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HEALTH • FAITH • ETHICS



Population, Ecology, and Women • Too Wounded to Be a Healer? • Taoism and Reproduction

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

COVER

The Gift.

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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

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Christine E. Gudorf

In the quest to limit burgeoning populations, governments have often implemented policies harmful to women. Religious standards for moral conduct with regard to sexuality and reproduction have also been shaped without regard for the voices, rights, and needs of women. At the recent United Nations International Conference on Population and Development held in Cairo, however, most government and religious representatives agreed that population regulation can succeed only through programs that treat women as subjects rather than as instruments of other causes, however worthy.

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INITIAL COMMENT

The Powers That Be

POWER IS AT ISSUE IN THIS ISSUE of *Second Opinion*. It is a topic that demands handling with care, since many treatments of the theme in today's scholarship are so marked by ideology that they patently represent efforts to replace one kind of power or sets of powers with other, similar ones.

One of the fashionable uses of the concept of power is traceable to the writings of Antonio Gramsci. The Italian revolutionary was sometimes described as "the Marxist you can bring home to mother," a description that made sense only if you had a certain kind of mother or if you knew relatively little of Marx and Gramsci. He was not really a "soft" Marxist, but his theory related more directly to societies this side of the old Iron Curtain than did many others.

The twist that made Gramscianism more convenient than some others is this: while someone, some set, has *hegemony*—the favored word for domination—there is always some complicity by the dominated. This has to be overcome. Thus slaves or peasants found no way to imagine being free and so endured slavery or serfdom. Thus women and children, the poor and the weak, "went along" with the domination by men in power. Witness the fact that women are often a majority among supporters of religious fundamentalist movements worldwide, movements that demand ever more submission from women. These women often themselves preach the gospel of such submission to males and oppose feminisms worldwide.

Second Opinion does not recognize itself as "ideological." It is directed to helping fulfill the mission

of the Park Ridge Center, which means that it is to see that the "faith dimension" is reckoned with in talk about caring and curing, healing and restoring, making moral and ethical sense. At the same time it has to be alert to the way power is wielded.

So it was that the Center attempted to help fulfill its mission during 1994 by staging scholarly events related to the United Nations International Conference on Population and Development (ICPD) at Cairo. Some religious voices made it clear that they were concerned about critiques of traditional authorities in matters of reproductive health and decision making. Clearly, out of numbers of religious and cultural traditions, women *were* asserting themselves at the ICPD. Ethicist Christine E. Gudorf here reviews some of the issues debated at Cairo and discusses the aftermath of the conference. Her conclusion is theistic: believers in God have to assert that "God did not create women to be victims" but is "eternally available to nurture and support them" to "recovery and integrity." God is not the authoritarian dominator but the nurturer and supporter.

The mission of the Center calls its representatives to listen to more religions than one, including nontheistic ones. I cochaired a pre-Cairo meeting at which efforts by some to produce theistic religious consensus were thwarted because numerous religions do not profess faith in God. In "Power-Over and Power-To," bioethicist Laura Shanner draws on Taoist insights to show how traditional dominating authority can be countered. Hers is not a call to conversion, as if Taoism were an option for many in Western cultures. It is an attempt to help readers see

that *wei wu wei*, doing without doing, is an alternative to "our controlling, autonomous, rights-based, power-over notion of reproduction." That alternative also deals with power, but it focuses on "humble responsibility" and the "power-to."

Much of the talk in medical ethics these years is, indeed, "rights-talk," an assertion of the power of the autonomous individual against corporate external authority. Well and good, but not well enough or good enough, argues physician Andrew F. Shorr as he explores the resources of Judaism for Jews and others in our secular, autonomy-promoting society. Shorr tells the story of the drama that erupted in the medical community, which has so much power in respect to the ill, when AIDS came to threaten medical professionals. He deals with controversial issues, "the duty to warn" and "the duty to treat." The conclusion: Jewish law has something to say to the secular world, challenging the power and authority of those who argue on the basis of non-Jewish, nonreligious philosophical grounds that have gone unchallenged for too long.

