or will the honest “expressions of pain, anger, and dismay” cause me to conclude that life is cruel and senseless? Will the New Testament passages I have recited for children and adults at numerous bedsides and funerals (particularly Matthew 11:28–30; Mark 10:13–16; and Romans 8:35, 37–39) bring me hope as they now do, or despair? And what of my relationship with God? How will my own encounter with death affect this preeminent relationship? God, the source of my love, power, and wisdom. God, without whose Holy Spirit I could not care for myself, let alone anyone else. God—whom I praise for the gift of Kathy, babies, friends, animals, nature, and life. God, whom I curse for allowing women and children to be abused and for allowing cancer, AIDS, rape, murder, and death.

Pastor Morgan writes, “I have learned that every sick person is blessed if she or he has one real

caregiver.” He identifies his wife. In my life that person is Kathy. When I was a 20-year-old college junior, my father suffered a massive stroke. He died six weeks later. I was devastated. Daddy was my best friend. Kathy’s silent presence comforted me during my many months of despair. At age 34, as I was about to begin my first position as director of a hospital chaplaincy program, my mother was diagnosed with colon cancer. The disease quickly metastasized to her liver. She died after undergoing inhumane suffering for 11 months. Kathy, grief stricken herself because of the 15-year relationship she shared with Mama, was with me every step of that awful journey. The acceptance of Kathy’s wonderful care over the years still does not give indication of how I will respond to her when I am faced with my own mortality. Will I receive her love and support, or will my anger, fears, and other feelings cause me to push her away?

And who will care for Kathy? My ministry unfortunately includes numerous people who, following the death of a loved one, were distanced from or abandoned by people who previously made up their support network. As one woman said to me a year after her 35-year-old husband died, “People who I could have sworn would never leave me—my best friend, sister-in-law, and members of our church—no longer call or visit. Others see me approaching and either cross the street or turn and walk in the other direction. It is as though I have a highly contagious disease.”

Near the end of his story Pastor Morgan says, “I know now that sometimes we have to experience how bad things can be before we find the real presence of God.” Although I have found this to be true, these are not comforting words.

A disturbing image comes to me at times. God is perched on a huge throne in Heaven, high above the problems of the world. When God is feeling insecure, God allows something traumatic to occur—death, illness—so that we will draw closer. I do not embrace this image, which reveals a cruel,

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manipulative God rather than the loving God I follow, but the image continues to visit me.

Only God knows what the future holds for me. I am grateful for those blessings of a life and career that could only have come from a God of love. Yet what I have witnessed of people afflicted by evil and

illness causes me often to wonder if God gives a damn about us. I am tempted to put a tidy ending to my messy struggles. But that would be the same as putting a tiny Band-Aid on a gaping wound. I owe more to readers and to myself.



Innocence (also *Tessie-Essie*).
Oil on canvas by Joseph Delaney, 1935.

Collection of The University of Arizona Museum of Art. Gift of C. Leonard Pfeiffer.

Female Circumcision/Genital Mutilation and Ethical Relativism

Loretta M. Kopelman

IN NORTHERN AFRICA AND SOUTHERN ARABIA MANY girls undergo ritual surgery involving removal of parts of their external genitalia; the surgery is often accompanied by ceremonies intended to honor and welcome the girls into their communities. About 80 million living women have had this surgery, and an additional 4 or 5 million girls undergo it each year (Kouba and Muasher 1985; Ntiri 1993). Usually performed between infancy and puberty, these ancient practices are supposed to promote chastity, religion, group identity, cleanliness, health, family values, and marriage goals. This tradition is prevalent and deeply embedded in many countries, including Ethiopia, the Sudan, Somalia, Sierra Leone, Kenya, Tanzania, Central African Republic, Chad, Gambia, Liberia, Mali, Senegal, Eritrea, Ivory Coast, Upper Volta, Mauritania, Nigeria, Mozambique, Botswana, Lesotho, and Egypt (Abdalla 1982; Ntiri 1993; Calder et al. 1993; Rushwan 1990; El Dareer

1982; Koso-Thomas 1987). Modified versions of the surgeries are also performed in Southern Yemen and Musqat-Oman (Abdalla 1982). Tragically, the usual ways of performing these surgeries deny women sexual orgasms, cause significant morbidity or mortality among women and children, and strain the overburdened health care systems in these developing countries. Some refer to these practices as *female circumcision*, but those wishing to stop them increasingly use the description *female genital mutilation*.

Impassioned cultural clashes erupt when people from societies practicing female circumcision/genital mutilation settle in other parts of the world and bring these rites with them. It is practiced, for example, by Muslim groups in the Philippines, Malaysia, Pakistan, Indonesia, Europe, and North America (Kluge 1993; Thompson 1989; Abdalla 1982; Koso-Thomas 1987). Parents may use traditional practitioners or seek medical facilities to reduce the morbidity or mortality of this genital surgery. Some doctors and nurses perform the procedures for large fees or because they are concerned about the unhygienic techniques that traditional practitioners may use. In the United Kingdom, where about 2,000 girls undergo the surgery annu-

Loretta M. Kopelman is professor and chair, Department of Medical Humanities, School of Medicine, East Carolina University, Greenville, North Carolina.

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ally, it is classified as child abuse (Thompson 1989). Other countries have also classified it as child abuse, including Canada and France (Kluge 1993).

Many international agencies like UNICEF, the International Federation of Gynecology and Obstetrics, and the World Health Organization (WHO) openly condemn and try to stop the practices of female genital mutilation (WHO 1992; Rushwan 1990). Such national groups as the American Medical Association (AMA 1991) have also denounced these rituals. Women's groups from around the world protest these practices and the lack of notice they receive. (A common reaction to the attention given to the Bobbitt case, where an abused wife cut off her husband's penis, was, "Why was there a media circus over one man's penis while the excision of the genitalia of millions of girls annually receives almost no attention?")

Most women in cultures practicing female circumcision/genital mutilation, when interviewed by investigators from their culture, state that they do not believe that such practices deprive them of anything important (Koso-Thomas 1987). They do not think that women can have orgasms or that sex can be directly pleasing to women but assume that their pleasure comes only from knowing they contribute to their husbands' enjoyment (El Dareer 1982; Abdalla 1982). Some critics argue that women who hold such beliefs cannot be understood to be making an informed choice; they thus condemn this custom as a form of oppression (Sherwin 1992; Walker 1992).

International discussion, criticisms, and condemnation of female circumcision/genital mutilation help activists who struggle to change these rites that are thoroughly entrenched in their own cultures (El Dareer 1982; Ntiri 1993; Kouba and Muasher

1985; Koso-Thomas 1987; Abdalla 1982). Not surprisingly, people who want to continue these practices resent such criticisms, seeing them as assaults upon their deeply embedded and popular cultural traditions.

Underlying intercultural disputes is often a basic moral controversy: Does praise or criticism from outside a culture or society have any moral authority within it? That is, do the moral judgments from one culture have any relevance to judgments about what is right or wrong within another culture? According to some versions of ethical relativism, to say that something is right means that it is approved of in the speaker's culture; to say that something is wrong means that it is disapproved. If

this is correct, there is no rational basis for establishing across cultures that one set of culturally established moral values is right and the other wrong. The right action is one that is approved by the person's society or culture, and the wrong action is one that is disapproved by the person's society or culture; there are moral truths, but they are determined by the norms of the society. On this view, then, the cultural approval of female circumcision/genital mutilation means that the practice is right; disapproval means that it is wrong.

In contrast to such versions of ethical relativism, other traditions hold that to say something is morally right means that the claim can be defended with reasons in a certain way. Saying that something is approved (such as slavery) does not settle whether it is right, because something can be wrong even when it is approved by most people in a culture. Moral judgments do not describe what is approved but prescribe what ought to be approved; if worthy of being called moral or ethical judg-

About 80 million living women have had ritual surgery involving removal of parts of their external genitalia, and an additional 4 or 5 million girls undergo it each year.

ments, they must be defensible with reasons that are consistent and empirically defensible. As we shall find, advocates of the practice of female circumcision/genital mutilation do not say, "We approve of these rituals, and that is the end of the matter." Rather, they try to defend the practice as useful in promoting many important goals. In fact, however, the practice is inconsistent with important goals and values of the cultures in which it is practiced. We find that we can evaluate some of the reasons given for performing these rituals and that despite our cultural differences about what to value and how to act, we share many methods of discovery, evaluation, and explanation. These enable us sometimes correctly to judge other cultures, and they us. Moral judgments can be evaluated at least in terms of their consistency and their relation to stable evidence, like medical or scientific findings. By this means certain moral claims can be challenged, even where we have different cultural values, and the practice of female circumcision/genital mutilation shown to be wrong. Thus, both intercultural and intracultural discussions, criticisms, and condemnation of female genital mutilation as well as support for activists seeking to stop the practice can have moral authority, or so I argue.

After considering some of the health hazards of female circumcision/genital mutilation, I review the version of ethical relativism that denies moral authority to cross-cultural moral judgments. By examining the cultural reasons used to justify female circumcision/genital mutilation, I want to show that many aspects of this discussion are open to cross-cultural evaluation and understanding and hence that this version of ethical relativism fails. After discussing some anticipated objections, I conclude that these relativists have a heavy burden of proof to show why we cannot make intercultural judgments that have moral force concerning female genital mutilation, just as we do concerning such things as oppression, intolerance, exploitation, waste, aggression, and torture or imprisonment of dissidents.

Types of Surgery and Their Health Consequences

FEMALE CIRCUMCISION/GENITAL MUTILATION TAKES three forms. Type 1 circumcision involves pricking or removing the clitoral hood, or prepuce. This is the least mutilating type and should not preclude sexual orgasms in later life, unlike other forms. When this surgery is performed on infants and small children, however, it may be difficult to avoid removal of additional tissue, because infants' genitalia are small, and the tools commonly used are pins, scissors, razors, and knives. In the southern Arabian countries of Southern Yemen and Musqat-Oman, Type 1 circumcision is commonly practiced.¹ In African countries, however, Type 1 circumcision is often not regarded as a genuine circumcision (Koso-Thomas 1987; Abdalla 1982). Only about 3 percent of the women in one east African survey had this type of circumcision (El Dareer 1982), and none in another (Ntiri 1993) where all the women surveyed had been circumcised.

Type 2, or intermediary, circumcision involves removal of the clitoris and most or all of the labia minora (the two extremes of Type 2 are shown in the figure on pp. 58–59). In Type 3 circumcision, or infibulation, the clitoris, labia minora, and parts of the labia majora are removed (see figure). The gaping wound to the vulva is stitched tightly closed, leaving a tiny opening so that the woman can pass urine and menstrual flow. (Type 3 is also known as Pharaonic circumcision, suggesting that it has been done since the time of the pharaohs [Abdalla 1982].) In some African countries most young girls between infancy and 10 years of age have Type 3 circumcision (Abdalla 1982; Ntiri 1993; Calder et al. 1993). Traditional practitioners often use sharpened or hot stones, razors, or knives, frequently without anesthesia or antibiotics (Rushwan 1990; Abdalla 1982; El Dareer 1982). In many communities

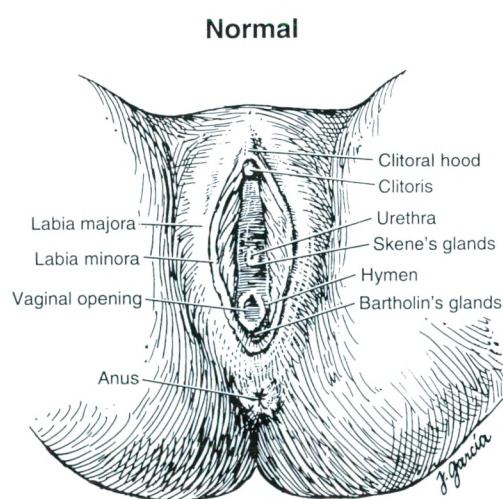
thorns are used to stitch the wound closed, and a twig is inserted to keep an opening. The girl's legs may be bound for a month or more while the scar heals (Abdalla 1982; El Dareer 1982).²

Types 2 and 3, both of which preclude orgasms, are the most popular forms. More than three-quarters of the girls in the Sudan, Somalia, Ethiopia, and other north African and southern Arabian countries undergo Type 2 or Type 3 circumcision, with many of the others circumcised by Type 1 (El Dareer 1982; Ntiri 1993; Calder et al. 1993; Koso-Thomas 1987; Ogiamien 1988). One survey by Sudanese physician Asma El Dareer (1982) shows that over 98 percent of Sudanese women have had this ritual surgery, 12 percent with Type 2 and 83 percent with Type 3. A 1993 study of 859 Somali women finds that all were circumcised, 98 percent with Type 3 and 2 percent with Type 2; on 70 percent of them, the surgery was done with a machete (Ntiri 1993).

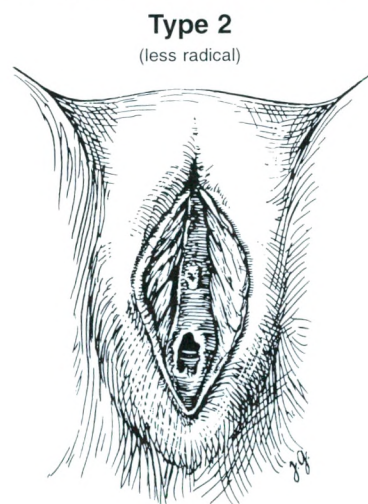
Medical science is divided over whether the practice of male circumcision has any benefits (see American Academy of Pediatrics 1989 and Alibhai 1993 for discussion of the pros and cons). In contrast, female circumcision/genital mutilation has no benefits and is harmful in many ways, with both short- and long-term complications documented in

a series of studies from Nigeria (Ozumba 1992), the Sudan (El Dareer 1982), Sierra Leone (Koso-Thomas 1987), and Somalia (Abdalla 1982; Ntiri 1993; Dirie and Lindmark 1992).

Almost all girls experience immediate pain following the surgery (Rushwan 1990; El Dareer 1982). El Dareer found other immediate consequences, including bleeding, infection, and shock correlating with the type of circumcision: Type 1, 8.1 percent; Type 2, 24.1 percent; and Type 3, 25.6 percent. Bleeding occurred in all forms of circumcision, accounting for 21.3 percent of the immediate medical problems in El Dareer's survey. She writes, "Hemorrhage can be either primary, from injuries to arteries or veins, or secondary, as a result of infection" (1982:33). Infections are frequent because the surgical conditions are often unhygienic (Rushwan 1990; El Dareer 1982). The inability to pass urine was common, constituting 21.65 percent of the immediate complications (El Dareer 1982). El Dareer found 32.2 percent of the women surveyed had long-term problems, with 24.54 percent suffering urinary tract infections and 23.8 percent suffering chronic pelvic infection. The published studies by investigators from the regions where these rituals are practiced uniformly find that women expressed similar complaints and had similar complications



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Removal of clitoris alone

from female circumcision/genital mutilation: at the site of the surgery, scarring can make penetration difficult and intercourse painful; cysts may form, requiring surgical repairs; a variety of menstrual problems arise if the opening left is too small to allow adequate drainage; fistulas or tears in the bowel or urinary tract are common, causing incontinence, which in turn leads to social as well as medical problems; maternal-fetal complications and prolonged and obstructed labor are also well-established consequences (Kouba and Muasher 1985; Rushwan 1990; El Dareer 1982; Koso-Thomas 1987; Abdalla 1982; Ozumba 1992; Ntiri 1993; Dirie and Lindmark 1992; Ogiamien 1988; Thompson 1989). El Dareer (1982:iii-iv) writes, "The result almost invariably causes immediate and long-term medical complications, especially at childbirth. Consummation of marriage is always a difficult experience for both partners, and marital problems often result. Psychological disturbances in girls due to circumcision are not uncommon." The operation can also be fatal because of shock, tetanus, and septicemia (Rushwan 1990).

As high as the rates of these reported complications are, investigator El Dareer (1982) believes that the actual rates are probably even higher for several reasons. First, female circumcision/genital

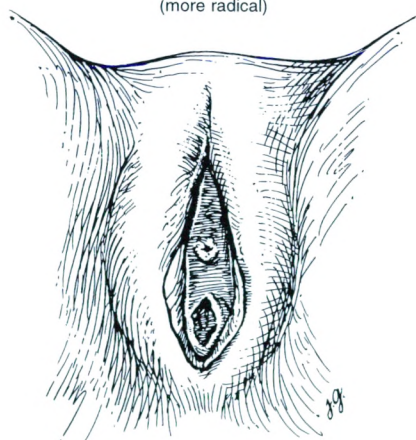
mutilation, although widely practiced, is technically illegal, and people are reluctant to discuss illegal activities.³ Second, people may be ashamed to admit that they have had complications, fearing they are to blame for them. Third, some women believe that female circumcision/genital mutilation is necessary for their health and well-being and so may not fully associate these problems with the surgery but assume that their problems would have been worse if they had been uncircumcised. Many women, as these studies show, are well aware of the complications from this ritual surgery. Nonetheless they strongly support continuing these practices. One study (Ntiri 1993) reports that 92 percent of the Somali women surveyed favor continuing Type 3 (76 percent) or Type 2 (24 percent) for their daughters.

Ethical Relativism

FEMALE CIRCUMCISION/GENITAL MUTILATION SERVES as a test case for some versions of ethical relativism because the practice has widespread approval within the cultures where it is practiced and widespread disapproval outside those cultures. *Relativism*, however, means different things to different "academic cultures." Indeed one of the most striking things

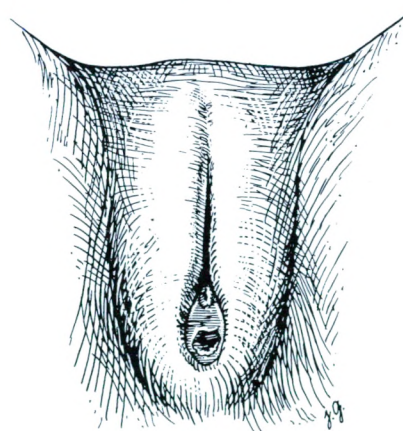
Type 2

(more radical)



Removal of clitoris and
part or all of labia minora

Type 3



Infibulation

Removal of clitoris, labia minora,
and part of labia majora

about the term *relativism* is that it is used in so many different ways, spanning the banal to the highly controversial. In the *Encyclopedia of Philosophy*, Richard D. Brandt (1967:75) writes, "Contemporary philosophers generally apply the term [ethical relativism] to some position they disagree with or consider absurd, seldom to their own views; social scientists, however, often classify themselves as relativists." Philosophers and those in religious studies often distinguish two ways to understand relativism: one is controversial, and the other is not (Brandt 1967; Sober 1991). The noncontroversial, descriptive version, often called *descriptive relativism*, is the view that people from different cultures *do* act differently and have distinct norms. Social scientists often work as descriptive relativists: they try to understand cultural differences and look for any underlying similarities. Those studying or criticizing female circumcision/genital mutilation, of course, recognize that we do act differently and have different values. But descriptions about how or in what way we *are* different do not entail statements about how we *ought* to act.

The controversial position, called *ethical relativism*, is that an action is right if it is approved in a person's culture and wrong if it is disapproved. Another version of this controversial view is that to say something is right means it has cultural approval; to say something is wrong means it has cultural disapproval. According to this view, which some call *cultural relativism* (Holmes 1993), there is no way to evaluate moral claims across cultures; positions taken by international groups like the World Health Organization merely express a cluster of particular societal opinions and have no moral standing in other cultures. On this view it is incoherent to claim that something is wrong in a culture yet approved, or right yet disapproved; people can express moral judgments about things done in their own or other cultures, but they are expressing only their cultural point of view, not one that has moral authority in another culture.

Many social scientists and (despite what Brandt says) some philosophers defend ethical relativism. For example, philosopher Bernard Williams (1985) argues that moral knowledge is inherited by people within particular cultural traditions and has objectivity only within those cultures. Anthropologists Faye Ginsberg (1991) and Nancy Scheper-Hughes (1991) point out that ethical relativism has held an important place in anthropology despite the uncomfortable consequence that acceptance of that position means that practices like female circumcision are right within the cultures where they are approved. Anthropologists by their own admission, however, do not use the terms *cultural relativism* or *ethical relativism* consistently (Shweder 1990). Often relativism is presented as the only alternative to clearly implausible views such as absolutism or cultural imperialism; sometimes it is used to stress the obvious points that different rankings and interpretations of moral values or rules by different groups may be justifiable, or employed to highlight the indisputable influence of culture on moral development, reasoning, norms, and decisions. It may also be used to show that decisions about what we ought to do depend on the situation—for example, that it may not be wrong to lie in some cases. These points are not in dispute herein or even controversial, so my comments do not apply to these versions of relativism.