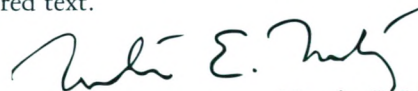
In "Dawn Runner" Lois M. Verbrugge tells a shocking story about the power of an attacker to interrupt her life. Here was a violent power not moved by state or corporate hegemony. It represented a potential power over our lives that is located in our imagination of terror—or, for those who have been mugged or attacked or violated, in the *reality* of terror and violence. "The court system" comes under criticism as an accomplice in the violence of attackers. Verbrugge countered the domination of violence through techniques of "biogenics," meditation, and

alternative modes of imagining. She announces that she can now say she is "proud of choosing again to live with some risks."

In a response to Verbrugge's story, Ellen Flookes discusses some more explicitly religious resources for stimulating both negative and positive images of power. One resource is the concept of "witnessing," as recognized by Jesus, who is associated with exhortations "to persevere with the courage to seek the spirit of truth." Speaking truth to power, the Quakers called this.

Maxine Glaz takes one more turn on the theme of power by resort to Henri Nouwen's by now classic concept of the "wounded healer." Nouwen wanted to show that "experiences of loss and pain can be facilitators of ministry." Those who suffer loss and pain surrender their hold on conventional power, authority, and domination. Glaz, a supervisor of those in clinical pastoral education, questions whether all who seek to enter professional ministry after the prolonged experience of abuse can become healers. Some can. She draws on "the basic impulse of the gospel to [help them] learn how to share the acceptance and grace which are ours" in the context of faith.

Such a sense of acceptance and grace has often been at the heart of the human impulse to counter the conventional powers. One does not need the voice of a "Marxist you can bring home to mother" to learn that. It's in many an ancient but often overlooked sacred text.



Martin E. Marty



Untitled.

Cast iron and clay by Judith Shea, 1957.

Collection of Peter Campus, New York. Reproduced by permission of the artist.

Power-Over and Power-To

Human Reproduction and Insights from Taoism

Laura Shanner

THE SEXUAL REVOLUTION OF THE 1960s was ushered in by the availability of increasingly reliable contraceptives; in later decades, the availability of new technologies to treat infertility expanded our expectations of “birth control” and “family planning” to include conception. Contraception, abortion, and infertility treatments often allow us to schedule pregnancies when we desire them, and our moral terminology surrounding reproduction tends to reinforce the notion of “birth control” by emphasizing our rights to control our bodies and to have access to the techniques available for doing so. Before we may speak meaningfully of a right to control our reproduction, however, we must first establish the ability or expectation of controlling it; it is this notion of reproductive control that I want to reconsider. I suggest that our presumption of medicine’s ability to control fertility, especially when we are attempting to initiate rather than prevent or terminate a pregnancy, is more limited than we would

like to admit and is prone to negative practical consequences.

In this article, I draw upon the ancient Chinese philosophy of Taoism for different images of reproduction, with special attention to infertility treatment. I am not pursuing a debate between Western notions of autonomy and Chinese communitarian ideals; instead, I seek to reconceptualize our understanding of the reproductive process. The problem is not to define the limits of our reproductive rights nor to arbitrate who ought to control the procreative options of individuals but rather to challenge our notions of controlling reproduction at all. The Taoist concepts of cycles, balance of opposites, and *wei wu wei*, or “doing without doing,” offer insight into healthy sexuality, pregnancy, and stress-induced infertility that is often lacking in Western discussions. Taoism teaches that any creative capacity has the power to destroy as well as to create and thus encourages a deep sense of responsibility and humility rather than the entitlement and control implied by most rights claims. Since vulnerable children must live with the consequences of our choices, such humility and responsibility are particularly important in the context of discussions about reproduction.

Laura Shanner is I'Anson Assistant Professor, Department of Philosophy and Centre for Bioethics, University of Toronto, Canada.