Nor do the criticisms offered herein necessarily challenge relativists who agree that cross-cultural moral judgments sometimes have moral force. Generally they wish to accent the role of culture in shaping our moral judgments, showing why it is dangerous to impose external cultural judgments hastily or stressing that there is often a link between established moral systems and oppression. For example, moral philosopher Susan Sherwin maintains that "normative conclusions reached by traditional theorists generally support the mechanism of oppression; for example, by promoting subservience among women" and concludes, "Feminist moral rel-

ativism remains absolutist on the question of the moral wrong of oppression but is relativist on other moral matters" (1992:58, 75). She uses this form of relativism to argue that female circumcision is wrong.

In contrast, the distinctive feature of the version of ethical relativism criticized herein is its defense of the skeptical position that one can *never* make a sound cross-cultural moral judgment, that is, one that has moral force outside one's culture.⁴ This version of ethical relativism is false if people from one culture can *sometimes* make judgments that have moral authority about actions in another society. Its defenders regard their view to be the consequence of a proper understanding of the limits of knowledge (Williams 1985; Ginsberg 1991; Shweder 1990). Many attacks, however, have been made on the skepticism underlying such ethical relativism (Bambrough 1979; Hampshire 1989), and my remarks are in this tradition.

I would begin by observing that we seem to share methods of discovery, evaluation, negotiation, and explanation that can be used to help assess moral judgments. For example, we agree how to evaluate methods and research in science, engineering, and medicine, and on how to translate, debate, deliberate, criticize, negotiate, and use technology. To do these things, however, we must first have agreed to some extent on how to distinguish good and bad methods and research in science, engineering, and medicine, and what constitutes a good or bad translation, debate, deliberation, criticism, negotiation, or use of technology. These shared methods can be used to help evaluate moral judgments from one culture to another in a way that

sometimes has moral authority. An example of a belief that could be evaluated by stable medical evidence is the assertion by people in some regions that the infant's "death could result if, during delivery, the baby's head touches the clitoris" (Koso-Thomas 1987:10). In addition, some moral claims can be evaluated in terms of their coherence. It seems incompatible to promote maternal-fetal health as a good and also to advocate avoidable practices known to cause serious perinatal and neonatal infections.

We need not rank values similarly with people in another culture, or our own, to have coherent discussions about their consistency, consequences, or factual presuppositions. That is, even if some moral or ethical (I use these terms interchangeably) judgments express unique cultural norms, they may still be morally evaluated by another culture on the basis of their logical consistency and their coherence with stable and cross-culturally accepted empirical information. In addition,

we seem to share some moral values, goals, and judgments such as those about the evils of unnecessary suffering and lost opportunities, the need for food and shelter, the duty to help children, and the goods of promoting public health and personal well-being (Hampshire 1989). Let us consider, therefore, the reasons given by men and women who practice female circumcision/genital mutilation in their communities. The information presented herein is based upon studies done by investigators who come from these cultures, some of whom had this ritual surgery as children (El Dareer is one such investigator). We can examine whether these reasons allow people from other cultures any way of entering the

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sions of ethical relativism
because the practice has
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outside those cultures.**

debate based upon such considerations as consistency or stable medical findings.

Reasons Given for Female Circumcision/Genital Mutilation

ACCORDING TO FOUR INDEPENDENT SERIES of studies conducted by investigators from countries where female circumcision is widely practiced (El Dareer 1982; Ntiri 1993; Koso-Thomas 1987; Abdalla 1982), the primary reasons given for performing this ritual surgery are that it (1) meets a religious requirement, (2) preserves group identity, (3) helps to maintain cleanliness and health, (4) preserves virginity and family honor and prevents immorality, and (5) furthers marriage goals including greater sexual pleasure for men.

El Dareer conducted her studies in the Sudan, Dr. Olayinka Koso-Thomas in and around Sierra Leone, and Raquiya Haji Dualeh Abdalla and Daphne Williams Ntiri in Somalia. They argue that the reasons for continuing this practice in their respective countries float on a sea of false beliefs, beliefs that thrive because of a lack of education and open discussion about reproduction and sexuality. Insofar as intercultural methods for evaluating factual and logical statements exist, people from other cultures should at least be able to understand these inconsistencies or mistaken factual beliefs and use them as a basis for making some judgments having intercultural *moral* authority.

First, according to these studies the main reason given for performing female circumcision/genital mutilation is that it is regarded as a religious requirement. Most of the people practicing this ritual are Muslims, but it is not a practice required by the Koran (El Dareer 1982; Ntiri 1993). El Dareer

writes: "Circumcision of women is not explicitly enjoined in the Koran, but there are two implicit sayings of the Prophet Mohammed: 'Circumcision is an ordinance in men and an embellishment in women' and, reportedly Mohammed said to Om Attiya, a woman who circumcised girls in El Medina, 'Do not go deep. It is more illuminating to the face and more enjoyable to the husband.' Another version says, 'Reduce but do not destroy. This is enjoyable to the woman and preferable to the man.' But there is nothing in the Koran to suggest that the Prophet commanded that women be circumcised. He advised that it was important to both sexes that very little should be taken" (1992:72). Female circumcision/genital mutilation, moreover, is not practiced in the spiritual center of Islam, Saudi Arabia (Calder et al. 1993). Another reason for questioning this as a Muslim practice is that clitoridectomy and infibulation predate Islam, going back to the time of the pharaohs (Abdalla 1982; El Dareer 1992).

Second, many argue that the practice helps to preserve group identity. When Christian colonialists in Kenya introduced laws opposing the practice of female circumcision in the 1930s, African leader Kenyatta expressed a view still popular today: "This operation is still regarded as the very essence of an institution which has enormous educational, social, moral and religious implications, quite apart from the operation itself. For the present, it is impossible for a member of the [Kikuyu] tribe to imagine an initiation without clitoridectomy . . . the abolition of IRUA [the ritual operation] will destroy the tribal symbol which identifies the age group and prevent the Kikuyu from perpetuating that spirit of collectivism and national solidarity which they have been able to maintain from time immemorial" (Scheper-Hughes 1991:27). In addition, the practice is of social and economic importance to older women who are paid for performing the rituals (El Dareer 1982; Koso-Thomas 1987; Abdalla 1982; Ginsberg 1991).

Drs. Koso-Thomas, El Dareer, and Abdalla agree that people in these countries support female circumcision as a good practice, but only because they do not understand that it is a leading cause of sickness or even death for girls, mothers, and infants, and a major cause of infertility, infection, and maternal-fetal and marital complications. They conclude that these facts are not confronted because these societies do not speak openly of such matters. Abdalla writes, "There is no longer any reason, given the present state of progress in science, to tolerate confusion and ignorance about reproduction and women's sexuality" (1982:2). Female circumcision/genital mutilation is intended to honor women as male circumcision honors men, and members of cultures where the surgery is practiced are shocked by the analogy of clitoridectomy to removal of the penis (El Dareer 1982).

Third, the belief that the practice advances health and hygiene is incompatible with stable data from surveys done in these cultures, where female circumcision/genital mutilation has been linked to mortality or morbidity such as shock, infertility, infections, incontinence, maternal-fetal complications, and protracted labor. The tiny hole generally left for blood and urine to pass is a constant source of infection (El Dareer 1982; Koso-Thomas 1987; Abdalla 1982; Calder et al. 1993; Ntiri 1993). Koso-Thomas writes, "As for cleanliness, the presence of these scars prevents urine and menstrual flow escaping by the normal channels. This may lead to acute retention of urine and menstrual flow, and to a condition known as *hematocolpos*, which is highly detrimental to the health of the girl or woman concerned and causes odors more offensive than any that

can occur through the natural secretions" (Koso-Thomas 1987:10). Investigators completing a recent study wrote: "The risk of medical complications after female circumcision is very high as revealed by the present study [of 290 Somali women, conducted in the capital of Mogadishu].

Complications which cause the death of the young girls must be a common occurrence especially in the rural areas. . . . Dribbling urine incontinence, painful menstruations, haematocolpos and painful intercourse are facts that Somali women have to live with—facts that strongly motivate attempts to change the practice of female circumcision" (Dirie and Lindmark 1992: 482).

Fourth, investigators found that circumcision is

thought necessary in these cultures to preserve virginity and family honor and to prevent immorality. Type 3 circumcision is used to keep women from having sexual intercourse before marriage and conceiving illegitimate children. In addition, many believe that Types 2 and 3 circumcision must be done because uncircumcised women have excessive and uncontrollable sexual drives. El Dareer, however, believes that this view is not consistently held—that women in the Sudan are respected and that Sudanese men would be shocked to apply this sometimes-held cultural view to members of their own families. This reason also seems incompatible with the general view, which investigators found was held by both men and women in these cultures, that sex cannot be pleasant for women (El Dareer 1982; Koso-Thomas 1987; Abdalla 1982). In addition, female circumcision/genital mutilation offers no foolproof way to promote chastity and can even lead to promiscuity because it does not diminish

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desire or libido even where it makes orgasms impossible (El Dareer 1982). Some women continually seek experiences with new sexual partners because they are left unsatisfied in their sexual encounters (Koso-Thomas 1987). Moreover, some pretend to be virgins by getting stitched up tightly again (El Dareer 1982).

Fifth, interviewers found that people practicing female circumcision/genital mutilation believe that it furthers marriage goals, including greater sexual pleasure for men. To survive economically, women in these cultures must marry, and they will not be acceptable marriage partners unless they have undergone this ritual surgery (Abdalla 1982; Ntiri 1993). It is a curse, for example, to say that someone is the child of an uncircumcised woman (Koso-Thomas 1987). The widely held belief that infibulation enhances women's beauty and men's sexual pleasure makes it difficult for women who wish to marry to resist this practice (Koso-Thomas 1987; El Dareer 1992). Some men from these cultures, however, report that they enjoy sex more with uncircumcised women (Koso-Thomas 1987). Furthermore, female circumcision/genital mutilation is inconsistent with the established goals of some of these cultures because it is a leading cause of disability and contributes to the high mortality rate among mothers, fetuses, and children. Far from promoting the goals of marriage, it causes difficulty in consummating marriage, infertility, prolonged and obstructed labor, and morbidity and mortality.

Criticisms of Ethical Relativism

EXAMINATION OF THE DEBATE concerning female circumcision suggests several conclusions about the extent to which people from outside a culture can understand or contribute to moral debates within it in a way that has moral force. First, the fact that a culture's moral and religious views are often intertwined with beliefs that are open to rational and

empirical evaluation can be a basis of cross-cultural examination and intercultural moral criticism (Bambrough 1979). Defenders of female circumcision/genital mutilation do not claim that this practice is a moral or religious requirement and end the discussion; they are willing to give and defend reasons for their views. For example, advocates of female circumcision/genital mutilation claim that it benefits women's health and well-being. Such claims are open to cross-cultural examination because information is available to determine whether the practice promotes health or causes morbidity or mortality. Beliefs that the practice enhances fertility and promotes health, that women cannot have orgasms, and that allowing the baby's head to touch the clitoris during delivery causes death to the baby are incompatible with stable medical data (Koso-Thomas 1987). Thus an opening is allowed for genuine cross-cultural discussion or criticism of the practice.

Some claims about female circumcision/genital mutilation, however, are not as easily open to cross-cultural understanding. For example, cultures practicing the Type 3 surgery, infibulation, believe that it makes women more beautiful. For those who are not from these cultures, this belief is difficult to understand, especially when surveys show that many women in these cultures, when interviewed, attribute to infibulation their keloid scars, urine retention, pelvic infections, puerperal sepsis, and obstetrical problems (Ntiri 1993; Abdalla 1982). Koso-Thomas writes: "None of the reasons put forward in favor of circumcision have any real scientific or logical basis. It is surprising that aesthetics and the maintenance of cleanliness are advanced as grounds for female circumcision. The scars could hardly be thought of as contributing to beauty. The hardened scar and stump usually seen where the clitoris should be, or in the case of the infibulated vulva, taut skin with an ugly long scar down the middle, present a horrifying picture" (Koso-Thomas 1987:10). Thus not everyone in these cultures

believes that these rituals enhance beauty; some find such claims difficult to understand.

Second, the debate over female circumcision/genital mutilation illustrates another difficulty for defenders of this version of ethical relativism concerning the problem of differentiating cultures. People who brought the practice of female circumcision/genital mutilation with them when they moved to another nation still claim to be a distinct cultural group. Some who moved to Britain, for example, resent the interference in their culture represented by laws that condemn the practice as child abuse (Thompson 1989). If ethical relativists are to appeal to cultural approval in making the final determination of what is good or bad, right or wrong, they must tell us how to distinguish one culture from another.

How exactly do we count or separate cultures? A society is not a nation-state, because some social groups have distinctive identities within nations. If we do not define societies as nations, however, how do we distinguish among cultural groups, for example, well enough to say that an action is child abuse in one culture but not in another? Subcultures in nations typically overlap and have many variations. Even if we could count cultural groups well enough to say exactly how to distinguish one culture from another, how and when would this be relevant? How big or old or vital must a culture, subculture, group, or cult be in order to be recognized as a society whose moral distinctions are self-contained and self-justifying?

A related problem is that there can be passionate disagreement, ambivalence, or rapid changes within a culture or group over what is approved or disapproved. According to ethical relativism, where there is significant disagreement within a culture there is no way to determine what is right or wrong.

But what disagreement is significant? As we saw, some people in these cultures, often those with higher education, strongly disapprove of female circumcision/genital mutilation and work to stop it (El Dareer 1982; Koso-Thomas 1987; Ntiri 1993; Dirie and Lindmark 1992; Abdalla 1982). Are they in the same culture as their friends and relatives who approve of these rituals? It seems more accurate to say that people may belong to various groups that overlap and have many variations. This description, however, makes it difficult for ethical relativism to be regarded as a helpful theory for determining what is right or wrong. To say that something is right when it has cultural approval is useless if we cannot

identify the relevant culture. Moreover, even where people agree about the rightness of certain practices, such as these rituals, they can sometimes be inconsistent. For example, in reviewing reasons given within cultures where female circumcision/genital mutilation is practiced, we saw that there was some inconsistency concerning whether women needed this surgery to control their sexual appetites, to make them more beautiful, or to prevent morbidity or mortality. Ethical relativists thus have extraordinary problems offering a useful account of

Beliefs that the practice enhances fertility and promotes health, that women cannot have orgasms, and that allowing the baby's head to touch the clitoris during delivery causes death are incompatible with stable medical data. Thus an opening is allowed for genuine cross-cultural discussion or criticism of the practice.

what counts as a culture and establishes cultural approval or disapproval.

Third, despite some clear disagreement such as that over the rightness of female circumcision/genital mutilation, people from different parts of the world share common goals like the desirability of promoting people's health, happiness, opportunities, and cooperation, and the wisdom of stopping war, pollution, oppression, torture, and exploitation.

These common goals make us a world community, and using shared methods of reasoning and evaluation, we can discuss how they are understood or how well they are implemented in different parts of our world community. We can use these shared goals to assess whether female circumcision/genital mutilation is more like respect or oppression, more like enhancement or diminishment of opportunities, or more like pleasure or torture. While there are, of course, genuine differences

between citizens of the world, it is difficult to comprehend how they could be identified unless we could pick them out against a background of our similarities. Highlighting our differences, however useful for some purposes, should not eclipse the truth that we share many goals and values and are similar enough that we can assess each other's views as rational beings in a way that has moral force. Another way to express this is to say that we should recognize universal human rights or be respectful of each other as persons capable of reasoned discourse.

Fourth, this version of ethical relativism, if consistently held, leads to the abhorrent conclusion that we cannot make intercultural judgments with moral force about societies that start wars, practice torture, or exploit and oppress other groups; as long

as these activities are approved in the society that does them, they are allegedly right. Yet the world community believed that it was making a cross-cultural judgment with moral force when it criticized the Communist Chinese government for crushing a pro-democracy student protest rally, the South Africans for upholding apartheid, the Soviets for using psychiatry to suppress dissent, and the Bosnian Serbs for carrying out the siege of Sarajevo.

And the judgment was expressed without anyone's ascertaining whether the respective actions had widespread approval in those countries. In each case, representatives from the criticized society usually said something like, "You don't understand why this is morally justified in our culture even if it would not be in your society." If ethical relativism were convincing, these responses ought to be as well.

Relativists who want to defend sound social cross-

cultural and moral judgments about the value of freedom and human rights in other cultures seem to have two choices. On the one hand, if they agree that some cross-cultural norms have moral authority, they should also agree that some intercultural judgments about female circumcision/genital mutilation may have moral authority. Some relativists take this route (see, for example, Sherwin 1992), thereby abandoning the version of ethical relativism being criticized herein. On the other hand, if they defend this version of ethical relativism yet make cross-cultural moral judgments about the importance of values like tolerance, group benefit, and the survival of cultures, they will have to admit to an inconsistency in their arguments. For example, anthropologist Scheper-Hughes (1991) advocates

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tolerance of other cultural value systems; she fails to see that she is saying that tolerance between cultures is *right* and that this is a cross-cultural moral judgment using a moral norm (tolerance). Similarly, relativists who say it is wrong to eliminate rituals that give meaning to other cultures are also inconsistent in making a judgment that presumes to have genuine cross-cultural moral authority. Even the sayings sometimes used by defenders of ethical relativism—such as “When in Rome do as the Romans” (Scheper-Hughes 1991)—mean it is *morally permissible* to adopt all the cultural norms in operation wherever one finds oneself. Thus it is not consistent for defenders of this version of ethical relativism to make intercultural moral judgments about tolerance, group benefit, intersocietal respect, or cultural diversity.

The burden of proof, then, is upon defenders of this version of ethical relativism to show why we cannot do something we think we sometimes do very well, namely, engage in intercultural moral discussion, cooperation, or criticism and give support to people whose welfare or rights are in jeopardy in other cultures. In addition, defenders of ethical relativism need to explain how we can justify the actions of international professional societies that take moral stands in adopting policy. For example, international groups may take moral stands that advocate fighting pandemics, stopping wars, halting oppression, promoting health education, or eliminating poverty, and they seem to have moral authority in some cases. Some might respond that our professional groups are themselves cultures of a sort. But this response raises the already discussed problem of how to individuate a culture or society.

Objections

SOME STANDARD REJOINDERS ARE MADE to criticism of relativism, but they leave untouched the arguments against the particular version of ethical relativism discussed herein. First, some defenders argue that cross-cultural moral judgments perpetuate the evils of absolutism, cultural dogmatism, or cultural imperialism. People rarely admit to such transgressions, often enlisting medicine, religion, science, or the “pure light of reason” to arrive at an allegedly impartial, disinterested, and justified conclusion that they should “enlighten” and “educate” the “natives,” “savages,” or “infidels.” Anthropologist Scheper-Hughes writes, “I don’t ‘like’ the idea of clitoridectomy any better than any other woman I know. But I like even less the western ‘voices of reason’ [imposing their views]” (1991:27). Scheper-Hughes and others suggest that, in arguing that we can make moral judgments across cultures, we are thereby claiming a particular culture knows best and has the right to impose its allegedly superior knowledge on other cultures.

Claiming that we can sometimes judge another culture in a way that has moral force, however, does not entail that one culture is always right, that absolutism is legitimate, or that we can impose our beliefs on others. Relativists sometimes respond that even if this is not a strict logical consequence, it is a practical result. Sherwin writes, “Many social scientists have endorsed versions of relativism precisely out of their sense that the alternative promotes cultural dominance. They may be making a philosophical error in drawing that conclusion, but I do not think that they are making an empirical one” (1992:63–64).

The version of ethical relativism we have been considering, however, does not avoid cultural imperialism. To say that an act is right, on this view, means that it has cultural approval, including acts of war, oppression, enslavement, aggression, exploitation, racism, or torture. On this view, the disap-

proval of other cultures is irrelevant in determining whether these acts are right or wrong; accordingly, the disapproval of people in other cultures, even victims of war, oppression, enslavement, aggression, exploitation, racism, or torture, does not count in deciding what is right or wrong except in their own culture. This view thus leads to abhorrent conclusions. It entails not only the affirmation that female circumcision/genital mutilation is right in cultures where it is approved but the affirmation that anything with wide social approval is right, including slavery, war, discrimination, oppression, racism, and torture. If defenders of the version of ethical relativism criticized herein are consistent, they will dismiss any objections by people in other cultures as merely an expression of their own cultural preferences, having no moral standing whatsoever in the society that is engaging in the acts in question.