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Clinical Infertility Treatment

THE FERTILITY-MANAGEMENT TECHNIQUES developed by contemporary Western medicine frequently involve high doses of hormones and invasive bodily manipulations to prevent, remove, or initiate pregnancies. In vitro fertilization and embryo transfer (IVF-ET or IVF) for the treatment of infertility offers one of the most compelling examples of a controlling attitude toward the body and reproductive activities. In a typical treatment cycle, women are given daily hormone injections to suppress their normal hormonal feedback loops and to hyperstimulate the ovaries to produce as many as 15 eggs rather than the usual 1 per month. Another hormone injection stimulates a timed ovulation, when the eggs are aspirated through a vaginal ultrasound probe and needle, or sometimes through laparoscopy. Ova are then mixed with sperm collected (usually) by masturbation, and the resulting embryos are transferred to the uterus two days later; excess embryos may be frozen for later transfer in a drug-free cycle. The GIFT technique (gamete intrafallopian transfer) involves retrieving the ova through a laparoscopy and then in the same procedure returning the eggs together with sperm to the fallopian tube so that fertilization, if it occurs, would take place in the body. Several other variations of IVF involve placing sperm and eggs or embryos at various stages within various locations in the woman's reproductive tract. Sperm abnormalities are increasingly treated by micromanipulation techniques in which an opening is made in the outer covering of the ovum to allow sperm to enter or in which a single sperm is injected directly into the ovum.

The IVF protocol involves several known and suspected risks, some of great magnitude, for the women who undergo it; several women have died while undergoing IVF protocols. Transvaginal egg retrievals have resulted in nerve damage, punctured bladders, peritoneal infections, and incontinence,

and laparoscopies involve the risks associated with full anesthesia. Every invasive procedure carries the risk of scarring and infection, which may complicate existing infertility or even *cause* infertility in a previously fertile woman undergoing a procedure to compensate for her partner's infertility.

The hormones used to hyperstimulate the ovaries present more frequent and worrisome complications. Hormonal manipulation through birth control pills causes well-documented short-term and long-term side effects, including increased rates of cardiopulmonary problems and some cancers; this previous experience and common sense indicate that other hormonal interventions should be approached with caution. Women taking hormone injections for infertility commonly experience severe mood swings, cramps, bloating, nausea, visual disturbances, hot flashes, diarrhea, temporary hair loss, dermatitis, lethargy, rapid weight gain, and ovarian enlargement and cysts. Ovarian hyperstimulation syndrome (OHS) may lead to acute fluid accumulation in the peritoneal, pleural, and pericardial cavities, in turn leading to pulmonary distress, blood clots, and in rare cases, death. It was reported to the World Health Organization in 1990 that severe OHS occurs in about 1 percent of patients and mild OHS in 8–23 percent of all patients given ovulation inducers, even when they are carefully monitored (St. Clair Stephenson 1991). Adequate long-term studies are lacking, but a review of preliminary reports indicates an increased risk of ovarian cancer following ovarian hyperstimulation (Whittemore et al. 1992).

Creutzfeldt-Jakob disease (CJD) is an invariably fatal neurological disease marked by rapidly progressing dementia that begins, on average, 15 years after exposure to the virus that causes "mad cow disease." Cases of this usually rare disease have been traced to patients receiving pituitary hormones for infertility treatment or growth deficiency. Among the approximately 30,000 people treated with human pituitary hormones worldwide, 53 cases of

CJD have been confirmed thus far. The deaths of four women in Australia prompted an inquiry by the federal Department of Human Services and Health (Australia 1994:1–2), which on June 30, 1994, concluded that several Australian policies regarding cadaver organ retrieval, the purification of pituitary hormones, informed consent, and medical follow-up had been violated. Between 1967 and 1985, 1,377 women and 62 men in Australia were given possibly contaminated pituitary hormones for infertility treatment, but because of the lengthy incubation period and the inability to diagnose CJD definitively until autopsy, the extent of the infection is unknown (Australia 1993).

Adequate follow-up studies have not been done to determine the effect of ovulation hormones on offspring exposed to them in utero, but several observations prompt concern. Frozen embryos transferred in drug-free cycles are substantially more likely to implant and initiate a pregnancy than are fresh embryos from recently harvested eggs, indicating systemic hormonal disruptions in the mother's body and/or directly deleterious effects on embryos. While the early IVF babies show no obvious increase in congenital malformations, Clomid (clomiphene citrate) is a chemical analog of diethylstilbestrol (DES), a teratogen known to cause cancer and malformations of reproductive organs in children exposed to it in utero. We cannot know for several more years—when these children themselves begin trying to have families—whether prenatal exposure to high doses of hormonal residues has similar effects on the fertility and long-term health of the offspring (Burfoot 1992; Klein and Rowland 1988).