Defenders of ethical relativism must explain why we should adopt a view leading to such abhorrent conclusions. They may respond that cultures sometimes overlap and hence that the victims' protests within or between cultures ought to count. But this response raises two further difficulties for defenders of ethical relativism. First, it is inconsistent if it means that the views of people in other cultures have moral standing and oppressors ought to consider the views of victims. Such judgments are inconsistent with this version of ethical relativism because they are cross-cultural judgments with moral authority. The second difficulty with this defense, also discussed above, is that it raises the problem of how we differentiate a culture or society.

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Second, some defenders of ethical relativism argue that we cannot know enough about another culture to make any cross-cultural moral judgments. We cannot *really* understand another society well enough to criticize it, they claim, because our feelings, concepts, or ways of reasoning are too different; our so-called ordinary moral views about what is permissible are determined by our upbringing and environments to such a degree that they cannot be transferred to other cultures. There are two ways to understand this objection (Sober 1991). The first is that nothing counts as understanding another culture except being raised in it. If that is what is meant, then the objection is valid in a trivial way. But it does not address the important issue of whether we can comprehend well enough to make

relevant moral distinctions or engage in critical ethical discussions about the universal human right to be free of oppression.

The second, and nontrivial, way to understand this objection is that we cannot understand another society well enough to justify claiming to know what is right or wrong in that society or even to raise moral questions about what enhances or diminishes life, promotes opportunities, and so on. Overwhelming data, however, suggest that we think we can do this very well. Travelers to other countries often quickly understand that approved practices in their own country are widely condemned elsewhere, sometimes for good reasons. For example, they learn that the U.S. population consumes a disproportionate amount of the world's resources, a fact readily noticed and condemned by citizens in other cultures. We ordinarily view international criticism

and international responses concerning human rights violations, aggression, torture, and exploitation as important ways to show that we care about the rights and welfare of other people, and in some cases these responses have moral authority.

People who deny the possibility of genuine cross-cultural moral judgments must account for why we think we can and should make them, or why we sometimes agree more with people from other cultures than with our own relatives and neighbors about the moral assessments of aggression, oppression, capital punishment, abortion, euthanasia, rights to health care, and so on. International meetings, moreover, seem to employ genuinely cross-cultural moral judgments when they seek to distinguish good from bad uses of technology, promote better environmental or health policies, and so on.

Third, some defenders of ethical relativism object that eliminating important rituals from a culture risks destroying the society. They insist that these cultures cannot survive if they change such a central practice as female circumcision (Schepers-Hughes 1991). This counterargument, however, is not decisive. Slavery, oppression, and exploitation are also necessary to some ways of life, yet few would defend these actions in order to preserve a society. Others reply to this objection by questioning the assumption that these cultures can survive only by continuing clitoridectomy or infibulation (El Dareer 1982). These cultures, they argue, are more likely to be transformed by war, famine, disease, urbanization, and industrialization than by the cessation of this ancient ritual surgery. A further argument is that if slavery, oppression, and exploitation are wrong whether or not there are group benefits, then a decision to eliminate female circumcision/genital mutilation should not depend on a process of weighing its benefits to the group. It is also incoherent or inconsistent to hold that group benefit is so important that other cultures should not interfere with local practices. For this view elevates group benefit as an overriding cross-cultural value, something that

these ethical relativists claim cannot be justified. If there are no cross-cultural values about what is wrong or right, a defender of ethical relativism cannot consistently say such things as "One culture ought not interfere with others," "We ought to be tolerant," "Every culture is equally valuable," or "It is wrong to interfere with another culture."

Comment

WE HAVE SUFFICIENT REASON, THEREFORE, to conclude that these rituals of female circumcision/genital mutilation are wrong. For me to say they are wrong does not mean that they are disapproved by most people in my culture but wrong for reasons similar to those given by activists within these cultures who are working to stop these practices. They are wrong because the usual forms of the surgery deny women orgasms and because they cause medical complications and even death. It is one thing to say that these practices are wrong and that activists should be supported in their efforts to stop them; it is another matter to determine how to do this effectively. All agree that education may be the most important means to stop these practices. Some activists in these cultures want an immediate ban (Abdalla 1982). Other activists in these cultures encourage Type 1 circumcision (pricking or removing the clitoral hood) in order to "wean" people away from Types 2 and 3 by substitution. Type 1 has the least association with morbidity or mortality and, if there are no complications, does not preclude sexual orgasms in later life. The chance of success through this tactic is more promising and realistic, they hold, than what an outright ban would achieve; and people could continue many of their traditions and rituals of welcome without causing so much harm (El Dareer 1982). Other activists in these countries, such as Raquiya Abdalla, object to equating Type 1 circumcision in the female with male circumcision: "To me and to many others, the aim and

results of any form of circumcision of women are quite different from those applying to the circumcision of men" (1982:8). Because of the hazards of even Type 1 circumcision, especially for infants, I agree with the World Health Organization and the American Medical Association that it would be best to stop all forms of ritual genital surgery on women. Bans have proven ineffective: this still-popular practice has been illegal in most countries for many years (Rushwan 1990; Ntiri 1993; El Dareer 1982). Other proposals by activists focus on education, fines, and carefully crafted legislation (El Dareer 1982; Abdalla 1982; Ozumba 1992; Dirie and Lindmark 1992; WHO 1992).

The critique of the reasons given to support female circumcision/genital mutilation in cultures where it is practiced shows us how to enter discussions, disputes, or assessments in ways that can have moral authority. We share common needs, goals, and methods of reasoning and evaluation. Together they enable us to evaluate many claims across cultures and sometimes to regard ourselves as part of a world community with interests in promoting people's health, happiness, empathy, and opportunities

as well as desires to stop war, torture, pandemics, pollution, oppression, and injustice. Thus, ethical relativism—the view that to say something is right means it has cultural approval and to say it is wrong means it has cultural disapproval—is implausible as a useful theory, definition, or account of the meaning of moral judgments. The burden of proof therefore falls upon upholders of this version of ethical relativism to show why criticisms of other cultures always lack moral authority. Although many values are culturally determined and we should not impose moral judgments across cultures hastily, we sometimes know enough to condemn practices approved in other cultures. For example, we can understand enough of the debate about female circumcision/genital mutilation to draw some conclusions: it is wrong, oppressive, and not a voluntary practice in the sense that the people doing it comprehend information relevant to their decision. Moreover, it is a ritual, however well-meant, that violates justifiable and universal human rights or values supported in the human community, and we should promote international moral support for advocates working to stop the practice wherever it is carried out.

NOTES

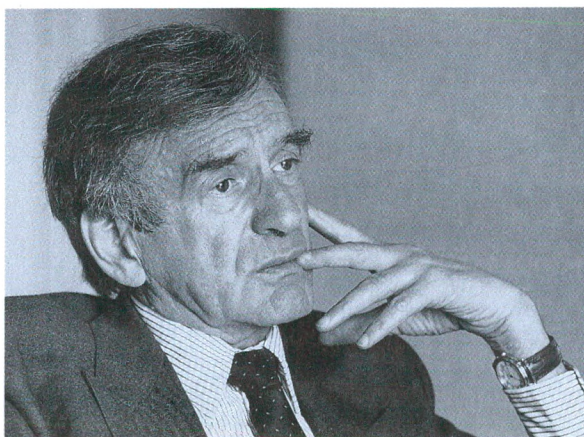
The author wishes to thank Robert Holmes, Suzanne Poirier, Sandy Pittman, Barbara Hofmaier, Richard McCarty, and Holly Mathews for their help in reviewing this manuscript, Juan Garcia for providing the drawings, and Jean Fourcroy for reviewing the drawings for accuracy.

1. According to Abdalla (1982:16), in these regions the unusual practice is followed of putting "salt into the vagina after childbirth . . . [because this] induces the narrowing of the vagina . . . to restore the vagina to its former shape and size and make intercourse more pleasurable for the husband."
2. Some authors cite incidences of a very rare operation they call Type 4, or introcision, where the vaginal opening is enlarged by tearing it downward, cutting the perineum (see, for example, Rushwan 1990). It is practiced in Mali and sometimes in Senegal and northern Nigeria (Kouba and Muasher 1985).
3. These laws are often the unenforced remnants of colonial days or governments do not care to apply them. For a fuller discussion of the history of these rituals see Abdalla 1982; El Dareer 1982; Fourcroy 1983; Ntiri 1993; and Ruminjo 1992.
4. In contrast to normative ethical relativism, opponents may take one of several general positions about the meaning of right and wrong. They may hold that rightness and wrongness are the same in some ways but not in others for different cultures; that they depend upon something in human nature, the natural order of things, or the human condition; or that they are absolute and unchanging, either in form or substance, for all people (Holmes 1993).

REFERENCES

- Abdalla, Raquiya H. D. 1982. *Sisters in Affliction: Circumcision and Infibulation of Women in Africa*. London: Zed Press.
- Alibhai, Shabbir M. H. 1993. "Male and Female Circumcision in Canada" (letter to the editor). *Canadian Medical Association Journal* 149, no. 1 (1 July): 16–17.
- American Academy of Pediatrics. 1989. "Report of the Task Force on Circumcision." *Pediatrics* 84, no. 2 (August): 388–91. (Published erratum appears in *Pediatrics* 84, no. 5 [November 1989]: 761.)
- American Medical Association. 1991. "Surgical Modification of Female Genitalia." House of Delegates Amended Resolution 13 (June).
- Bambrough, Renford. 1979. *Moral Skepticism and Moral Knowledge*. London: Routledge and Kegan Paul.
- Brandt, Richard D. 1967. *Encyclopedia of Philosophy*, s.v. "ethical relativism."
- Calder, Barbara L., Yvonne M. Brown, and Donna I. Rac. 1993. "Female Circumcision/Genital Mutilation: Culturally Sensitive Care." *Health Care for Women International* 14, no. 3 (May–June): 227–38.
- Dirie, M. A., and G. Lindmark. 1992. "The Risk of Medical Complication after Female Circumcision." *East African Medical Journal* 69, no. 9 (September): 479–82.
- El Dareer, Asma. 1982. *Woman, Why Do You Weep? Circumcision and Its Consequences*. London: Zed Press.
- Fourcroy, Jean L. 1983. "L'Eternal Couteau: Review of Female Circumcision." *Urology* 22, no. 4 (October): 458–61.
- Ginsberg, Faye. 1991. "What Do Women Want?: Feminist Anthropology Confronts Clitoridectomy." *Medical Anthropology Quarterly* 5, no. 1 (March): 17–19.
- Hampshire, Stuart. 1989. *Innocence and Experience*. Cambridge, Mass.: Harvard University Press.
- Holmes, Robert L. 1993. *Basic Moral Philosophy*. Belmont, Calif.: Wadsworth Publishing.
- Kluge, Eike-Henner. 1993. "Female Circumcision: When Medical Ethics Confronts Cultural Values" (editorial). *Canadian Medical Association Journal* 148, no. 2 (15 January): 288–89.
- Koso-Thomas, Olayinka. 1987. *The Circumcision of Women*. London: Zed Press.
- Kouba, Leonard J., and Judith Muasher. 1985. "Female Circumcision in Africa: An Overview." *African Studies Review* 28, no. 1 (March): 95–109.
- Ntiri, Daphne Williams. 1993. "Circumcision and Health among Rural Women of Southern Somalia as Part of a Family Life Survey." *Health Care for Women International* 14, no. 3 (May–June): 215–16.
- Ogiamien, T. B. E. 1988. "A Legal Framework to Eradicate Female Circumcision." *Medicine, Science and the Law* 28, no. 2 (April): 115–19.
- Ozumba, B. C. 1992. "Acquired Gynectresia in Eastern Nigeria." *International Journal of Gynaecology and Obstetrics* 37, no. 2: 105–9.
- Ruminjo, J. 1992. "Circumcision in Women." *East African Medical Journal* 69, no. 2 (September): 477–78.
- Rushwan, Hamid. 1990. "Female Circumcision." *World Health*, April–May, 24–25.
- Scheper-Hughes, Nancy. 1991. "Virgin Territory: The Male Discovery of the Clitoris." *Medical Anthropology Quarterly* 5, no. 1 (March): 25–28.
- Sherwin, Susan. 1992. *No Longer Patient: Feminist Ethics and Health Care*. Philadelphia: Temple University Press.
- Shweder, Richard. 1990. "Ethical Relativism: Is There a Defensible Version?" *Ethos* 18:205–18.
- Sober, Elliott. 1991. *Core Questions in Philosophy*. New York: Macmillan.
- Thompson, June. 1989. "Torture by Tradition." *Nursing Times* 85, no. 15: 17–18.
- Walker, Alice. 1992. *Possessing the Secret of Joy*. New York: Harcourt Brace Jovanovich.
- Williams, Bernard. 1985. *Ethics and the Limits of Philosophy*. Cambridge, Mass.: Harvard University Press.
- World Health Organization. 1992. *International Journal of Gynaecology and Obstetrics* 37, no. 2: 149.

"I know I've been an object of hate and a victim of hate. So I want to understand what makes a person hate. What is the structure, the fabric, the texture of hate? Once it's there, can you remove it? What I've felt is that hate is like cancer. I don't think I can change hate into love in a person. If it's there, it's there to stay. You may fight it with laws, but it is there."



On the Genesis of Hate

An Interview with Elie Wiesel

Second Opinion: Stalin once said that the death of a person is a tragedy, but the death of a million is a statistic. You are someone who began with the awareness of the millions but always focused on the individual. Today we are going to focus not on the violence of groups—nation against nation, for example—but on the violence of individuals: physician against patient, husband against wife, parent against child, clergy against women or boys. What from your experience would most carry over to those situations? What's the difference between one against one as

opposed to impersonal force against one?

Wiesel: Stalin was wrong, obviously—wrong even within his own terminology. To him, the death of one person was not a tragedy; the death of a person was nothing. He gave orders to have his best friends killed. He read the protocols of the trials of his closest allies and enjoyed reading about their torture—their weaknesses, shortcomings, and failings. Strangely enough, all of them believed that he did not. They always said to the torturer, “You know, one day Stalin will learn about this, and he will punish you.” Because the death of one person meant nothing to him, the death of millions of people didn't mean anything to him either. I have learned that the center of the universe is not a community but one person. The universe has many centers—each

human being. Everyone has a uniqueness in the universe, and anyone can say that he or she is in the image of God. Because God is unique, so we are all unique.

Second Opinion: What goes wrong that the uniqueness of the individual gets lost? There are many Stalins, and there are rivers of blood. What is it in the victimizer, the torturer, the executioner that makes this possible?

Wiesel: Fortunately there are not many Stalins. Only one Hitler, one Eichmann, only one Genghis Khan, one Attila the Hun. Maybe each generation has one Stalin. I don't know what goes wrong in the individual psyche. All my life I have directed my attention and devoted my energy to understanding the victim, not the killer. In my novels I write of victims, and the killers are almost secondary. To me the

Elie Wiesel is Andrew W. Mellon Professor in the Humanities, University Professor, and professor of religious studies, Boston University. He is a survivor of Auschwitz and Buchenwald. He established the Elie Wiesel Foundation for Humanity, which seeks to advance the cause of human rights and peace.

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killers are important as killers but not as human beings. The victims are important as human beings. I cannot say "I" in place of the killer. As a novelist it seems I have to say "I," but I cannot say "I" for the killer. Maybe I'm afraid of what I might find there. I don't really know what happens to the individual killer. I do know that some were mad and that the winds of madness were blowing in history. I think the Crusades were madness. I think the Inquisition was madness. Maybe what we saw in 1939–45 was also madness. We don't know why. We don't know where it comes from. We don't know where it is headed. But the fallout will still be here.

Second Opinion: Do you find the language of the demonic appropriate or alien? One chronicler of the Nazi era—although not given to talk about the supernatural—said that with the rising of Nazism on German soil, one could all but hear the wing beats and hooves, as if primal forces were coming from the earth. Is that at all useful?

Wiesel: That language may be useful for some. We all have our own questions, our own quest. I have no solution; the questions I had in 1945 are still unanswerable. But I don't talk of the demonic. I do not want to insult the demons. Also, it's too easy. Human beings can be inhuman—meaning that to be inhu-

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himself as a ruler,
and we are all his
prisoners.
God himself is his
prisoner.
The fanatic decides
what God should be.
He gives orders to
God. Therefore,
fanatics are
dangerous for the
whole world, not
only to one people.”



man is also a human aspect. I don't like the word *monster*, for instance. Eichmann, the SS or the KGB executioners—they're people, they're not monsters; they're human beings. If they were monsters, it would be easy. "OK, they're not I." That doesn't mean that there is a monster in all of us. I don't believe that. I don't believe there is an Eichmann in all of us. That's not true. A human being should be judged by what he or she is doing. If we have not killed, we are not killers or even potential killers. I think it's unfair to see in every human being a potential killer. We are not Cain. Cain left no descendants.

Second Opinion: If we are not Cain, who are we?

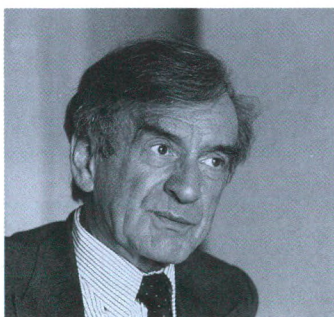
Wiesel: We are those who ask who we are. Cain did not ask who he was. You know as well as I do that the problem with Cain and Abel was that Abel spoke and Cain wouldn't listen. We are those who listen. The executioner never listens. The fanatic never listens. The danger of the twenty-first century is not an economic or political issue, it's fanaticism. Fanaticism is growing and growing everywhere—in the Muslim world, even in the Jewish world. Look what happened at Hebron. The fanaticism of one man may sabotage the peace process. (I hope with all my heart that it won't.) There is Rwanda, Burundi, Yugoslavia.

I asked, What is the fanatic? What does the fanatic want to say? I learned quite a lot from that. I learned that first of all fanaticism is stupid. A fanatic doesn't hear, except his own voice. A fanatic sees himself as a ruler, and we are all his prisoners. God himself is his prisoner. The fanatic decides what God should be. He gives orders to God. And therefore fanatics are dangerous for the whole world, not only to one people.

Second Opinion: Theologian Robert McAfee Brown years ago wrote a book [*Elie Wiesel: Messenger to All Humanity*] in which he said many people have read you as giving voice to Job, but he reads you as giving voice to Jeremiah. Tell us a bit about Jeremiah.

Wiesel: I am neither Job nor Jeremiah. I love Jeremiah. Job intrigues me. To this day I start with Job. I love Job. Because of all the enigmas of his story, Job is still alive. The fact that he was broken so fast puzzles me. The fact that he gave in so fast puzzles me. The fact that he recovered so fast puzzles me even more. All of a sudden he gets back his wealth and position, and he and his wife have several more children. What about the first children? And the new children that he has—won't they feel guilty? Because had there been no catastrophe, he wouldn't have had more children.

"The good doctor is the one who uses his or her own Being—with a capital B—to help the Being in the patient. Anyone who destroys or who damages or hurts that Being is guilty."



Jeremiah is different. Jeremiah is the only prophet who foresaw the catastrophe, who lived the catastrophe, who survived it. There is something about this man who quarrels with God. Job doesn't quarrel with God. Job wants to accept God. But he protests against God's indifference. The moment God says, "I'm here!" Job is here. It is easier for Job to accept an unjust God than an indifferent God. Jeremiah knows that God is not indifferent. Jeremiah already also knows that his own ways, his pathways, will never be understood. He is a prophet. Jeremiah, because he has foreseen the catastrophe, may feel guilty, thinking "Had I not foreseen the catastrophe, it would not have occurred."

Second Opinion: In our work at the Park Ridge Center we don't begin with "hospital-system" or allocation-of-resources questions. The fixed point is the patient, the sufferer. Suppose a male physician abuses a young woman patient. We've established that if you were writing the novel you would look at the patient. On what resources could the patient draw? If she believes in God, is she better off with an indifferent God?

Wiesel: For the patient the physician is God. You don't think the same way when you are lying in the hospital bed. The patient waits for the doctor

impatiently and with anxiety and with hope. If the doctor smiles, then the whole universe is bathing in sun. If the doctor looks concerned, then the patient is moved to despair. I hear of the indifferent physician; I think that physician should be outlawed. I hear of the cruel physician; I think that physician should go to jail. He or she may be the greatest physician in the world, capable of curing cancer. Still, that physician should go to jail. "God" the physician—I'm putting *God* in quotation marks—has no right to be cruel for his own personal pleasure.

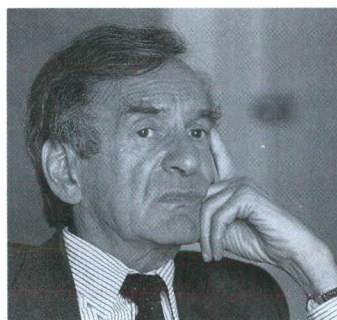
My own experience with physicians is good. I realize that there is something divine in physicians' work. In Judaism, the doctor is a messenger of God. Persons cannot heal. Only God can heal. God gives doctors the mission to heal.

Second Opinion: Who is the good doctor?

Wiesel: The good doctor is the one who uses his or her own Being—with a capital B—to help the Being in the patient. Anyone who destroys or who damages or hurts that Being is guilty.

Second Opinion: Some people say that surgery is good in America because it's a highly competitive game. Taskmasters work residents 18 hours a day, and that discipline produces

"Some victims in my tales do not survive, and often they are Jews. The tragedy is that the victims are always weaker than the killer. One killer with a machine gun is stronger than a thousand allies. It is the killer who wins."



excellence. That seems to contradict your image of the good doctor. Or can you be a good surgeon and a bad doctor?

Wiesel: When surgeons come out of the operating room, they seem almost indifferent. They are not, but they look indifferent. I've asked a few surgeons about that. They said, "You cannot get involved too much. You'll be destroyed. Especially oncologists." I know a little about this because my sister died of cancer. I've met oncologists, and some are examples of humanity. Yet if they became personally involved with patients they would go to pieces, because the enemy, the cancer, is so strong. We know our limitations. I understand why surgeons must keep a distance.

Second Opinion: A patient can be trapped in the depersonalization of the modern, technical hospital. Nights are long when you are threatened with death. Are there support systems along the way?

Wiesel: The nurses. Nurses are more important than physicians. When I was 12, I had bursitis. At that time it was very serious. It struck me on Shabbat, when no one was supposed to travel. There were no surgeons in my town. My mother went to the rabbi to ask for special permission to travel. We didn't have cars, so we took a carriage to a large city that had a surgeon. I remember that I

fell in love with a nurse. I woke up from the anesthesia and saw a beautiful nurse. She came and she gave me tea.

When I had an accident in New York and came to the hospital, my dream was to find again this kind of nurse I could fall in love with. I would call for the nurse because the pain was excruciating—they had to turn me over every half hour or so—and I couldn't get the nurses. Then they told me why. It was July, and all of them were in another room watching baseball! So a friend of mine put a television set in my room, and then all of them came in my room.

Second Opinion: I'd like for you to look at several relationships where one person has power over another and then draw some conclusions about victims. Take, for example, the domineering, perhaps abusive, husband and the wife trapped by circumstance. What do you see?

Wiesel: I have not seen; I'm protected in a way. I try to think back, and I don't remember ever seeing my parents quarrel. Why? Because my father was always absent except for Shabbat. Either he was in the store or he was acting as an intercessor for the community, ransoming a prisoner or getting documents for a refugee. I saw him only on Shabbat. After the war I did, of course, see such family crises. Nothing is more traumatizing for a child, I imag-

ine, than to know that his or her parents are enemies. Each parent seeks to have the child, at least, on his or her side, and in doing so the parents wound the child.

Second Opinion: Is the man in that circumstance "God"?

Wiesel: The child becomes God in the parents' eyes. They go to the child and say, "Tell us who is right." What is the child going to do? In the Jewish tradition, God avoids entering a household where there is no peace. I understand that. God doesn't want to take sides. God should take the side of the child.

Second Opinion: What about the relationship between teacher and student?

Wiesel: The teacher is not God. The teacher should be an older friend. I'm proud that in my whole career as a professor never has a student felt humiliated in one of my classes, by me or by another student. Even if the student makes a fool of him- or herself, the others, instead of laughing at the student, rally around to protect, shield, and comfort. The teacher should understand the extraordinary privilege that is his or hers to be a teacher. I am so passionately involved with my teaching, with my learning, and with my students that I couldn't live without it.

Second Opinion: What about the rabbi who is dealing with the deep spiritual issues? Do they have to have a shield like the surgeon, or are they especially called never to have a shield, to be passionately involved like the teacher?

Wiesel: I recognize rabbis as my teachers, my guides, my masters. Few have had the occasion to read my works *Souls on Fire* and *Four Hasidic Masters and Their Struggles against Melancholy*. What I love about Hasidic rebbes is that they involved themselves with every single person—young or old, strong or weak, learned or unlearned. The result: most of them suffered. One of them, as you remember, was in isolation. Others suffered from deep anguish and melancholy. They were exposed to so much suffering, and they became involved in it. In the face of so much pain they had the choice to give up faith or give up wisdom. And they chose to give up wisdom.

Second Opinion: Is that the real calling of the profound rabbi or priest-minister?

Wiesel: I'm not the rabbi. I cannot tell you. I know that a Hasidic rabbi must.

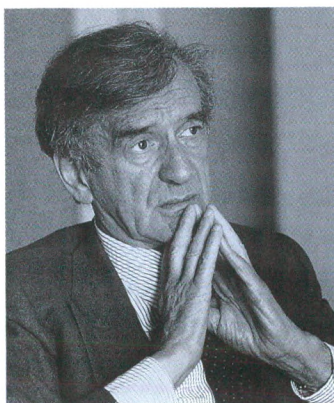
Second Opinion: We define the surgeon as someone who couldn't stay rational if she got involved, but we are calling this spiritual leader to be involved.

Wiesel: I think the rabbi must be involved. Why? Because the Jewish tradition doesn't have clergy. The rabbi has only one function—rabbi means teacher. You can be born without the rabbi, circumcised without the rabbi, bar mitzva'd without the rabbi, married without the rabbi, die without the rabbi. You need rabbis because they are teachers. Today they are also social servants, communal servants, which is good. People go to rabbis because they need the system, the ritual, the function of their tradition to know what to do. The rabbi comes and tells them this is the tradition, this is the flavor of this, and this is what to do. It's very important.

Second Opinion: In the Hebrew Scriptures the words for *heal* and *save* are very similar. What heals? In the case of your sister, you can't do much because the cancer overwhelms. The auto accident—you can't help being hit, but you can still be healed.

Wiesel: After my sister died, I studied the laws and the tradition of mourning for the first time. We don't study that in our youth. I realized that Jewish tradition is extraordinary, sensitive, wise, compassionate—every step is certain. First comes the shock. Between death and burial the mourner is in shock. Therefore the mourner is freed from fulfilling the positive commandments of God. He doesn't have to pray,

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But at the same time
we should say, ‘The
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My ancestors have
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am not they.’”



he doesn't have a book with him. The mourner is allowed time to be restored to reality gradually—at the burial, during the first seven days, then 30 days, then a year of mourning. What heals is the community. The mourner is never alone. That is what is really important. The Bible speaks of death—what is the expression? “He was being gathered with his ancestors.” That is what helps the mourner. God will gather thousands and thousands of dead together, and that gives a certain solidity to the mourning.

Second Opinion: Why is the richness of that tradition so often overlooked? Every religious tradition we study has it, and sensitive people within it learn to draw upon it; sometimes they learn first from crisis. What is it about the world that keeps so many from drawing on a resource?

Wiesel: I don't know. It's so beautiful. It's so necessary. Maybe it's our fault. Maybe it's my fault. I'm not teaching it. How can I accuse anybody else?

Second Opinion: To return to the theme of the relationships in which one person has power over another, it has become common today for the language of the victim to be almost institutionalized. There are acronyms for groups of people who have been abused. Is that useful, or has it become political instead of humanistic?

Wiesel: It's important for some people to know that they are not the only ones who were abused. In being a part of a group, the pain, I imagine, is diminished. I don't like groups. I like individual human beings.

Second Opinion: Theologian Ellen Charry warns against letting one's story be only the story of the victim, because that gives too much power to the dominator. I've always been impressed that your stories start with the victim, but in a strange way the victim survives, endures.

Wiesel: Some victims in my tales do not survive, and often they are Jews. The tragedy is that the victims are always weaker than the killer. One killer with a machine gun is stronger than a thousand allies. It is the killer who wins. The *tale* of the victim survives. Ultimately there is a certain victory—a sad victory, a melancholy victory—attached to the victim rather than the killer. Hitler lost the war, but we Jews didn't win it. Politicians say, "We won." How can you speak of victory when you've lost six million people? So I don't listen to politicians.

Second Opinion: This puts an extra burden on the storyteller, doesn't it? Not to tell the story is to dishonor the sufferer.

Wiesel: It's hard to deal with suffering. We don't know how. I have written some 36 books—

three or four a year on that subject—and believe me, I know how unforgiving and insufficient my testimony is.

Second Opinion: Not to tell the story is to dishonor the sufferer, yet we can do it only selectively. Let's return to our earlier discussion of the doctor-patient relationship. I've been told that 80 percent of notifications of death, when the family is not present at the hospital, are done by telephone. If you spoke at a medical school and could talk about the power of story, what would be your central theme?

Wiesel: Strangely enough, I get many letters from cancer patients, who somehow identify with some of my stories. Of course, I answer them immediately. Then I often get invitations to give commencement addresses at medical schools. I wonder, "Why me?" I'm not good in medicine. I'm not a scientist. I don't even know the name of my bones. What can I tell them? It's my ignorance they want, to measure what they see. In Israel, when a soldier dies in battle, they always have an officer or a rabbi inform the family. I think it's a human touch. I don't think it should be done by telephone. But I cannot give you a formula. It would be against my theory, my philosophy. Every case is unique.

Second Opinion: But the story could open their minds to look-

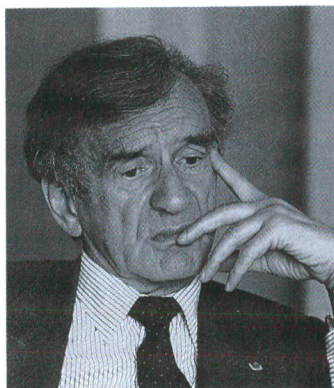
ing for other stories. The hospital nearest here will have Pakistani physicians and Jewish anesthesiologists and Catholic patients and so on. Can they, can we, learn from each other's stories? Christians are learning from your Jewish stories, but can a physician learn in a culture where there is no grand narrative?

Wiesel: Life is the greatest narrative, and death is the end of the narrative. We all learn from one another, not only the way we live, but also the way we die. If my stories were to be received by only one group, they would be the wrong stories. I believe that with all my heart. I as a Jew speak of Jewish stories, but I hope these Jewish stories are universal. You should see them in the light of your own experience.

Second Opinion: Some people would say that the grand narratives of the Bible—Abraham and Isaac, for example—might themselves contribute to violence. The New Testament gives a picture of the God who says, "Sacrifice your own son." God does not interrupt the sacrifice of his own son. Some interpretations, and they are not *incredible*, say these exacerbate the problem instead of resolve it. I don't agree with that. I'd like to hear you on it. Can the narrative create problems? You've done a great deal with the Abraham and Isaac story. Does the violence in the story itself, the picture of God, contribute to our problem?

Wiesel: The binding of Isaac has always disturbed me. I'm still troubled, because I believe that the binding of Isaac, together with the appearing of the Law at Sinai, is the most important episode in Jewish history. God asked Abraham to kill his own son. Telling this story cannot help anyone. I'll give you another example. In one of my courses we talked of violence and religion, and we came to the Inquisition and the Crusades. In Jewish history, the Crusades are a catastrophe—the culmination of injustice and brutality. I looked at the Catholic students. Should I diminish the story of my past and the holy Crusades in order not to antagonize good, sincere, devoted Catholics? Should I say what I hear about St. Louis? St. Louis is the one who gave the orders to burn the Talmud. How could he be a saint? What should I do? That is really the question. Should I say truth commands me to tell the tale the way I see it, or should I spare the feelings and sensitivities of my good friends and allies? I try not to hurt people. When I hurt someone, I suffer. I feel so guilty. I don't sleep. That's why I cannot write a negative review. Why should I make that poor writer look stupid? I tell the tale the way I feel it. I try to say it gently, with as much friendship as I can. Today's Catholics or Christians or Protestants are not guilty for what Luther said—we are responsible for what *we* are

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doing, not for others that came before us. I think we should remember the past. But at the same time we should say, “The past is the past. My ancestors have done this and that. However, I, now living in your midst, next to you, am not they.”

Second Opinion: Elie Wiesel: messenger, witness, storyteller, teacher. Is it the role of teacher that gives continuity?

Wiesel: I think one word you've missed is *father*. It's very important. A turning point in my life really was when I had a son. Really to learn what it means to bring life into this world. I became much more active, going places, traveling whenever I was needed, writing articles and petitioning for people in jail.

Second Opinion: How do all these things relate to your present work with your foundation, where you are attempting to understand the roots of hate?

Wiesel: I have a desire to understand. In 1965 I went back to Germany—20 years after leaving. I wanted to find hate—my hate, not only theirs. I realize I cannot hate the Germans. I cannot judge these people. Still, I know I've been an object of hate and a victim of hate. So I want to understand what makes a person hate. That's how I began. Whoever hates begins hating one family, one group, one communi-

ty. For the last seven or eight years I've been organizing seminars on the anatomy of hate, the genesis of hate. What is the structure, the fabric, the texture of hate? Once it's there, can you remove it? How? Is there a remedy?

In the beginning people didn't want the word *hate*. They asked, "Why don't you go in the opposite direction, and study *love* or *tolerance*?" I said, "No, the word *hate* is a shock, and I want to shock." Now, *hate* is a word that is everywhere. You even have what you call "hate crimes." If I have a conclusion for the moment, it's a very pessimistic

conclusion. I may change it. I hope I change it. What I've felt is that hate is like cancer. I don't think I can change hate into love in a person. If it's there, it's there to stay. You may fight it with laws, but it is there.

Second Opinion: What do you think is responsible for this new genesis of hate that we are experiencing?

Wiesel: I don't think it's new. Take anti-Semitism; it vanished on the surface immediately after the war because it wasn't fashionable. In 1948 it wasn't nice to be

anti-Semitic. Hate is not genetic. There is a component of mystery in it. Sometimes one element is dominant, at other times another one is. It's like love. What is love? It's this and this and this plus the unknown. The same with hate. It's that and that and that plus something else. Anti-Semitism exists for economic reasons and for religious reasons and for social reasons plus something else. I think we are all responsible for our own hate. I as a teacher am responsible for my own students. If they hate, it's my fault.



Watch Out.

Oil on canvas by Ken Goodman, 1983. 62 x 62 inches.

Courtesy of Brooke Alexander, New York. Photo: Ivan Dalla Tana.

Guns and Voices

Drew Leder

TWO YEARS AGO I CALLED THE MARYLAND STATE Penitentiary, a maximum-security prison for perpetrators of violent crimes, most of them “lifers.” For a while I had been toying with the idea of teaching philosophy in a prison setting. Though I’m no Platonist, I imagined the mind soaring free from the body incarcerated, and I could think of no better use to which to put the tools of my training. I teach at Loyola College in Maryland, a private institution primarily serving white, middle-class students, and I wanted to reach beyond.

During the summer there were no regular college courses, and the prison school was happy to have me volunteer. So were the prisoners—in a strange way, they seemed less incarcerated than my regular students, at least in the classroom. They weren’t simply “doing time” in class like so many of my reluctant sophomores fulfilling core requirements—they were there because they wanted to be, hungry for ideas.

The course, though not for college credit, was open only to students college level and beyond.¹ We started by focusing on questions of justice and

imprisonment, suffering and liberation. We studied Socrates on trial, Epictetus, the crippled Stoic, the Book of Job, Jesus on the cross, King’s “Letter from Birmingham Jail.” The summer ended, but we just kept going, around the world to the Chinese Tao te Ching, Indian Hinduism, the shamans of Bali, African philosophy.

Our conversations proved so powerful that we started to record them. From the tapes we produced an article for the journal *Lingua Franca* (July/August 1993), and we are now working on a book. Increasingly we have keyed on the nature of violence: both that which they have been subjected to and that which they have perpetrated, as victim turns into victimizer in the cycle of brutality.

Below we explore the intertwining of creativity, power, and violence, using Thomas Moore’s *Care of the Soul* (HarperCollins, 1992). The transcriptions of our taped conversations have been edited and condensed.

Drew: Last week we talked about Thomas Moore, who wrote that the word *violence* comes from the same root as the word for life, *vis*. He noted that the kind of energy used in destructive violence can be channeled into creative endeavors. In fact, if you try

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to repress that violent energy, it is more likely to come out in destructive ways. Let's begin today with something that Moore wrote about guns. I don't have any extra copies with me, so I will read this passage aloud.

There are signs in society, too, that the gun is a ritual object. Guns are both banned and adored. A gun is one of the most numinous [that means sacred, mystical]—mysteriously fascinating and disturbing—objects around us. Those who protest its banishment [in other words, people who are against gun control] may be speaking for a rare idol of power that keeps the strength of life, *vis*, before our eyes. A gun is dangerous not only because it threatens our lives, but also because it concretizes and fetishizes our desire for power, keeping power both in sight and also removed from its soulful presence in our daily lives. . . . The soul is explosive and powerful. Through its medium of imagination, which is always a prerequisite for action and is the source of meaning, it can accomplish all things. In the strength of its emotions, the soul is a gun, full of potential power and effect. The pen, expressing the soul's passion, is mightier than the sword because the imagination can change the life of a people at their very roots. (Pp. 134–35)

I think he is saying that guns are not just weapons; they have become symbols, incarnations, of power and energy. Our

•
CHARLES BAXTER.
34 years old;
African American;
a Muslim imam;
earned a
bachelor's degree
in business.

•
WAYNE BROWN.
36 years old;
African American;
in prison has
become a serious
weight lifter and
devout Christian;
earned a degree
from a theological
seminary; serving a
life sentence.

•
TONY CHATMAN.
35 years old;
African American;
before entering
prison was active
in the anti-
apartheid
movement; earned
a bachelor's degree
in psychology and
criminal justice;
serving a
life sentence.

•
JACK COWAN.
46 years old;
African American;
earned bachelor's
degrees in
management
science and sociol-
ogy (honor roll
student every
semester).

society is both repelled by and attracted to the gun. Moore says guns are dangerous not only because they kill people but also because pouring our soul energy into guns keeps us from expressing that soul energy in a more creative fashion. I was interested in seeing your reaction to this as people who have been around guns a lot. Do you think there is something ritualistic—almost sacred—in the symbol of the gun?

John: When I first started dealing with guns, my first reaction was fear. It represented so much. Now you are a guy in the neighborhood who carries a gun. Someone told me when I was younger, "Man, stay away from that. Once you pick it up you never put it down." I didn't pay him much attention, because I was caught up into the lifestyle. But that gun became a crutch. I wouldn't go anywhere without a gun.

Once I was paying my rent downtown, and the people said, "We can't take cash, we need a money order." I'm running across the street to the bank, and this .25 in my pocket hits the ground. I scoop it off the curb, tuck it back, and run in the bank like it ain't nothing. I am standing in line to get this money order, and I'm saying to myself, "Oh man have you lost your mind? You just picked up a gun and put it back in your pocket right in plain view." I'm standing there, and all these thoughts are coming through my mind. The gun became so much a part of me. When I got up in the morning and got dressed, the gun was going with me. It wasn't like, "Well, I don't need a gun today."

Once the word gets out that you are carrying a gun, guys look at you different. Everybody gets into a frame of mind that when they come to deal with you it is

going to be a shooting situation. So the fear reverses: you say, "I've got to keep it now, because they are coming toward me."

Drew: So when you have the gun you become an embodiment of power, but in a way you also become more vulnerable. Now everyone is going to deal with you like that, knowing you have a gun.

Jack: When I was four or five the main thing I wanted for Christmas was a gun. Just watching cowboys on TV, I wanted the two guns and holster and all that.

Drew: Why do kids want these toy guns? Is it the same reason adults do?

Jack: It's basically the same. Power. If the little kid has a gun and everybody's playing cowboys and Indians and he starts to shoot longer and faster he's going to win. Everybody would want to play with him.