For all of these risks and complications, IVF is

usually unsuccessful in its stated purpose of producing pregnancies. Reported success rates at the world's best clinics average 18–22 percent, but these numbers reflect pregnancies—not live births—among women who completed the treatment cycle to egg retrieval; the numbers do not include the patients who discontinue the protocol before harvesting eggs. IVF and its related procedures have a higher than normal miscarriage rate and high rates of perinatal mortality and low birth weight (St.

Clair Stephenson 1991; Bartels 1990; Great Britain 1994). Live birth rates, on average close to 14 percent of completed cycles, are determined by dividing the total number of babies born into the number of treatment cycles; however, since approximately 30 percent of IVF pregnancies result in multiple births (Great Britain 1994), the likelihood that a patient will take a child or children home is substantially lower than 14 percent. In 1988, the Australian government esti-

imated that only 8.8 percent of patients who underwent IVF treatment actually took home a child or children (Batman 1988).

Although IVF has been used on patients with many causes of infertility, very few studies have focused on its success according to diagnosis. Approximately one-third of infertility cases are idiopathic, or have no known cause; for these patients, the available evidence indicates that being left alone for two to three years results in a higher spontaneous pregnancy rate than the pregnancy rate with IVF. Accordingly, the conclusion reached by both Canada's Royal Commission on New Reproductive Technologies (RCNRT) in 1993 and the World Health Organization (WHO) in 1990 is that the

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standard definition of infertility should be changed from the lack of pregnancy following one year of unprotected intercourse to the lack of pregnancy following two years of unprotected intercourse.

There has long been a folklore about fertility suppression due to stress, based upon the observation that many infertile couples suddenly achieve a pregnancy after adopting a child, taking a long vacation, or ending treatment. Such cases are often dismissed as mere anecdotes in spite of their prevalence, are rarely studied, and are downplayed by many patients. It is commonly accepted in environmental and population biology, however, that fertility is suppressed in periods of environmental or psychological stress; humans would be unique in an extraordinary way if we did not also experience temporary infertility due to stress factors (Wasser and Isenberg 1986). The high incidence of idiopathic infertility may reflect this phenomenon in humans, and it is likely that many identified cases of hormonal imbalances or suppressed sperm production are psychogenic or stress induced.

It has been documented that sperm production may drop during IVF treatment (Harrison et al. 1987), and physical symptoms of infertility such as a lowered sperm count or disrupted ovulation cycles have been observed to appear in a previously healthy person following the diagnosis of infertility in the other partner (Kemeter 1988). In an informal discussion during a site visit, members of the Queensland Fertility Group in Australia indicated to me that the success rate is higher in their two-month annual clinic held in Mackay, a northern Queensland beach town that makes even the busy clinical staff feel as though they are on holiday, than in their central Brisbane headquarters.¹ The IVF program itself thus clearly causes physical and emotional stresses that may reduce fertility, creating a physical backlash that seems as likely to compound the problem as to relieve it.



A Taoist Approach

EVEN IN THOSE CASES in which the infertility is relieved by new reproductive technologies, we have good reason to be concerned about their risks and therefore to seek a different model of reproductive intervention. I will draw from the writings of Chuang Tzu and from Lao Tzu's *Tao Te Ching*, composed in the sixth to second centuries B.C.E. in China, for an alternative vocabulary and imagery of power.² The Taoist writings purport to offer a comprehensive metaphysical, epistemological, moral, and social framework. What follows is a very brief interpretation of Taoist insights, with a special emphasis on notions of power and other concepts relevant to reproductive decisions. We need not accept the entire Taoist metaphysical system, however, to profit from its concepts and attitudes.

Before proceeding, I should note that the Taoists were highly critical of philosophy. The *Tao Te Ching* opens with a frequently repeated caveat for scholars:

The Tao that can be told is not the
eternal Tao.

The name that can be named is not the
eternal name. (1 G)

Those who know are not learned.
The learned do not know. (81 G)

Knowledge of the Tao is intuitive and experiential rather than intellectual or conceptual, and both Lao Tzu and Chuang Tzu rebuked scholars for confusing book-learning with genuine understanding. Duly chastised, I hereby proceed to analyze the Taoist concepts relevant to contemporary reproductive medicine.

It is generally accepted that the Tao is present at three levels: the mystical or metaphysical Tao (the Way of the Universe), the Tao manifest in the world (the Way of Nature), and the Tao of humanity (the Way by which people should live). These three levels of the Tao are interrelated and difficult to separate: the way humans should live depends directly

upon the order of nature, which in turn reflects the Tao that orders the universe. Understanding the Tao thus requires an understanding of each level, and the realization that all levels are not only related to the others but are also manifestations of the same phenomenon (Needham 1956; Welch 1965; Creel 1953).

The metaphysical Tao, the ordering principle of the universe, is incomprehensible, eternal, and unchanging. The Tao is not static, however; it is “unchanging in the sense that it does not increase or diminish, but is constantly changing in the sense that it is in perpetual motion” (Ch’en 1977:5). It is the creative, sustaining source of all tangible objects and living things and therefore is present in everything. The Taoist worldview is thus one of unity, where dualities or multiplicities are regarded as artificial distinctions.

Yin and yang at first seem to be a duality that contradicts the pervasive unity. Yin is feminine, passive, receptive, nurturing, mystical, the life energy of the earth; yang is masculine, aggressive, dominating, destructive, rational, the essence of the heavens. Yin and yang can be translated literally as the “dark side” and “light side” of a hill, however, pointing to the ultimate unity that encompasses a superficial duality (Waley 1958:110). The hill is a single reality, and the sunny and shady sides are just different ways of looking at it.

Yin and yang provide the basis for the eternal motion of the Tao, which is circular, returning, and balanced. When one of a pair of opposites is stressed at the expense of the other, the natural motion of the Tao draws the extreme back toward its antithesis, or to the center. Ch’en Ku-Ying refers to this phenomenon as “antithetical rotation,” in which the opposites are returned to the point of origin (Ch’en 1977:8).

Returning is the motion of the Tao. (40 G)

What is in the end to be shrunk

Must first be stretched.
 Whatever is to be weakened
 Must begin by being made strong.
 What is to be overthrown
 Must begin by being set up . . .
 It is thus that the soft overcomes the hard
 And the weak, the strong. (36 W)

The revolving motion is sustained by simple cause and effect, not a god or teleology. Extremes trigger a return to maintain balance, constantly readjusting the edges around a central pivot. As with a spinning top, excess weight or pressure on one side (either yin or yang) causes a “wobble” and eventual collapse. The contemporary biological term *homeostasis* refers to the dynamic balancing of multiple factors in a body or ecological system; extremes that throw the biological system out of balance result in illness, injury, death, or ecological crisis. Dramatic natural phenomena such as earthquakes, lightning, famines, and population explosions are the most vivid manifestations of *Te*, the Tao’s revolving, returning energy correcting an extreme.

Because the universe is utterly indifferent to the processes it sustains, what one considers good or bad depends upon where one stands in relation to it. The rain that quenches thirst and nourishes crops can drown an unsuspecting animal or form a wall of water that destroys anything in its path. Accordingly, there is a sense of moral relativism to Taoism, since one cannot establish whether a particular happening is actually good or bad. On the other hand, the Taoist is not left without guidance: working against the power and motion of the Tao is a great mistake. Perhaps because violence is manifest in the backlash that follows an extreme, the Tao favors passivity. As Lao Tzu tells us:

Yielding is the way of the Tao. (40 G)

When he is born, man is soft and weak;
 In death he becomes stiff and hard.
 The ten thousand creatures and all plants and

trees while they are alive are supple and soft,
But when they are dead they become brittle
and dry.

Truly, what is stiff and hard is a companion of
death;

What is soft and weak is a companion of life.