Charles: I remember the first time that I ever carried a gun. A dude said, "Shorty, hold a gun for me." I wasn't more than 13, and he was 17 or 18. I was scared, but I felt like I belonged. When I gave the gun back, it seemed like I went back to the little dude that I was. I shrunk.

Drew: So there was some sort of power that you felt almost transformed you into a different kind of person with more power?

Charles: And not only that, it is the same with America. Americans with their guns and their arms feel as though they are a superpower. America spends a lot of money on defense, on arms and weapons to protect themselves. And they attack a lot of other countries.

Wayne: Ever since the discovery of gunpowder the rich and the powerful were trying to get their hands

on it. Then they would steal from the poor or the minority. They would use this gunpowder to keep and defend what they had stolen. Every time the minority want to rise, there was always that gun there to keep them in check. Even after the end of slavery, when people tried to rise up, the gun was there to keep them down. The police, the so-called representatives of justice, use guns unjustly to keep people in their place. We have had leaders who began to speak to the oppressed people. Always a gun was used to bring them down.

Over time people, especially people who are relegated to ghettos, become frustrated. They say, "I can't take this no more." They remember a TV western or something that they have seen in actual life where a gun was used, and it was very effective. Children see parents come home with this hopeless mentality. The children say, "It's not going to be like that for me." They start to get angry. They say, "I am going out there and I'm going to get mine." Because they have been relegated to a particular place, this anger has built up in them over the years. They take guns and turn them on each other, because their anger cannot be expressed in a way that would be beneficial.

Tony: Then once you've got that gun, you have the power over life and death. I'm 35. When we were coming up most of the time if you had a beef with somebody, at the most you might have a knife . . . maybe a chain, or a baseball bat, and that is how you took care of your beefs. If you got your butt whipped you accepted it.

John: People say violence on TV makes all this violence come about. I don't think so. I think the reason is the greater accessibility of guns, especially to younger kids. When I was 13 or 14, getting a gun was out of this world. Get a gun from where? If you did, it was an old ragged revolver, it had a rubber band on it, tape to hold it together. Now they are pulling out brand-new fresh pretty-looking big

spanking-new guns. Where does a little boy get a gun like that? When I was coming up, there might be one gun in the whole neighborhood. If you had a beef you had to come looking for me, and I had to duck past my mother and go up in the attic, and by the time I got to him, he might have calmed down or the other guy might have left. Now everybody's got the gun right in his hands. It don't give people the opportunity to think. For any problem you have, grab the gun and solve it.

Tony: I started carrying a gun when I was in high school in L.A. I lived in what's known as Blood territory, and I got banked one day in school—five of them jumped me. I decided I wasn't going to get banked any more. I bought me a .38 and carried it until the day I got arrested right here. I have had fights one-on-one, with that .38 under my arm in a holster, and I never pulled it. Not everybody can do that. There is a guy in this jail, the first thing that comes out of his mouth, any argument you have, is "If I had my gun, you'd do what I want you to do. I could do some straightening." Well, can't you straighten it without the gun? Which makes me think that if he ain't got his gun he must not be a man. He can't solve any problem without a gun. Every situation in your life, is that how you are going to settle it?

Drew: You can almost become addicted to it.

Tony: Yes. It's 105 degrees outside and he wears a jacket. He is not considered a "zap out" in here. He wears a jacket when it's 105 outside, because he has been carrying a gun all his life, and it's a habit. I said,

•
O'DONALD
JOHNSON.
19 years old;
African American;
in juvenile
facilities from
ages 10 to 13;
at 15 awarded
scholarship to
Maryland Institute
of Art; then
arrested for first-
degree murder;
sentenced to life
plus 20 years—
all suspended but
55; earned GED in
prison and
currently in
college program.

•
ARLANDO
("TRAY")
JONES III.
26 years old;
African American;
earned bachelor's
degree in
psychology;
strong interest in
philosophy
and religion;
serving life plus
35 years for first-
and second-degree
murder.

•
DREW LEDER,
M.D., Ph.D.
39 years old;
Jewish; an associ-
ate professor of
philosophy at
Loyola College in
Baltimore,
Maryland.

"What's the matter? You're in jail. You don't have a gun." He said, "It don't make no difference, I always wear it. I've got to have my jacket on." And he is dead serious. He says, "When I'm in the streets I have to wear a jacket to cover my pistol." It is ingrained in his brain.

O'Donald: The gun I had wasn't so much how much power it had but how it looked. I used to spend hours just cleaning it, looking at it, holding it. If I saw a gun that looked ugly I didn't want it. I don't think it was because of the power a gun can display. I think there is more to it.

Donald: When you are carrying a gun, I think other people can tell. Some kind of way a gun makes you light up. If you don't have a gun on you, a dude might mug you down. People don't mug you if you've got your gun on you. They can detect something more about you that wasn't there before.

Drew: Why do you think that is? Do you think you carry yourself differently?

John: You have a gait or favor the side or how you wear your jacket or your leg might be a little stiff—little things, because it really has your body off balance.

Drew: Is it just physical or is it also psychological?

Tony: It's psychological too, because you feel secure. If I get in a beef and I've got a revolver, I know I got 6 buddies to help me. If it's an automatic, I know I got 15.

Selvyn: My first encounter with guns was at home. I was living with my grandmother. My mother bought me a cap gun set for Christmas, and she used that to preach to me about the evils of guns. The gun set up on the shelf, and I wasn't allowed to touch it. I became fascinated with guns, with any kind of projectile or thing that explodes. But I never saw a gun as a form of violence toward other people. When I came here, I was exposed to people that was selling, transporting guns. All I had to do was go to a friend's house and pick one. I always carried a gun. Then circumstances led to me getting an assault and battery and robbery charge. That's when I said, "Wait a minute. I got to stop carrying this." If I had been presented with the same circumstances again, it might not have been just assault and robbery; it could have been murder.

Tray: In my lifestyle, having guns was a hindrance. I never liked having guns in my possession. I felt more powerful when I could tell somebody, "Now go take care of that." The person who had the gun was usually at the lower part of our hierarchy. When a dude used to tell me, "Go take care of that," it seemed like a lot of my power was taken from me. When I could tell somebody else to do it and I could hear the sounds of it coming from somebody else's hands, I felt the power then, probably like Reagan and Bush when they heard the bombs dropping. The gun is nothing in and of itself. It is the atrocity that is in a man's heart. That's where the power comes from.

Drew: Let me ask a different question. Some say there used to be a morality that held people in check, a religious upbringing that taught them to turn the other cheek. But Moore also suggests there could be a negative side to that. It can teach you to repress all your violent life force since you have to always be good, submissive, turning the other cheek.

Charles: My religion doesn't teach me that. The Qur'an teaches me to fight those that oppress you. If

somebody strikes me I'm going to strike them back, and I'm acting justly.

Donald: If you really study the scripture of most religions, the only time you can physically kill another man is when some people's lives are threatened or they're being enslaved. I don't think there is any philosophy that will justify a man not counter-acting that violence with equal violence.

Drew: I go to Quaker meetings, and Quakers are extreme pacifists, so I would like to follow up on this idea. I hear people saying that sometimes—in a situation of oppression and injustice—you can try to overthrow it with physical violence. But the person who restrains himself, who turns the other cheek rather than strikes back, may emanate a kind of power that not only transforms himself but perhaps transforms the others. That is the kind of principle Gandhi was using, or Muhammad Ali, when he refused to fight in the Vietnam War. They weren't just being meek and mild. Often they were standing up very courageously, even putting their lives on the line for principle.

Donald: People like Gandhi and his predecessors, even if they didn't actually perpetrate violence, somebody somewhere did so to facilitate what they did. The same with Martin Luther King Jr.—the threat of violence coming from Malcolm X may have helped him accomplish a lot of things he accomplished. The alternatives were King or Malcolm X or the Black Panthers.

Charles: I want to say that in the Qur'an (2, 30), when God is getting ready to create man, and the angels question Him, "Why are you going to create one that is going to shed blood on the land and violence?" God said, "I know that which ye know not." He knew man was going to be violent. Abraham was violent when he broke them idols up, but he was trying to make his point. Moses killed a man.

(Jumping out of his chair, his voice getting louder) Jesus went into the marketplace and kicked over the tables. He was a violent man, he didn't take no shit, he wasn't no chump!

John: But violence will destroy the one who originates it. Let's talk about us and these other guys in here: violence is their main way of solving a problem and is the thing that came back and destroyed them. If you're doing karate, you don't fight the force, you can flow with it. By flowing with it, you can use the energy from the force. Turning the other cheek may be an extreme expression of how you can let the energy that comes from violence destroy itself—without you putting yourself in a violent position.

Drew: I want to change the subject a bit. Going back to guns, I have heard some of you say that having a gun can give a person a tremendous sense of power, especially someone who does not feel he has a lot of power in ordinary life. To get people to put down their guns, you would have to substitute images and means for them to express power in creative and life-enhancing ways.

Tony: A good example of what you are talking about is the controversy over so-called gangster rap. When people criticize the rappers, the rappers ask, "Would you rather us get up here and sing on TV and rap about what's going on in the streets with guns and dope and violence, or would you rather us get out in the streets and do it?" The rappers are saying, "This is what is going on in the neighborhood; you can't hide it." A lot of things that go

•
DONALD THOMPSON.
37 years old;
African American;
a committed
Muslim;
completing a
bachelor's degree
in management
science; serving a
life sentence for
murder and
armed robbery.

•
•**SELVYN TILLET.**
34 years old;
from Belize;
a committed Black
Nationalist and
Muslim; currently
in general studies
college program;
serving life plus
20 years.

•
JOHN WOODLAND.
38 years old;
African American;
Muslim;
president of the
prison's Project
Turnaround,
designed to help
kids in trouble;
since entering
prison, has
intensively studied
African cultures
and earned a
college degree.

•
NOTE:
Some of the
prisoners declined
to state the length
of their sentences
or the nature of
their crimes.

on in the inner city and in the neighborhood are hid. You only see what the mass media wants you to see. They can't do that anymore. The media can control the news, can control the newspaper, but they can't control my record. If I make a record and people like it, anybody can go buy it.

Drew: So there is a power to having a voice.

Tray: Everybody needs some kind of medium to get their power thing on. One time Frederick Douglass said that a man without force is without the essential dignity of being human. In the penitentiary some things I do show my power, and I don't have a gun. Even if a person has a gun, if the next man ain't scared of you you aren't going to get no power. People always give that power. You can get power by having a gun or being good with words or being good with your imagination.

John: Look at Spike Lee. For African Americans a camera or a video is now a way of getting their power across. The rappers use the microphone to get their rage out. They are saying this is how it is, and we don't like it.

Drew: Again it is a vehicle of communication. This is my voice, this is how I see the world. And that gives the power to bring about change—political power.

John: You don't have to do it with a gun anymore. We get on the microphone, we have a camera, we have Spike Lee, Robert Townsend. Spike is a real good example, and he's very militant too. He says, "I know you don't like what I'm doing and I

know why you don't like it. I'm telling you something that you have been able to keep quiet for years, but you can't keep me quiet anymore because now I've got the camera."

Drew: Let me ask a question. We started talking about guns and the power they have. Now we've moved on to other ways of expressing yourself, finding a voice, having an impact. How about this class? Can it become a tool of power for the people in it?

John: This project we are working on right now, if it turns into a book, to me that's a sense of power. It's a way you can pass something on to others, to your family. They can hold and read it and get an idea of what you were really like, what you wanted to offer to society. If it becomes a successful book, then it really becomes a thing of power. People will want to know, who is this guy who made these comments? You know I'd like to meet him, I'd like to help him. I sent the little article we did for *Lingua Franca* to my aunt and my uncle, and they were very impressed. They could see that I was doing something other than time.

Wayne: Coming to the class and doing the reading, I have developed a power to create from a philosophical perspective and from what I believe as a Christian. For example, I wrote a sermon based on this class, because I got so tired of the same old boring stuff, Sunday after Sunday. We read Foucault on the "panopticon," and I compared Jesus to the guard in the guard tower. He can see everyone. I used that as a word of encouragement, you know; God sees us, and we see God, so we don't need to feel abandoned and alone.

Drew: The power of the sermon to move people is a kind of power very different from the kind you get from a gun.

Tony: To me, the thing about the class is the camaraderie. I think about the [*Lingua Franca*] article. We did something together that was cohesive. I could live to be 190 years old, and I'll never forget that. It's not the 50 dollars. It is the fact that somebody out there read what we were doing, listened to it. When you asked us about that, you said nothing about no money. We didn't do it expecting money. The fact that what we did was good enough that they wanted to share with their readership, that's power. I said all this to my daughter. She's 12, and she is smarter than I am, so when I get something like that I shoot that straight to her.

Drew: When you are stuck inside the walls of the penitentiary it is harder to have power, because it is harder to have an effect on the world out there. But it sounds like through these kinds of writing projects there is a way to get over the prison walls.

Tony: You can have my body, but you can't keep my words. My words are already out there hopefully.

NOTE

1. Inmates who were working at the college level had secured their education in prison through the federal Pell Grant Program. The Pell Grant Program provides federal money to finance higher education for low-income Americans. Since the program's inception two decades ago, prisoners—whose income is effectively zero—have been eligible to apply for these funds. This has enabled colleges and universities to establish extension programs, sending books and professors into the prisons. Nationwide, some 25,000 inmates are enrolled. Unfortunately, both the House and Senate versions of the crime bill under consideration at press time would forbid the use of Pell Grant funds by prisoners. Since most states do not fund college-level education for prisoners, this could mean the end of higher education for prisoners, despite statistics indicating that inmate participants have a significantly lower recidivism rate upon release.



Warsaw 1943.

Serigraph by Ben Shahn, 1963.

Warsaw 1943.

Private collection. ©1994, Estate of Ben Shahn/VAGA, New York. Photo: Philip A. Charles.

Serigraph by Ben Shahn, 1963.

Private collection. ©1994, Estate of Ben Shahn/VAGA, New York. Photo: Philip A. Charles.

REFLECTION

The Road to Itoman

Marius L. Bressoud Jr.

IN JUNE 1945, I KILLED THREE PEOPLE IN AN ACT OF aggressive euthanasia. I first described the incident in a book-length account I wrote for my children and grandchildren about my experiences during the last great battle of World War II on the island of Okinawa. During 80 days of ground combat I led a platoon of Marine Corps riflemen as we fought through areas with substantial civilian population. My purpose in writing was not simply to chronicle a bunch of old war stories but to record my response to those events and the issues of life and death, pride and pain, faith and ethics that they raise. The event occurred as we fought along the network of muddy roads that led through farming villages to the coastal town of Itoman and the last major line of Japanese defense at the southern end of the island.

ONE NIGHT ON THE ROAD TO ITOMAN there were more attempts than usual by either civilians or Japanese soldiers to get past our defensive position. We had already seen the tragic consequence of civil-

Marius L. Bressoud Jr. is a self-employed public affairs consultant and writer.

ians trying to pass through our lines in the dark rather than identifying themselves in broad daylight so we could screen and intern them. At night we simply could not take a chance and fired at anything that moved in the dark.

This night we were aware of small groups of people crawling, even running, just yards in front of us. We would fire and the noise would stop. Then after a while it would begin again. We fired again. Once more the noise would stop. The process was repeated several times during the night.

As soon as day broke we cautiously searched the ground in front of us. There were no bodies. But we discovered a cave not more than 25 feet to our left front. It had a small, natural entrance, one we had not noticed the night before. It opened down into the ground and was angled in such a way that someone inside could not fire on us easily. We guessed that the infiltrators were civilians, but we could not be sure.

None of us spoke any Japanese. I got out my Japanese phrase book and in a loud voice, carefully pronouncing all the English phonetic equivalents, repeated phrases like "Come out with your hands above your head" and "We will not hurt you." There was no response. I repeated my entreaties a couple of times and may have added some other phrases. There was not a peep from the cave. It was unthinkable to walk away from it. If there were Japanese soldiers

inside, we knew they would emerge again to attack us or other American units passing through the area, and we could not take the chance of entering the cave. Silhouetted against the outside light we would have been perfect targets.

We had a demolition man with us, and I asked him to blow the cave entrance shut. He thought he could do it, and it looked to me as if the ground above the opening would collapse and seal it shut. But when the explosion went off and the smoke began to clear we saw that the cave entrance had been enlarged rather than closed. And the screams of women and cries of children told us we had a large group of civilians on our hands.

One of my squad leaders then did one of the bravest things I ever witnessed. He grabbed his rifle and a flashlight and dropped into the cave. It wasn't the kind of act for which the United States Marine Corps was likely to award a medal. But we had learned that this kind of cave was very likely to harbor soldiers as well as civilians. He gambled his life in the act.

He prodded and we helped or dragged the people out. There must have been 15 or more of them, mostly women and children. There were two or three middle-aged men. Two women and a small boy were alive but seriously or fatally wounded. We were unable to tell if their injuries were the result of our firing at them during the night or of the explosion and partial collapse of the cave. One young woman, found totally naked, had a broken leg but was otherwise uninjured.

When all the civilians had been pulled out, we heard two or three rifle shots from deep inside the cave, and my hero squad leader emerged. He had

killed a single unresisting Japanese soldier who refused to leave.

I could not spare a single fighting man to escort the ragged band of civilians to the rear. But there was one very sick rifleman—suffering from dysentery, I believe—who I had considered sending back in any case. We assembled the group, rigged a makeshift litter that two of the middle-aged men could drag, placed the young woman with the broken leg on it, and covered her with some clothing we found. No one claimed responsibility or even showed

concern for the three too seriously hurt to be moved. Overseen by one very sick Marine, those who could move headed north. Left unconscious on the ground were the three who were seriously injured. They looked to us like a boy of nine or ten, his mother, and his grandmother.

By that time I had received orders to stand by to resume the advance. As we packed up to move on, Joe Taylor, my platoon sergeant, came to me and said we couldn't just leave those three people there on the ground. At first, I thought he meant that we should try somehow to get them to medical help. The thought was ridiculous under the circumstances, and I said so. But no, he understood that. What he

meant was that someone should finish them off before we moved out.

I told him to get a volunteer and see to it. In a few minutes he came back to me and said no one would volunteer. I looked him in the eye and asked, "No one?" He responded, "No one." "OK," I said, "I'll do it myself." My carbine still had 10 or 11 rounds in it, and, after all, I needed only three. I slipped off the safety and walked over to where the

**If I learned anything
on Okinawa I learned that
I don't need an
all-encompassing code of
conduct that attempts to
answer every question and
anticipate every situation.
Conditionality and
uncertainty leave room for
faith in making decisions
and acting on them, room
for forgiveness and
restoration.**

people still lay just outside the cave entrance.

All three were lying motionless on their backs, the grandmother on the left, the boy in the middle, the mother on the right. Some very thoughtful person in the platoon had covered their heads with clean white cloths so that I did not have to look at their faces. The cloths were about the size of large linen dinner napkins and appeared freshly laundered and pressed. I imagined that they were part of some family treasure that the grandmother had not wanted to leave behind when she fled her home.

I fired one round through each head and thought I was done. But the grandmother moved. I fired a second round through each head. Then I saw—or thought I saw—the mother's body twitch. I fired a third round into each head. By this time the cloths and the heads were a mess. It had not been a neat gangland-style execution after all. I was overcome with emotion I cannot possibly describe. I fired my last round or two somewhere, I forget where, and returned to where I had left my pack, thoroughly ashamed. I was ashamed not because I had killed them but because I had done it in a thoroughly emotional and unprofessional manner. I had made a mess of it. Here I was, a professional killer, so overcome with emotion that I did not recognize involuntary body movements as the natural consequence of a bullet in the brain.

Neither Taylor nor any other member of the platoon ever said a word to me or, to my knowledge, to anyone else about the incident. After all, no one else was willing to do the job that all seemed to agree was necessary. Perhaps they recognized what had happened to me.

IN 1945 I WOULD NOT HAVE KNOWN what the phrase *active euthanasia* meant. In 1994, with euthanasia a subject of discussion for medical ethicists and theologians, recalling the experience drives me to reflect in more detail about my own inner response to the issues it raises.

Eighty days of ground combat and the military service that preceded and followed them form part of the emotional and spiritual foundation of my life. Before I was nine I began intensely intimate and personal conversations with God. Later, I began to grasp the reality of the ultimately unknowable creator and

sustainer of the universe. On Okinawa I learned to hold these two experiences in balance and to be at ease with not having all the answers to life's questions. I learned to read Holy Scripture for its deepest and most lasting meaning. I found it is not a satisfactory quick fix for a current problem.