Therefore the weapon that is too hard will be
broken,

The tree that has the hardest wood will be cut
down.

Truly, the hard and mighty are cast down;

The soft and weak set on high. (76 W)

It is at this point that we encounter the distinction between *yu wei*, or “striving,” and *wei wu wei*, “doing without doing,” or working effortlessly with the nature of things. The Way of Tao is deceptively simple: all one has to do is to understand the Tao and work with it rather than against it. Striving to change the universe, nature, or even other people is bound to fail, because natural forces are far more powerful than individual human will. In politics, people should lead from within and by example rather than by force to prevent distrust and disharmony.³ The foolishness of building a house in a floodplain is a good example of striving and its backlash: building a levee requires energy not only to overcome gravity but also to withstand the force of the water behind it. The natural cycle of events (spring rains and melting snow) is then compounded by antithetical rotation and the return of extremes to a balance (the tendency for redirected water to seek its own lowest level), resulting in broken dams and flooded plains. As the *Tao Te Ching* observes:

That which goes against the Tao comes to an
early end. (30 G)

Only by knowing when it is time to stop can
danger be avoided. (32 W)

Peace is easily maintained;
Trouble is easily overcome before it starts.

Deal with it before it happens.

Set things in order before there is confusion.

A tree as great as a man's embrace springs
from a small shoot;

A terrace nine stories high begins with a pile
of earth;

A journey of a thousand miles starts under
one's feet. (64 G)

In those times when problems cannot be avoided, *wei wu wei* suggests how to recover from them. A famous story concerns a sage who fell into a raging river. Ignoring the shouting of his students on the shore, he rested his head in his hands, lifted his feet, and floated a great distance down the river. When he finally emerged, the students asked him why he did not swim to safety. The sage replied that swimming against the current would have exhausted him and caused him to drown. By understanding the nature of the water and floating with it, he was able to rest until he reached a shallow eddy (Merton 1965:45–47; Legge 1959:246–48).

Finally, *wei wu wei* includes the promise that great accomplishments can be achieved with ease, if only the Tao is followed. The ability to “do without doing” is often displayed by athletes who perform difficult feats with seeming effortless. As athletes in a slump have observed, thinking too much about the mechanics not only ruins the activity but often results in injury. Achieving effortless proficiency requires practice and training, but in the end the learning must be left behind so that a genuine understanding of one's body, the objects being used, and the unique elements of the situation can come together in a nearly intuitive response. *Wei wu wei* captures the quality of spontaneity, a simple joy in the accomplishment of one's goals, and the tranquility that comes from the relinquishment of striving, competing, overpowering, and attempting to control things. Energy that would have been lost in useless struggle can then be redirected to accomplishing one's goals with greater ease.

Reproductive Power

THE TAOIST VOCABULARY OF BALANCE, cycle, and *wei wu wei* stands in sharp contrast to the chemical and physical control of reproductive functions attempted by contemporary Western infertility clinics. I suggest that the Taoist images provide a much richer and more realistic framework for understanding human reproduction than does an image of the body as a malfunctioning machine to be physically manipulated until it meets standards of performance and that the Taoist concept of power is more appropriate to reproductive decision making than is the notion of “birth control.”

Given the current medical climate that celebrates technology and dramatic intervention, coupled with social norms that not only emphasize the importance of having one's own biological children but also stress individual rights and liberties, a dramatic shift to a Taoist perspective is quite unlikely. We have much to learn from this perspective, however, and may gradually embrace a different approach to reproduction and notions of control as we recognize the inherent limitations and dangers of our current ways of thinking. While the full Taoist metaphysical system seems alien to most Western minds, many elements of the approach are quite familiar after all.