At first glance my killing of these three people appears not to meet the usual criteria governing a decision to end the suffering of terminally ill or injured persons: I had no professional medical input and no personal knowledge of the injured; the injured people had no ability to speak for themselves and no advocate to represent them.

In fact, there was medical input of a sort. By that point in the campaign we had experienced 70 days of often bitter combat. Thirty-one of the 42 men who originally made up the platoon had been killed or wounded. We had tended them, held them in our arms, dragged them out of the line of fire, wiped their blood from our hands, then fought along the road to Itoman with a dozen green replacements. The platoon had killed hundreds of Japanese soldiers and Okinawan civilians, anonymous victims of the insanity of war. We knew something about the physical and medical aspects of gunshot and shrapnel wounds. But I never before or since stood over people and blew their brains out, and I never killed with such emotion. Although nameless, the three were no longer unknown—their relationships and humanity were evident to us all.

Did I do the best I could under the circumstances? I do not know, and I will not second-guess the young lieutenant who made that decision or attempt to justify it. Isn't that all right? If I learned anything on Okinawa I learned that I don't need an all-encompassing code of conduct that attempts to answer every question and anticipate every situation. Conditionality and uncertainty leave room for faith in making decisions and acting on them, room for forgiveness and restoration.

The Okinawa experience was a time of intense spiritual formation for me. My primary tool in that process was the Episcopal *Book of Common Prayer*. Up to this time, Holy Communion was the service I had found most meaningful. But I began to see that it is clearly the thanksgiving meal of a community of believers, not the offering of a solitary Christian. I

turned to the daily offices of morning and evening prayer.

There on a hillside, overlooking the sea, following the events on the road to Itoman, I read for the first time the opening psalm of morning prayer, the Venite.

*O come, let us sing unto the Lord,
let us heartily rejoice in the strength of our
salvation.
Let us come before his presence with thanksgiving,
and show ourselves glad in him with psalms.*

Sing? Rejoice? Be thankful? Set against the death and maiming of almost all the men who had landed with me 11 weeks earlier, set against my own weariness and pain, what was there to sing about?

*For the Lord is a great God,
and a great King above all gods.
In his hand are all the corners of the earth,
and the strength of the hills is his also.
The sea is his and he made it,
and his hands prepared the dry land.*

Yes, this bloodied hill, that sea with its broken ships and bodies, all still in God's hands.

*. . . we are the people of his pasture
and the sheep of his hand.*

I am. The Japanese soldiers I have killed and those who will still try to kill me, we are all his people. We are all, in some mysterious, crazy, not-to-be-understood way, held in God's hands. What then do I say about the matter of the grandmother, the mother, and the boy?

Is it wrong to kill another human being? Yes. Is it always wrong, regardless of the circumstances, to kill another human being? Yes. Is it always more wrong to kill another human being than to take some other action? Ah . . . now I cannot answer "yes" or "no." I must first find myself in such a situation, then work out the answer. It is a question that is answerable only in the midst of a concrete real-life dilemma.

That leads me to conclude that euthanasia—in contrast to "letting die"—cannot be codified, institutionalized, or regulated. I fear the consequences of establishing some agency with the power to make such life-and-death decisions. Misuse of that power seems to me inevitable. I believe that euthanasia should continue to be legally as well as morally impermissible. If, in a specific situation, someone believes it is the only possible course and carries it out, then that person must be prepared to face the consequence: the imperfect judgment of a legal system staffed by other fallible human beings. I do not pretend that this is a good solution to the problems created by our desire to end the suffering of terminally ill people. There is no good solution. But it is the only one I can now imagine that reconciles my desire for both love and justice.

ON THE BIOETHICS FRONT

The Power of the Nonrational in Demands for Marginally Beneficial or Useless Treatments

Ernlé W. D. Young

E. Haavi Morreim. 1994. "Profoundly Diminished Life: The Casualties of Coercion." *Hastings Center Report* 24, no. 1: 33–42.

Robert M. Veatch. 1993. "Forgoing Life-Sustaining Treatment: Limits to the Consensus." *Kennedy Institute of Ethics Journal* 3, no. 1: 1–19.

Candace Cummins Gauthier. 1993. "Philosophical Foundations of Respect for Autonomy." *Kennedy Institute of Ethics Journal* 3, no. 1: 21–37.

FOR TOO LONG, BIOETHICS HAS BEEN ASSUMED to be a sheerly rational enterprise. What has been omitted from the textbooks and ignored in discussions about particularly vexed issues (such as futility) is any mention of the powerful nonrational component of moral choice. By *nonrational* I do not mean *irrational* (a term with pejorative connotations). What I do mean is that moral choice draws on deeply held beliefs and the values to which they give rise, as well

as on various biases, assumptions, and even prejudices—none of which may be amenable to rational persuasion. These beliefs and values are often held unconsciously. They invariably evoke strong feelings, even passion. They can become matters for which people are willing to die, if need be, and they operate at a level other than and separate from that of rational principles and duties.

Beliefs and values are not necessarily religious in nature. Often they are, as is evident to those who have had dealings in the medical setting with fervent Roman Catholics, devout Jews, Jehovah's Witnesses, Christian Scientists, or fundamentalist Protestants (as was apparent in the Wanglie saga), for example. Frequently, in fact, these nonrational elements are not religious. Secular, scientific, ethnic, and cultural beliefs also inform decisions made in medicine and the life sciences as directly as do rational analysis and reasoned argument (Payer 1988). In different ways, Morreim, Veatch, and Gauthier all recognize that nonrational beliefs commonly underlie not only the moral choices but also the claims and demands that directly affect patients' lives.

Morreim uses the word *principles* as if it were a synonym for *beliefs*. This is a mistake. Principles belong in the category of rationality in ethics. This one criticism aside, her analysis is persuasive. She notes that although there is a general agreement that physicians are entitled to forgo futile (including

Ernlé W. D. Young is codirector of the Stanford University Center for Biomedical Ethics, Palo Alto, and clinical professor of ethics in the Departments of Medicine and Pediatrics, Stanford University Medical School, Stanford, California.

cruel) or wasteful interventions, “this agreement does not resolve the question of whether physicians should be permitted unilaterally to determine whether and when to support patients whose lives are profoundly diminished” (p. 34). The worth attributed to a profoundly diminished life depends on basic beliefs. “At one extreme are the vitalists, who believe that all human life is fully valuable, regardless of its quality. On the other side are the ‘qualitists’ (for lack of a better term), who believe that there are some conditions under which a life is no longer of value to the person who has it—that such a person would be better off, or no worse off, dead” (p. 34). Each side “draws on moral assumptions that are too basic to defend or refute rationally” (p. 34). That is, these beliefs are essentially non-rational—not amenable to rational persuasion. This, perhaps, is why proponents of each (for example, in the ongoing abortion debate) frequently resort to coercive tactics—in the streets and through the courts.

Morreim goes on to address the questions of how physicians, patients, and society may be protected from coercion: physicians from being coerced by patients whose beliefs may differ from theirs and vice versa, and society from being coerced by patients “extracting tax money to cover costly services for unusual or idiosyncratic beliefs” (p. 40). Her responses to these questions are at times compelling. I will later come back to her third response, strategic limit-setting on two distinct levels.

Veatch’s conclusion, which may serve as a starting point for a brief review of his article, is that we are discovering “novel situations to which the [moral and legal] consensus cannot be applied directly. Unlike the controversy over active mercy killing, it is not necessarily that there is enormous moral or legal disagreement about these cases. Rather we are discovering new twists on the old problems for which our old principles—proportionality, autonomy, substituted judgment, and best interests—do not provide clear conclusions” (pp. 17–18). This closing statement follows a detailed discussion of the types of patients in the general categories of those who are legally incompetent and those who are not.

Veatch seems to recognize that the lack of consensus is the result of divergent belief systems. Take,

for example, his discussion of the incompetent patient who has no surrogate: “The problem is who should make the momentous determination that these patients who cannot speak for themselves would literally be better off dead” (p. 12). He observes that attending physicians sometimes have assumed this decision-making role, but he objects that “such decisions are fundamentally moral, not technical. If a physician makes the choice it will necessarily reflect personally held religious and philosophical values, and there is no reason why this vulnerable patient should be subjected to the personal values of a randomly assigned care giver” (p. 12). Similarly, he holds that “the value commitments of the professions serving on [an ethics committee] would still distort its judgments” (p. 13). He then declares that “for this narrow group of vulnerable patients, a good case can be made that a formal judicial review should be provided to maximally protect them against abuse” (p. 13).

Surely, Veatch cannot mean to imply that judicial review alone is value free. Perhaps he believes that judicial reviews are less biased than the judgments of attending physicians or of the members of ethics committees and hence could serve as a desirable check and balance against blatantly subjective bias.

On the other hand, the experience of trained professionals also provides a useful check and balance against decisions taken in the ivory tower of hypothetical judicial impartiality divorced from any consistent clinical experience. If nonrational beliefs and their derivative values are invariably operative, is it not preferable that these beliefs be informed by long experience of what life and death appear to be like for incompetent, persistently vegetative, or comatose patients?

Veatch tends unfairly to denigrate the beliefs and values of experienced clinicians and the professionals serving on ethics committees while sanctifying those of persons engaged in formal judicial review. He does not help us understand why those of one group ought to be invested with greater authority than those of another. Also, while judicial reviews may protect patients, physicians, and society from coercive nonrational beliefs and values in some cases, such mechanisms are too costly and cumbersome to

help much in the trenches of health care, where physicians and patients together daily confront disease and death.

Gauthier, our third author, carefully examines the nature of autonomy in the writings of John Stuart Mill and Immanuel Kant: "In tracing the roots of respect for autonomy back to Kant and Mill, it becomes apparent that personal autonomy as self-determination is best understood not as a positive freedom, a freedom to receive or be given something, but rather a negative freedom, a freedom from interference" (p. 33). Thus, what began as a negative right to noninterference in matters of private choice, with the strict proviso that one's choices ought not to harm or endanger others, is now believed (at least in American popular culture) to be a positive entitlement—to whatever one wants, especially if someone else is paying for it. In a recent (28 March 1994) front-page article in the *New York Times* with the headline "Patients' Lawyers Lead Insurers to Pay for Unproven Treatments," one physician made virtually the same point made by Gauthier: "The reasoning goes as follows: 'I want, and if I want something, I need it; if I need it, I have a right to it; if I have a right to it, someone else has an obligation to provide it.'"

Gauthier notes that recent efforts to define futile treatment and formulate policies for withholding it give rise to an apparent conflict between the principles of respect for autonomy and distributive justice. The conflict is apparent only because the nature of autonomy has come to be misconstrued. This prompts her conclusion that

concerns for social justice may require . . . that physicians take more responsibility for assessing the effectiveness of medical treatments before offering them as reasonable alternatives to patients. . . . Society, as well, will need to engage in public discussion . . . to determine the socially acceptable limits of "costworthy" care. This is because these judgments, like futility judgments, involve not only medical facts but values; and it is the values of a society that must be ultimately employed in the effort to justly distribute that society's resources. However, the promotion of social justice in these ways will not conflict with the principle of respect for patient

autonomy, if this principle is strictly applied according to its philosophical foundations in Immanuel Kant and John Stuart Mill. (P. 35)

There's the rub. If those responsible for distributing society's limited resources *believe* that respect for autonomy allows for the escalation of wants into needs, into rights, into entitlements for which others must pay, how effective can reason be in persuading them otherwise? And if reason doesn't work, what defense is there against others being held hostage to these beliefs?

This brings us back to Morreim, and to protecting society from coercion by the beliefs of certain members. She holds that "citizens should be able to spend their own money as they wish, including [the] purchase of extravagant health care" (p. 39). (I'm not sure that all would agree with her.) But "people should not be free to dip into common funds at will" (p. 39). She draws attention to the phenomenon, noted in the *New York Times* article quoted earlier, that "judges adjudicating questions about health insurance coverage tend to favor ill patients' claims against insurers trying to deny coverage. According to some commentators, judges often step beyond traditional contract law, requiring insurers to pay for treatments that are questionable, sometimes even clearly excluded, under the terms of the contract" (p. 40) (so much for Veatch's vaunted judicial impartiality).

Morreim suggests that *policies* promise more effective protective measures: "policies addressing fiscal resource allocation should be pursued on two basic levels: private citizens and their insurance policies, and tax-supported health care programs" (p. 40). Citizens should be given "considerably more choice over the kinds of coverage they purchase" (p. 40). Those who believe that the life of persons in a persistent vegetative state is infinitely valuable, for example, and who are thus opposed to limiting treatment for them, ought to be able to purchase insurance to meet the cost of continuing to provide it. This right to purchase insurance, she argues, should extend to "treatments that are experimental, or not cost-effective" (p. 40). However, with respect to tax-supported health care programs, "while we should not forbid patients and families to purchase

exotic care for those with profoundly diminished lives, neither must we pay for it. A person is not wronged in being denied what was never owed" (p. 40).

Implementing such policies to protect against the potentially coercive power of nonrational beliefs requires a next step with respect to tax-supported health care programs. Physicians themselves must more rigorously define the limits of appropriate treatment for patients in various diagnostic categories such as persistent vegetative state. That is as far as Morreim takes us.

To press this promising argument further, however, definitions of appropriate treatment need to include not only medical indications but philosophical and economic considerations as well. The central philosophical issue is raised by asking a question: What is the purpose of intensive care? I suggest that the purpose is to buy time for the patient's body to heal itself. If or when the body has virtually no potential to do so, then intensive care is no longer appropriate. More time (and more resources expended) will not serve this underlying purpose.

The economic factor is equally important. In many ways, whether or not a treatment regimen is medically futile depends on the extent of the available resources. Here is an analogy: I inherit a 1915 Model-T Ford in extremely bad condition. I want the car restored to its original pristine state (there are craftspeople who can do this), but I also have a finite budget for this project—let us say \$10,000. That may not be enough money to accomplish my goal. It may cover the cost of restoring one part of the car, but \$10,000 is unlikely to cover the cost of complete restoration. My project then becomes futile, not because it cannot be done, but because it cannot be done within the limits of my budget. As society at large and individual hospitals define the budget available for medical restoration projects, some medical treatments will be futile in this sense.

Despite the current lack of consensus about forgoing life-sustaining treatments, about which Veatch writes; the deeply held beliefs about the worth of profoundly diminished life, noted by Morreim; and the notion of autonomy as positively entitling one to whatever one wants, as criticized by Gauthier; it should still be possible to hold the line

against nonrational, "autonomous" coercion in the name of distributive justice and the common good. Considering medical indications, the ultimate purpose of treatment, and economic realities, the medical profession should be able to define, carefully and more precisely, the limits of appropriate interventions for patients in various diagnostic categories.

Limiting medical interventions, however, should never be equated with withdrawing or withholding care—even from those whose demands are not met. Caring is a continuing professional obligation and virtue. Medically, it will take the form of palliative treatments for discomfort, debilitation, and pain. Pastorally, it will require compassion, wisdom, and strength in enabling patients and their families to come to terms with human finitude and to recognize that point when death need no more be fought as an enemy but rather may be embraced as a friend.

REFERENCE

Payer, Lynn. 1988. *Medicine and Culture*. New York: Penguin Books.

Medical Students Face Ethical Dilemmas

Cheryl Mac Leod Darling

William Branch, Richard J. Pels, Robert S. Lawrence, and Ronald Arky. 1993. "Occasional Notes: Becoming a Doctor—Critical-Incident Reports from Third-Year Medical Students." *New England Journal of Medicine* 329, no. 15: 1130–32.

Dimitri A. Christakis and Chris Feudtner. 1994. "Becoming a Doctor" (letter to the editor). *New England Journal of Medicine* 330, no. 10: 720.

Cheryl Mac Leod Darling is clinical research associate, Hematology/Oncology Division, Lutheran General Hospital, Park Ridge, Illinois.

James Dwyer. 1994. "*Primum non tacere*: An Ethics of Speaking Up." *Hastings Center Report* 24, no. 1: 13–18.

Chris Feudtner and Dimitri A. Christakis. 1994. "Making the Rounds: The Ethical Development of Medical Students in the Context of Clinical Rotations." *Hastings Center Report* 24, no. 1: 6–12.

IN 1991, AN ASSOCIATION OF AMERICAN MEDICAL Colleges (AAMC) working group concluded that insufficient attention had been given to everyday ethical dilemmas and professional development standards for medical students. The articles cited here contribute to the medical literature from the past decade that argues that medical school training is abusive to students. These articles also discuss the implications of such training for ethics education.

In Branch et al. 1993, third-year medical students were asked to write up critical-incident reports at the beginning, middle, and end of a year-long course on the doctor-patient relationship, which met weekly. Critical-incident reports are short narratives about events that participants judge to be significant. The authors studied 100 such narratives and found that students reported "a deep-seated conflict" in "maintaining empathy for patients while becoming acculturated to medicine" even though they rated their clerkships positive educational experiences (p. 1130). They concluded that 95 percent of the narratives concerned such a conflict. They subdivided those narratives into four categories:

1. Expressions of empathy: Students strongly identified with their patients.
2. Difficulty in acculturating: Students expressed an inability to identify with the teams of physicians they were assigned to.
3. The struggle between empathy and acculturation: Students, when in the role of doctor, had trouble maintaining empathy for patients.
4. Blending empathy with acculturation: In vexing situations, students successfully used or maintained empathy.

The authors use quotations from student narratives to illustrate each category, although they do not elaborate on their methodology for categorization. Students were asked to read their reports aloud so

that questions regarding what happened and why, and what alternative solutions existed could be explored.

In their March 1994 letter responding to Branch et al., Christakis and Feudtner argue that "a deeper analysis than the dialectical model of empathy and acculturation" is required to understand the unique problems encountered by medical students in training. Further, according to them, the categories described by Branch et al. neglect

students' struggle with the interpersonal dynamics of power and authority that permeate the hierarchical structure of medical teams. . . . Many of the examples . . . involved students who had witnessed their superiors' rude or even unethical behavior. A student's initial bewilderment when witnessing such behavior may become blind acceptance alarmingly quickly. By calling this process "acculturation," we may unintentionally gloss over the abusive or coercive aspects of medical education and care. (P. 720)

Christakis and Feudtner note in the letter that many physicians view the experience of "critical incidents" as "rites of passage" in medical training. They also address this problem in their article "Making the Rounds," noting that "the cycle of disturbing experience followed by systematic forgetting repeats itself" (p. 7). This discussion constitutes only one part of the authors' reflection on ethical issues within the context of institutional social structure and culture, including the hierarchy of authority and power in the hospital where clinical rotations occur.

For their article, Feudtner and Christakis gathered student narratives throughout an academic year from a monthly four-and-one-half-hour session with 10 to 20 students. The subject of these sessions was "ward" ethics. The authors asked students to write up case reports of ethical dilemmas and, if they wished, to be prepared to talk about them. With no faculty or housestaff present, the authors served as facilitators only and let the students take the discussion where they wished. From the sessions, a conceptual image emerges of students' ethical life, moving through developmental stages from novice to mat-

uration by dealing with a progressive series of intellectual, emotional, and ethical challenges.

Novice concerns include students' feeling that they are taking something from the patient—entering into a person's private life without being fully able to give something (that is, medical knowledge) in return. As a novice, the student has limited medical knowledge, is ignorant of how the medical system works, and is motivated by the desire to become a physician. Thrust into the everyday clinical world to learn procedures, talk with patients, and serve as an underling on the medical team, the student remains anxious about grades, has limited time and knowledge, and is only beginning to develop relationships with patients and other members of the health care team.

Handling unprecedented personal responsibility and workload under constant supervisory surveillance, students must prove themselves repeatedly. The very nature of the underling role creates dilemmas for the vulnerable student. For example, students frequently reported feeling pressure to do things that seemed unethical or struggling to adhere to their principles or to conform to the norms of the culture they found themselves in. Congruent with the findings and assessment of Branch et al., the students' desire and need to learn procedures may conflict with providing empathic care for patients.

The self-doubt experienced by novices in the clinical setting, combined with their vulnerability, can be overwhelming and can interfere with ethical development. The culture expects "silence" about the most troubling aspects of learning medical care. The authors refer to Renée Fox's term *unstructured silence* and her research indicating that the majority of housestaff do not reveal their most significant mistakes to their attending physicians (Fox 1989). Dwyer's piece expands on the issue of remaining silent.

Guilt and a sense of isolation may occur when students feel they have acted improperly or when they have observed a superior commit an unethical act. Paradoxically, students who have emerged successfully from the frustration and disillusionment of clinical rotation may grieve the loss of the physician they had hoped to become.

Contributing to students' disillusionment and

frustration is their sense of powerlessness or loss of control in forestalling death or failing to affect the course of many diseases. The student is usually not fully prepared for the magnitude of medical uncertainty in diagnosis, prognosis, and therapy; the extent of human error in providing health care; or the demanding schedule and social deprivation of medical training.

Learning that the ideal of the patient-physician relationship is rarely, if ever, found can be traumatic. Not only do the students observe failure on both sides (patient and provider) of the ideal relationship, they also are frequently alarmed or dismayed by their own negative feelings toward patients and their own behaviors.

In the face of these disheartening disparities between ideals and realities, ethics education has been wanting. These articles encourage ethics educators to move past core values and (1) focus on students' experiences; (2) provide safe and supportive havens outside the hierarchical medical team, free from recrimination or grade anxiety; and (3) move from an overreliance on philosophical analysis to a candid scrutiny of medical social structure and culture.

Based on his experience conducting numerous ethics courses, seminars, and case conferences, Dwyer expands and reflects on the students' fear of speaking up or finding a voice for concerns about ethically troubling practices in medicine. While students may be quick to quote the Hippocratic maxim of "Do no harm," Dwyer wishes more students would keep in mind the Socratic maxim "First, do not be silent."

Dwyer begins by presenting five cases that illustrate basic ethical or moral dilemmas that confront medical students in their introduction to the clinical milieu. The cases clearly demonstrate "novice" issues:

1. Acronyms or derogatory language applied to patients
2. Informed consent treated as documentation independent from the process of communication between patient and provider
3. Performance of procedures that do not appear to be medically indicated in order to give students the opportunity to practice
4. Relevant physical findings not documented by other health professionals

5. Questions raised regarding the rationale for medical treatments

The ethical issue presented for discussion is, Should students voice their disagreement? Exploring whether the best course of action is to remain silent, Dwyer effectively uses excerpts from Melvin Konner's *On Becoming a Doctor* that demonstrate the intrapsychic and contextual socialization experiences of keeping quiet. Dwyer summarizes by saying that while "the practice of keeping quiet may simplify one's life, it is morally problematic" in two ways (p. 14).

First, silence adopted as a blanket policy may neglect important differences among cases. For example, concerns about improper care differ markedly from concerns about the role of spiritual healing in a case. Second, students who keep quiet as a medical school survival tactic ignore any ethical responsibility to speak up. Although students face certain risks and repercussions when they speak up, Dwyer argues that they must learn to do so "if they are to meet their responsibilities to patients, colleagues, and the profession of medicine." For example, professional standards of care and self-regulation involve legal, moral, and public responsibilities to assess colleagues and report unethical or incompetent behaviors. Speaking up can affect students' image in their professional community, their career prospects, and their sense of self. Further risks may include being graded by someone they have offended, being ridiculed for asking a question or voicing concerns, being viewed as lone dissenters or disloyal team members, being considered unprofessional for criticizing other professionals, and being seen as rats or tattletales.

Admittedly, students have less power and authority than practicing professionals, and they may have fewer or different obligations. Dwyer contends that, at minimum, "students are obligated to take notice of bad practices and to try to conduct themselves in a better way when they become full-fledged physicians . . . [and] like all human beings, [they] have a moral obligation to prevent harm when they can do so at little risk or cost to themselves" (p. 15).

Considering the range of roles students assume in the process of training (observers, auxiliaries for

residents, caregivers, counselors, patient advocates, researchers, teachers), their primary task is still to learn to become good physicians. Dwyer argues that learning to be a good physician includes developing the qualities, characteristics, habits, knowledge, and skills of a good physician. Just as they "practice" taking medical histories, doing physical exams, differentiating diagnoses, and starting IVs, students need to develop the skill or habit of voicing disagreement, questioning the reasoning of others, and engaging in reflection and dialogue. Moving the argument further, Dwyer takes the point of view that in certain circumstances not speaking up is a failure of learning and caring:

If medical students learn to keep quiet in all situations, and do so without qualms, then their sense of moral concern is exhausted by some narrow account of responsibilities and obligations. If they experience qualms but still keep quiet, then their sense of moral concern exceeds the narrow account but has not found expression at a cost that is acceptable to them. Thus it is true that the practice of always keeping quiet is a failure of caring. It is a failure in the process of learning to care, a failure that occurs either by allowing narrowly defined responsibilities to exhaust a sense of caring or by not adequately expressing a residual, open-ended sense of caring. (P. 16)

Dwyer outlines some general factors for students to keep in mind in deciding when and how to speak up: the nature and certainty of their judgment; their specific role in the situation; the potential harm to patients; the probable effectiveness of speaking up; and the likely cost to themselves. Uncertainty about one's own ethical judgment or competence to question medical appropriateness is not necessarily cause for keeping quiet. A degree of uncertainty is inherent in ethics and medicine, and students need to establish a threshold of certainty for voicing concerns. In evaluating their role in a given situation, students have a greater obligation or moral weight when they are directly involved in a case than when they simply hear about one. However, if an issue is serious enough, Dwyer affirms that even those on the periphery should speak up. In contrast, if speaking

up will be ineffective (not accomplish anything), the student has no obligation to speak up. However, Dwyer cautions students to guard against the rationalization that speaking up will always be ineffective.

These articles contribute to a body of knowledge that is in desperate need of attention and application. These voices cry for change and support from leaders in academic and community settings, including administrators, physicians, other health care pro-

fessionals, and ethics educators. Those who view issues through the lens of systems theory as applied to abuse in families or organizations have an even greater obligation to act. Perhaps the greatest challenge presented here, however, involves reflecting on our own behaviors, including our own contributions to the silence and our own reluctance to address the influence of hierarchical structures of authority and power—the context in which many of the ethical dilemmas emerge in medical education and practice.

REFERENCE

Fox, Renée C. 1989. "The Human Condition of Health Professionals." In *Essays in Medical Sociology: Journeys into the Field*. 2d ed. New Brunswick, N.J.: Transaction Books.

SUGGESTIONS FOR FURTHER READING

- Bickel, J. 1991. "Medical Students' Professional Ethics: Defining the Problems and Developing Resources." *Academic Medicine* 66:726–29.
- Christakis, D. A., and C. Feudtner. 1993. "Ethics in a Short White Coat: The Ethical Dilemmas that Medical Students Confront." *Academic Medicine* 68:1130–32.
- Glaser, John W., and Ronald B. Miller. 1993. "A Paradigm Shift for Ethics Committees and Case Consultation: A Modest Proposal." *HEC Forum* 5, no. 2: 83–88.
- Landis, David A. 1993. "Physician Distinguish Thyself: Conflict and Covenant in a Physician's Moral Development." *Perspectives in Biology and Medicine* 36, no. 4: 628–41.
- McKegney, C. 1989. "Medical Education: A Neglectful and Abusive Family System." *Family Medicine* 21:432–57.
- Miles, S. H., L. W. Lane, J. Bickel, R. M. Walker, and C. K. Cassel. 1989. "Medical Ethics Education: Coming of Age." *Academic Medicine* 64, no. 12: 705–14.
- Richman, J. A., J. A. Flaherty, K. M. Rospenda, and M. L. Christensen. 1992. "Mental Health Consequences and Correlates of Reported Medical Student Abuse." *Journal of the American Medical Association* 267:692–94.
- Rosenberg, D., and H. Silver. 1984. "Medical Student Abuse: An Unnecessary and Preventable Cause of Stress." *Journal of the American Medical Association* 252:739–43.
- Sheehan, K. H., D. V. Sheehan, K. White, A. Leibowitz, C. DeWitt, and D. C. Baldwin Jr. 1990. "A Pilot Study of Medical Student 'Abuse': Student Perceptions of Mistreatment and Misconduct in Medical School." *Journal of the American Medical Association* 263:533–37.
- Silver, H. K., and A. D. Glick. 1990. "Medical Student Abuse: Incidence, Severity, and Significance." *Journal of the American Medical Association* 263:527–32.
- Slomka, Jacquelyn, and Anita Duhl Clinken. 1992. "Letters: Violence in the Hospital." *Journal of the American Medical Association* 268:984–85.
- Walker, Margaret Urban. 1993. "Keeping Moral Space Open: New Images of Ethics Consulting." *Hastings Center Report* 23, no. 2: 33–40.

NOTEBOOK

"Many of the health care issues under debate in Washington are being rendered irrelevant by the dramatic grass-roots innovations of local churches and synagogues across America," says Lewis M. Andrews in a recent article. "While major religions have become less involved in the 'harder' aspects of medicine, such as surgery and pharmacology, they have never lost interest in the 'softer' problems of emotional healing and long-term support—what used to be called pastoral care.

"In the burgeoning area of outpatient services and aftercare, mainstream religions have created one of the most significant innovations in recent years: the 'parish nurse movement.' Started in the Midwest almost a decade ago by a Lutheran minister, Granger Westberg, it bases nurses at individual churches and synagogues to meet the health care needs of the congregations. . . . Now there is even a National Parish Nurse Resource Center, in Park Ridge, Illinois.

"The potential of churches and synagogues to improve the quality of health care in America has made 'Congregation-Based Health Ministry' the hottest topic within virtually all the denominations of every religion," says Andrews. What makes congregation-based health programs "so interesting is that they address what are widely regarded as the most costly, unwieldy elements of any health care plan: geriatric medicine, visiting nursing, and long-

term therapy for mental-health and substance-abuse problems. And individual churches and synagogues are uniquely suited to provide such services. Not only do many congregations willingly subsidize health care professionals to service their flocks but, more important, they can call up enthusiastic volunteers to supply patients with emotional support and follow-up care relatively cheaply.

"The real reform of health care in America may mean not only changing our conception of how we finance it but opening our minds to the idea that some forms of care—counseling, home nursing and even the guidance needed for staying healthy—are best delivered outside the conventional hospital or medical center."

(*Wall Street Journal*, 5 July 1994)



In 1992, 54 percent of hospital surgeries did not require an overnight stay, compared with 21 percent 10 years ago. If the current trend continues, by 1995 nearly two-thirds of hospital-based surgeries will be performed on an outpatient basis.

(*American Hospital News*, 6 June 1994)





How often do Americans attend church or synagogue? Percentage of those responding to the poll:

	Jan. 1992	Sept. 1992	March 1994
Weekly	31	34	35
Almost Weekly	9	10	15
Monthly	15	15	16
Never	16	14	9

(*Economist*, 11 June 1994)



About \$16 billion of \$87 billion spent this year on inpatient care will be for treatment of conditions attributable to smoking. Smoking-related illness is the single largest drain on Medicare's trust fund, expected to consume \$800 billion over the next 20 years. Medicare beneficiaries with histories of smoking are at much higher risk for tobacco-related diseases because generally they have smoked more heavily and for a longer time than those younger than 65.

(*American Medical News*, 6 June 1994)



Number of 552 award-winning health promotion projects reviewed by the Centers for Disease Control and Prevention that focused on homicide: 1.

(*Factbook on Health Care for the Poor and Underserved*, Meharry Medical College, 1993)



Despite fund-raising and cost-cutting efforts, the retirement liability for members of U.S. religious orders increased by \$1.4 billion over the past two years to reach \$6.3 billion. . . . The \$150 million raised in six national collections for retired religious since 1987 failed to cover even the retirement cost

increases attributable to inflation alone, estimated at \$200 million per year, the report said. . . . There was some good news in the data. "The amount of assets



designated for retirement continues to grow and now totals \$4.543 billion in 1993," the report said. In addition, the number of religious who will have to draw from those retirement funds is down 19 percent since 1985.

(*St. Louis Review*, 29 July 1994)



In 1991, 21,000 children died from injuries, more than died from all childhood diseases combined. Nonfatal childhood injuries consume \$4.75 billion in health care dollars annually. . . . According to Ted Miller, an economist who specializes in safety issues, every \$15 spent on bicycle helmets or child-safety seats saves \$30 in medical expenses. And every \$10,000 invested in poison control centers saves more than \$75,000. . . . "Injury prevention is an answer to a legislator's prayer," said Dr. Miller. . . . "It helps people while saving money."

(*American Medical News*, 13 June 1994)



Percentage of victims of violent crime who are pre-teens and teens: 81.

(*Factbook on Health Care for the Poor and Underserved*, Meharry Medical College, 1993)



All across the country, doctors are coming to grips with the notion that violence is a major public health threat on a par with tuberculosis, tobacco, and HIV/AIDS. And some, such as John P. May, a physi-

cian at Chicago's Cook County Jail clinic, have come up with new approaches to end the cycle of violence. Last year, May and some friends launched an anti-violence poster campaign aimed at young African-American males. The campaign, Rise High Projects, has since been adopted in several cities, including Chicago, Sacramento, and Atlanta. May was inspired to action after realizing that violence was largely ignored in public health messages to inner-city youths. "We really need to look at the No. 1 killer of young people, and that's violence," says May. "How can we be effective in other health promotion strategies until we can empower them to overcome the risk and fear of violence?"

The variety of physician approaches to violence reflects both the diversity within medicine and the multifaceted nature of violence. "For some physicians, interaction with their patients—knowing what questions to ask to assess their level of risk from violence—will be their primary way of making a difference," says Dr. Patricia R. Salber, president of Physicians for a Violence-Free Society, a newly organized group of about 450 doctors and other health professionals. "Other physicians may want to get involved through organized medicine or as leaders in their communities, speaking to the Rotary Club and so on. Those who enjoy the political process, like I do, can help write or review bills that have to do with violence prevention so that they can be legitimately introduced as 'health care bills.'"

Another barometer of physician interest in violence prevention is that more than 10,000 doctors have joined the American Medical Association's two-year-old National Coalition of Physicians Against Family Violence, a campaign to educate the medical community on how to identify, treat, and prevent domestic violence.

Each year, violence is responsible for an estimated \$5.3 billion in medical costs and \$23.9 billion in lost productivity. Firearm injuries alone are responsible for \$429 million in hospital costs.

(*American Medical News*, 21 March 1994)



Taking her own diagnosis as a jumping-off point, Sandra Steingraber began to research the causes of

cancer. Today she has a doctorate in biology and is in the thick of the growing effort to call attention to the link between cancer and long-term exposure to environmental contamination.

"We are in the middle of a cancer epidemic," she says. "Cancer rates have risen exponentially. Childhood leukemia and brain-cancer rates are skyrocketing. Testicular cancer in men is increasing. Prostate cancer is hitting men at younger ages, and it's becoming more deadly. I'm convinced that the increase is due to environmental contamination. I really see cancer as a human rights violation."

A particular focus of her interest is a class of chemicals known as organochlorines. "What makes organochlorines a unique class of compounds is that a chlorine atom is attached to a carbon atom. That never happens in nature naturally, and that combination tends to be very, very toxic."

Steingraber has taken as her role model Rachel Carson, a biologist who died in 1964 who was noted for writing *Silent Spring*, a 1962 exposé of the dangers of pesticides. "Rachel Carson was dying of breast cancer when she wrote *Silent Spring*, but she kept it a secret because she didn't want her scientific objectivity questioned. I see myself as her intellectual daughter because I am also a writer and a biologist and a woman with cancer."

Steingraber wants to see cancer patients treated differently. "I developed a rule at some point that I didn't let anyone touch me until they looked in my eyes and told me their name. It's funny how uncomfortable doctors feel about that because they wanted to distance themselves too." . . . Steingraber says that people with cancer look just like everyone else and that cancer is a hidden epidemic. To offset that, she keeps on her office walls photographs of women who have had mastectomies.

"If I do eventually die of cancer, I'm going out shouting. Anyone who does not go gently into that good night gives me hope."

(*Chicago Tribune*, 24 April 1994)

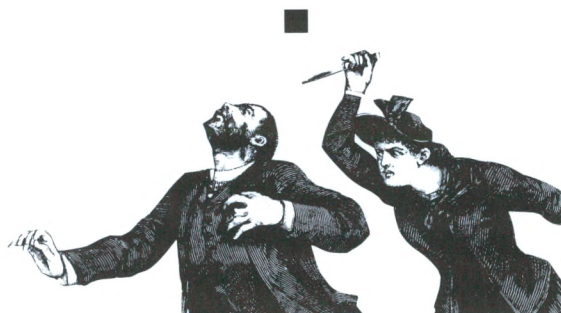


Although reported cases of sexually transmitted diseases (STDs) have risen dramatically over the last decade, a new survey finds that few women believe

they are personally at risk for STDs. The survey found that of the 1,000 women surveyed

- 84 percent said they were not concerned about contracting an STD. Those at highest risk—women 18 to 24, those with multiple partners, and those whose current partners have had multiple partners—were least likely to consider themselves vulnerable.
- 32 percent said they knew almost nothing about STDs other than HIV/AIDS.
- 49 percent knew very little or nothing about the genital herpes virus, while 63 percent had little knowledge of *Chlamydia*, now the most common STD in women, with an estimated 3 million cases diagnosed in 1993.
- 49 percent said they rely on monogamy for protection against STDs, 30 percent reported using condoms, and 6 percent said they do nothing.

(*American Medical News*, 2 May 1994)



Number of televised murders the average American child will view by high school graduation: 32,000.

(*Factbook on Health Care for the Poor and Underserved*, Meharry Medical College, 1993)

Health care costs would go down as much as \$17 billion per year “if Americans reduced their daily intake of saturated fat by just 8 grams,” said Margo Wootan, a scientist at the Center for Science in the Public Interest and the study’s chief author. Eight grams is about the amount of fat in a half-cup of a premium ice cream.

Such a reduction would mean that saturated fat would account for 10 percent of the calories in



Americans’ diet instead of the estimated 13 percent. That would be enough to bring about a 36 percent reduction in coronary heart disease, which costs society \$48 billion a year, according to American Heart Association figures.

The report urges lawmakers to require government and private insurers to pay for nutrition counseling and to expand research on diet’s impact on disease.

(*New York Times*, 3 May 1994)

The blood products advisory committee, the sole panel advising the Food and Drug Administration on regulations governing blood used in transfusions and medical products, has come under fire for having no voting members who represent blood-products consumers. Critics say that without better consumer representation, the risks are too high for a repeat of a tragic breakdown in the early 1980s when the committee failed to swiftly recommend stringent tests of blood and restrictions on donors after indications that HIV was a serious threat.

Advocates for blood-products consumers worry that committee members’ vested interest might make them less willing to tackle a problem, especially if proposed safeguards were costly or upset business routines. “Their interests are fundamentally opposed to [those of] the user of blood,” says Corey Dubin, vice president of the Committee of Ten Thousand, a national hemophiliacs group.

But committee members say they listen to consumers’ concerns. “A lot of the negative image of blood bankers today comes from the perception that we are a closed circle. I don’t think that’s true,” says Michael Busch, scientific director of Irwin Memorial Blood Centers in San Francisco and a [blood products advisory] committee member.

The panel typically debates the costs and benefits of imposing a screening test for every potentially harmful virus in blood products. The seemingly straightforward matter of trying to detect a new virus is shaped by a complex interplay of economic and medical factors. In the case of the new strain of HIV [a discovery recently reported by *Lancet*], Dr. Busch said that before responding, the FDA must guarantee that any new test doesn't reduce the ability to detect the major strains of HIV. Moreover, each test carries a hidden cost: the potential for "false positives," which lead to the unnecessary discarding of donated blood and the possible exclusion of the donor from future giving.

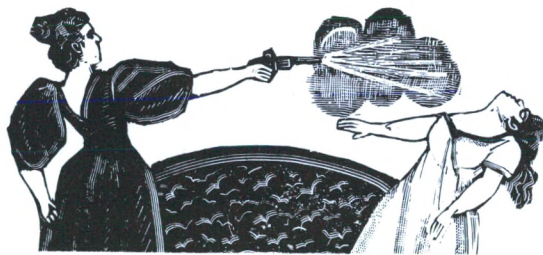
Blood bankers acknowledge that if cost were no object, the chance of becoming infected from a blood product would be infinitesimal.

Dana Kuhn, a hemophiliac and medical counselor, would like "to know that every bit of technology was being used to extract viral contaminants from blood," he says. "I'd like the standard set to be the highest purity of blood available."

(*Wall Street Journal*, 10 June 1994)



An average of 102 people in the United States die from gunshot wounds each day, 14 of them younger than 20, according to the National Center for Health



Statistics. In 1988, one in six pediatricians reported treating a child for a gun-related injury. STOP (Steps to Prevent Firearm Injury) is a free kit for physicians from the Center to Prevent Handgun Violence. It contains a monograph, audiotape, patient pamphlets, office posters, and a bibliography. The kit advises physicians first to warn parents of the risks of gun ownership, but if they are determined to keep one at home, to empty it and lock it up. Other tips:

- Counsel children about the real-life dangers of guns.
- Advise pre-teens and teens about nonviolent ways to solve problems.
- Tell parents who do not own guns to note risks to their children at locations where they play and visit.
- Advise gun-owning parents to store firearms safely, even around well-behaved children.

(*American Medical News*, 11 July 1994)



Close to a quarter of all Americans 65 or older were given prescriptions for drugs that they should almost never take, a study has found. Some of the drugs can produce amnesia and confusion, others can cause serious side effects like heart problems or respiratory failure. And, the Harvard Medical School investigators said, there is no need to prescribe these drugs to older people, either because safer alternatives are available or because the drugs are simply not needed.

For example, more than 1.3 million older Americans had prescriptions for propoxyphene, an addictive narcotic that, the authors say, is no better than aspirin in relieving pain.

"A lot of the problem is that doctors frequently ascribe side effects of drugs to old age," said Dr. Steffi Woodhandler, lead author of the study. "If a patient loses memory or loses balance, they say it's old age."

Dr. Robert Butler, chairman of the department of geriatrics at Mount Sinai School of Medicine, said older people also attributed severe side effects to old age. Dr. Butler said he often conducted what he called a brown bag test with elderly patients, asking them to bring in every medication they had in a brown bag. "You'd be shocked," he said. "Sometimes Mrs. Jones next door got a good result with her arthritis medication so our patient will take Mrs. Jones's drug. Some are taking medications that are five or six years old." He added that many older people do not take their medicines at the right time or in the right doses.

Dr. Robert Kane, a researcher at the University of Minnesota School of Public Health, said pressures

on doctors might lead to inappropriate prescriptions. "As physicians feel under pressure to spend less and less time with their patients, they often don't spend the time needed to take a thorough drug history. And one of the most common ways to terminate an interaction with a patient is to write a prescription. There is a tendency to substitute the use of drugs for time and attention." Dr. Kane suggests that older people take lists of their medications to their doctors and ask about interactions and side effects.

(*New York Times*, 24 July 1994)



Almost half of 424 British doctors polled in a recent survey had been asked by a patient to take active steps to hasten death. A third of those had complied with the request. In May of 1994 the British government refused to lift the legal ban on euthanasia. But almost half the doctors surveyed said they would consider taking active steps to end a patient's life if euthanasia was legalized.

(*American Medical News*, 6 June 1994)



Religion has long been neglected as a factor in international affairs, says a new study by scholars and diplomats affiliated with the Center for Strategic and International Studies. For instance, when a Central Intelligence Agency analyst proposed an examination of the leading religious leaders in Iran under Shah Mohammed Reza Pahlavi, the idea was

rejected as mere "sociology." But now that the cold war has been replaced by so many conflicts between groups divided by religious and ethnic loyalties,



calls to study religion's effect on statecraft may fall on more receptive ears.

The new book, *Religion: The Missing Dimension of Statecraft*, faults not only the underestimation of religious differences as a source of conflict, but also the neglect of religious institutions and leaders as catalysts in ending warfare or bringing about peaceful democratic change. One of the authors, military strategist Edward Luttwak, suggests that "religious attachés" be assigned to countries where religion is particularly important.

The authors contend that the American principle of separation of church and state has caused American foreign policy specialists to slight the role of religion in foreign policy. Douglas Johnston, the center's vice president and a former Defense Department official, says many Americans are desensitized to the fact that much of the world does not operate this way.

(*New York Times*, 9 February 1994)

BOOKS

The Long Road of Recovery for Trauma Survivors

Sandy Pittman

Judith Lewis Herman, *Trauma and Recovery* (New York: Basic Books, 1992), 276 pp.

SOME 11 YEARS AGO, WHEN MY DAUGHTERS WERE still very young (four and seven), I was complaining to another working mom about how the demands of mothering interfered with the demands of working. How, I asked her, can I arrange for care, lessons, and transportation for my children in a way that frees me for work? She replied by telling me how she had answered that very same question—but turned on its head. She had asked herself, How can I arrange work so that it frees me for care, lessons, and transportation for my child? That revelatory moment—which showed that I was asking the wrong question because I had made the wrong assumption about which task was more important—has stayed with me not only as a significant personal insight but also as a homey example of what feminism offers the world. In short, the gift of feminism, of speaking directly from women's experience, is not simply a helpful but somewhat peripheral corrective to conventional ways of thinking (ways that so predominate that they are considered neutral rather than expressions of a male point of view). The great gift of feminism is that it asks different questions based on

a different understanding of what is important. As feminism comes of age, this will occur not just with so-called women's books and women's issues but in every area of life.

Judith Lewis Herman's book *Trauma and Recovery* is a stunning example of this gift of feminism come of age. Herman explicitly acknowledges her indebtedness to feminism, to feminist psychologist Jean Baker Miller, and to her mother; the book's "intellectual mainspring is a collective feminist project reinventing the basic concepts of normal development and abnormal psychology, in both men and women" (p. ix).

Giving expression (in 236 text pages) to the feminist truism that "the personal is political," Herman asserts that the suffering of rape victims, battered women, and abused children is as significant as the suffering of combat veterans and political prisoners. But this book is not primarily about separating and emphasizing the privatized traumas of victims of family abuse and sexual violence. Rather, it is "about restoring connections: between the public and private worlds, between the individual and community, between men and women. It is a book about commonalities: between rape survivors and combat veterans, between battered women and political prisoners, between the survivors of vast concentration camps created by tyrants who rule nations and the survivors of small, hidden concen-

tration camps created by tyrants who rule their homes" (p. 3).

Herman describes the damage common to all trauma survivors. The traumatic event "shatter[s] . . . the construction of the self that is formed and sustained in relation to others" (p. 51). Relationships to loved ones and to the community are damaged, and faith in divine or natural order is undermined. Belief systems that gave meaning no longer make sense. (One might almost say that the damage is to the soul. Certainly this book provides a rich text for theological reflection.) The soul-destroying nature of the traumas that Herman discusses are witnessed in the heartbreaking example provided by psychiatrist William Niederland, who studied survivors of the Holocaust. "While the majority of his patients complained, 'I am now a different person,' the most severely harmed stated simply, 'I am not a person'" (p. 94).

As there are commonalities in the traumatic syndromes, so there are commonalities in the healing process. Herman lists the three fundamental steps in recovery: "establishing safety, reconstructing the trauma story, and restoring the connection between survivors and their community" (p. 3).

Because recovery involves not only remembering and telling the story of the trauma but also recognition and restitution on the part of the community, the issue of silencing is central. Herman cites as one example of that silence the late-nineteenth-century studies of hysteria, a disorder most brilliantly explored by Freud.

The cherished value of privacy . . . rendered women's reality practically invisible. . . . Women were silenced by fear and shame, and the silence of women gave license to every form of sexual and domestic exploitation. (P. 28)

While the returning soldier receives a certain amount of recognition and public approval not accorded victims of domestic violence or rape, the price of that approval is silence about the reality of war. She quotes a Vietnam veteran.

The town could not talk and would not listen. "How'd you like to hear about the war?" he might have asked, but the place could only

blink and shrug. It had no memory, and therefore no guilt. The taxes got paid and the votes got counted. . . . It was a brisk, polite town. It did not know shit about shit, and did not care to know. (P. 66)

Perpetrators wish to preserve silence and do what they can to promote forgetting. "Secrecy and silence are the perpetrator's first line of defense" (p. 8). His goal (to promote forgetting) is made easier by the bystander's natural inclination not to want to hear anything too awful; even more, the bystander hopes she will not feel compelled to act on that information. "It is very tempting to take the side of the perpetrator. All the perpetrator asks is that the bystander *do nothing*" (p. 7, emphasis added).

Given the powerful forces at work to maintain silence, it is not surprising that breaking the silence happens in the context of political movements sufficiently strong to challenge the status quo. Three forms of trauma have received attention in the past century: hysteria was brought to the public's notice during the anticlerical movement in nineteenth-century France; combat neuroses were first studied after World War I and commanded national interest following the Vietnam War; and public consciousness about sexual and domestic violence has been achieved in the context of a strong feminist movement.

One of the greatest strengths of Herman's book is its recognition that the position of the traumatized person is a morally difficult and nuanced one and that blanket assertions that deny victims any sphere of moral action fail to address their deepest needs. Peer groups not only give people who have survived similar traumas a place to tell their story, get and give support, and organize politically; they also are places where people can grapple with issues of guilt and shame. Herman notes that for all victims of trauma—from combat veterans who may have committed "gratuitous cruelties" (p. 64), to abused women who may have failed to protect their children, to rape victims who may have naively or defiantly taken unnecessary risks—simple pronouncements that absolve them of all responsibility are not helpful. Although intended to be affirming and salutary, such pronouncements "represent a refusal to

engage with the survivor in the lacerating moral complexities of the extreme situation" (p. 69).

At the same time that Herman states the need for moral engagement, she cautions the readers about the meaning and conditions for such. It is appropriate only "after it has been clearly established that the perpetrator alone is responsible for the crime" and in an environment that "protects against shaming and harsh judgment" (p. 199).

Even as Herman describes steps trauma survivors must take on the road to recovery, she also stresses the importance of emotional support from family and friends to mitigate the impact of the trauma. Such emotional support does not mean that the survivor has license to treat loved ones in any way. Herman gives as an example the instance of a combat veteran's family who accorded him "too much latitude for angry outbursts and emotional withdrawal" (p. 64). Herman also stresses society's obligation: "Once it is publicly recognized that a person has been harmed, the community must take action to assign responsibility for the harm and to repair the injury. These two responses—recognition and restitution—are necessary to rebuild the survivor's sense of order and justice" (p. 70).

Perusal of any daily paper sobers us with the realization that great harm is being done to millions of people; Herman's book tells us that there will be no easy recovery for these people. Any temptation to urge survivors to "buck up," "bounce back," or "get on with life" is unrealistic and unkind. Herman does a great service to all trauma survivors by marshaling evidence from a variety of sources that show we all have our breaking point. She writes, "With severe enough traumatic exposure, no person is immune" (p. 57). Herman begins her book by noting that "the ordinary response to atrocities is to banish them from consciousness" (p. 2). Her book itself is a powerful effort against that banishment.

Who should read this book? I'm tempted to say, "everybody." Beyond the professional psychologists and trauma survivors who constitute the obvious audience, many other professionals might benefit from reading this text. It is a rich source for theological reflection and a natural casebook for discussing theodicy. It could serve as a jumping-off point for discussion for women's groups, men's

groups, and for students and teachers of sociology, political theory, nursing, medicine, and education. It should be required reading for all lawmakers and voters to serve as an antidote to the idea that there are simple solutions to complex problems. This thoughtful, nuanced, compassionate, and profound book is well written and readily accessible to the general reader.

BOOK NOTES

Paul Brand and Philip Yancey, *Pain: The Gift Nobody Wants* (New York: HarperCollins, 1993), 288 pp.

PAIN MANAGEMENT HAS BECOME a burgeoning field within clinical medicine, in part because of the debate over ethically appropriate care of the dying. The desire to manage or control pain, however, sometimes shades into a desire to eradicate pain altogether. Coauthored with Philip Yancey, Paul Brand's autobiographical account of his career in medicine serves to highlight the important role pain plays in life. The authors are very clear: the health of the body depends on its attentiveness to its pain network.

Brand grew up a missionary child in northern India. After studying medicine in England, he returned to India, where he became a pioneer in the treatment of leprosy. On one level the book is a moving account of lives lived in the service of others. On another level, it is a colorful history of the fitful advances in medical knowledge and treatment. Conventional wisdom once held that leprosy was an inevitably disfiguring disease that caused the skin and flesh to rot away. Through astute observation and research, however, Brand became the first to prove that people with leprosy in fact literally destroy themselves because they do not feel pain. Their lack of sensation prevents them from changing behaviors that lead to injuries for which they do not seek medical attention. Brand agrees that pain certainly is unpleasant, but for those people who cannot experience it, a life of no pain is finally destructive. Though leprosy patients cannot be saved from their condition, the disease can be arrested, and the person taught a new attitude of self-care. For Brand the

chief contribution of the physician then becomes one of joining with the patient as a partner in the task of restoring dignity to a broken spirit.

It is with this last lesson that Brand is theologically most provocative. For him pain is a blessing from God; instead of silencing pain, we should listen to it as the body's most effective way of communicating. Brand believes that as a society gains the ability to limit suffering, it loses the ability to cope with the suffering that remains. It is the philosophers and theologians of the West, he claims, not the Third World, who worry obsessively about the "problem of pain" and point an accusing finger at God. Accompanying this obsession is the medical attitude that pain exists to be eradicated. In the U.S., for example, pain is resented and feared. As a result, ours has become a culture seeking instant pain relief. Individual and social pain and discomfort are usually masked by drugs or other "therapies," yet silencing pain without considering its message is like disconnecting a fire alarm to avoid receiving bad news. Considering pain from a theological viewpoint, Brand argues that it is physically, emotionally, and spiritually essential to us as living beings. After all, pleasure, a sense of well-being, and joy are almost impossible to feel and appreciate unless one is also able to experience pain. It need not be a fearsome enemy. Instead, pain can be a loyal friend—if we learn to listen to, respond to, and manage it appropriately.

Part autobiography, part medical mystery, and part practical theology, this highly readable book is recommended for all within the caring professions.

—Edwin R. DuBose

Richard M. Zaner, *Troubled Voices: Stories of Ethics and Illness* (Cleveland: Pilgrim Press, 1993), 161 pp.

PROBABLY EVERY CLINICAL ETHICIST has at some point tried to explain to someone what he or she does. More often than not a blank stare greets the response that one is a "clinical ethicist." If anything at all follows that reply, it is usually the question, "What's that?" and the fumbling explanations begin.

The author of *Troubled Voices* is a clinical ethicist. A professor of medical ethics at Vanderbilt, Richard Zaner describes in this volume his own 10 years' experience as a philosopher-ethicist in a clinical setting. Like many clinical ethicists, particularly those involved with the humanities, he wonders why he is there and what he contributes as he confronts the complex network of relationships, the various forms of human suffering, and the many quandaries that the combination of illness and technology has created. Zaner does not engage in tedious theoretical explanations of the nature and role of the clinical ethicist. Rather, he invites the reader "to make rounds with him"; to meet some of the patients and their families and friends; to hear their stories of loss, limits, disability, hope, illness, suffering, and dying; to struggle with them to make sense of their situations; to resolve the conflicts; to make the "right" decisions.

These are people, young and old, who must confront terminal illness (theirs or a loved one's), who must pursue or forgo lifesaving treatments, or who must decide whether to terminate a pregnancy. The people we meet share their thoughts about what it's like waiting for someone else to die so that they might have a transplant, about living with end-stage renal disease, about the resistance and the fears accompanying the opportunity to gain information about one's genetic heritage.

Zaner's account also gives us a glimpse of what an ethicist working in a hospital does. Clinical ethicists who read this book will surely recognize many of the experiences described. Reflecting on his years of experience, Zaner finds that communication—listening, conversing, clarifying, interpreting, guiding, giving feedback—is central to the ethicist's work.

Ethicists are rather like readers and interpreters of obscure texts. They help to identify, in the midst of complex relationships and clinical problems, just what needs specific notice and attention. [They] help pick out key decision points and options. They help people go through their options and possible outcomes in the light of their own concerns and values, finding what seems most valuable to them. . . . The ethicist has to become a sort of detective, col-

lecting and probing clues and hints, most often nestled within an inevitable bristle of emotions. They then hold them up for inspection and help these people test them to see if they make sense, are viable, and stand up to the test. (P. 151)

Zaner also describes the clinical ethicist as a catalyst, a facilitator, a trigger for crucial conversations. She enables people to talk and allows them to be heard, at times is "called on" simply to be present to patients, and, always, compassionately "affiliates" with patients.

A good phenomenologist, Zaner balances his description with interpretation and reflection. His storytelling skills are well complemented by his philosophizing skills. Woven throughout the stories are reflections about what it means to be a *moral* creature, the necessity of making moral choices in personal and societal relationships, and the use of advance directives and surrogate decision making.

Early in his book, Zaner comments that "talking about clinical ethics is remarkably different from engaging in it" (p. 36). But Zaner's narrative approach gives the reader a *feel* for the work of clinical ethicists in people's experience of illness. Readers will likely come away with greater insight into people's struggles with difficult and painful medical and moral choices and into the ways a clinical ethicist might contribute to their resolution. It would be wonderful if when asked what a clinical ethicist does one could hand the inquirer a copy of Zaner's book.

—Ron Hamel

David Schiedermayer, *Putting the Soul Back in Medicine: Reflections on Compassion and Ethics* (Grand Rapids, Mich.: Baker Books, 1994), 192 pp.

IF THIS BOOK BECOMES A MOTION PICTURE, it will probably be a documentary rather than a drama like the recent film *The Doctor*. Like *The Doctor*, David Schiedermayer's book portrays the landscape of modern medicine as apparently barren of soul. Yet Schiedermayer believes that this landscape conceals nutrients to make the practice of medicine life-giving again, to both physicians and their patients.

Through a panorama of stories, essays, Christian biblical homilies, and meditations, Schiedermayer shows the reader some ways to perceive and participate in the resouling of American medicine.

Speaking variously as a physician, an ethicist, and a Christian preacher, Schiedermayer names some of the harsh winds that have driven soul away from modern medicine: lack of time, preoccupation with technology, greed, cynicism, guilt. The book's first chapter, "The Heart Man," through a wonderful parable set in West Africa, presents a recurring theme: time and greed first shrivel, then steal, the hearts of caregivers. The seventh chapter, "Treating Gomers," points to the wind of cynicism:

It is quite easy to be cynical—to deny the wound or withdraw from decay. . . . But meanwhile, underneath, we want to embrace the value of the person's life . . . to love the person. So we feel even more guilty. We are denying our calling, and then we are also being defensive about our denial. And we deny our own woundedness. (P. 80)

What revives the parched soul of medicine for caregivers and patients? Knowledge and awareness of ethics helps. The author includes substantive and informative chapters on professional ethics and the ethics of patient care. Caregivers may ground themselves in the core values of medicine for sustenance and guidance as they encounter patients making agonizing decisions. These include decisions to discontinue death-defying technologies when the time is right, to cease pouring liquids through tubes into comatose and permanently unconscious persons, and to strive to match beneficial treatments with patients' hopes. Caregivers may draw sustenance and guidance, too, from the nature of medicine as a profession and a calling, experiencing the life that flows from a commitment to caring service and avoiding the ever-looming temptation of the "special love for gold."

More profound than ethics, for Schiedermayer, is the soul-enlivening brought about by faith—biblically grounded Christian faith, in his case. The physician nourishes the soul of medicine by learning from pastoral care colleagues how to listen, how to read Scripture, how to pray with patients at the bed-

side, and how to forge a place to put and interpret suffering—without trying to cure or withdraw from it. The Christian physician can be partners with patients at a deeper level than the doctrine of informed consent requires, surpassing and encompassing mere ethical and legal requirements in the spirit of the compassion modeled by Jesus. The Christian physician's caring, even in the midst of the ICU and the AIDS pandemic, can be a vessel of the inexhaustible fountain of divine grace, both for the physician and for patients. By honoring patients in this spirit, the physician enlivens the soul of medicine. "Physicians are imperfect imitators of God,

who bears with us (and doesn't abandon us) through all our failures" (p. 47).

Some books hide their authors more than they reveal them. Not this one. David Schiedermayer's soul enlivens his stories, anecdotes, and insights. He elicits from his readers the recognition that medicine's soul is always available as an enlivening presence in the encounter between caring physicians and the patients who need their caring as much as their knowledge.

—Daniel O. Dugan
Senior Associate for Healthcare Ethics

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 30 double-spaced pages.
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4. Figures, diagrams, tables, and charts, if appropriate, should be submitted on separate pages and keyed to their position in the text. In addition, a list of legends or captions should be typed separately.
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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.
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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.

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