There are several obvious manifestations of Tao in reproduction: Yin and yang are reflected in female and male sexes, both of which are necessary for human reproduction to occur. The cyclic nature of the Tao is revealed in the menstrual cycle, and in the larger life cycle of birth, growth, maturity, reproduction, and death. Famine and disease in overpopulated areas, followed by population explosions and postwar “baby booms,” reflect population cycles in environments. The roles of *yu wei* and *wei wu wei* emerge in stress-induced infertility: the stresses of the IVF treatment cycle and striving to overcome infertility cause or intensify reproductive suppression in some patients. Striving against infert-

ility (*yu wei*) thus leads to a backlash contrary to the desired end. Couples who unexpectedly initiate pregnancies after adopting a child or ending infertility treatment demonstrate *wei wu wei*—“doing without doing.” Other manifestations of the backlash from technological reproductive striving include hormonal side effects, scarring from surgery, and lowered implantation rates during hyperstimulated ovarian cycles. The likely but largely unexamined long-term side effects of large doses of hormonal drugs may reveal a much more serious backlash for both women and children.

Although reproduction seems to be a paradigm of Taoist principles, we need not adopt the Taoist metaphysical system in order to envision reproduction as a power or capacity that people have. We are able to produce gametes, to engage in sexual activities, to initiate new human lives, to construct young bodies during pregnancy, to give birth, and to nurture children to maturity. Each of these activities requires energy, sometimes unnoticed (as is gametogenesis) and sometimes consciously redirected (as are sexual urges or labor pains with patterned breathing). Reproduction is thus a very active and productive process.

In each of these activities, we may perceive ourselves to be part of a process larger than we are: we are participating in a cycle of birth, life, and reproduction that started long before we arrived as individuals and that will continue long after our departure. Lovers typically feel swept away by both their emotions and their physical passion and experience joy by yielding to it. Joseph Needham translates *jang* to mean “to yield up, to cede, to give up the better place, hence to invite” (1956:61). This statement of *wei wu wei* at work socially is particularly charming in the case of seduction, which stands in contrast to the overpowering, controlling sexuality of rape. Menstruation and labor for women, and erections for men, are often experienced as processes beyond their control. Women have learned that working with their contractions rather

than attempting to control the course of labor reduces pain and fetal distress. We recognize that a child produced through our reproductive capacity is another person; this process clearly transcends the individual and even the partners, because the child is part of both of them but is neither of them.

Power-Over and Power-To

THE KEY CONCEPT HERE involves the perceived relationship between oneself and the other persons, objects, events, or environment that one is attempting to influence. It is a distinction between *power-over* and *power-to*. Variations on the distinction are common in contemporary discussions of science and the environment, Western medicine and alternative therapies, leadership strategies, and gender and race relations. Power-over suggests a type of control that involves separation of oneself from, and a transcendence of the self over, the object of control. Figuratively speaking, the controller rises over the other to have power over it. Power-over concentrates power in the agent(s), allows arbitrary demands to be made of the object of control, and often connotes a sense of aggression, or, literally, overpowering. Hierarchical structures require a concept of power-over in order to rank their members. Michel Foucault's discussion of the power-knowledge nexus illustrates the layers of control built into medicine and other social institutions and tends to emphasize the negative, ominous aspect of the power-over relationship (Foucault 1975, 1980a, 1980b). While this negative connotation is common and usually deserved, power-over need not always be destructive. For example, a parent might exert positive but forceful power over a child by pulling her safely out of the path of an oncoming car. The medical attempt to hyperstimulate ovaries and surgically initiate pregnancies seems to be a clear example of the exertion of a power-over, and often destructively overpowering, attitude toward our bodies and the procreative process.

Power-to, on the other hand, connotes a sense of empowerment that may involve tapping one's internal strength or capacities, receiving an infusion of power from an outside source, or redirecting external power to one's advantage. Agents are often aware of being involved in a process or project larger than themselves. Their power is not separate from or transcendent over an object of control but rather is enmeshed in the context in which the agents act or exert influence. An agent thus is not an autonomous entity with power over the world, other people, or even one's own body, but is an active element within a larger, functioning system such as an environment or community. Aggression, overpowering, and arbitrary demands are less likely to emerge in such a conception of power, since the power itself arises largely from the context of the action. It would be self-defeating to overpower the source of one's own strength or to use the power in a manner contrary to the nature of its source. As power-over usually has negative connotations but need not always be destructive, power-to is usually characterized—I believe incompletely—as a positive force. Power-to has destructive aspects of its own. The creation of any object involves the alteration or destruction of raw materials, a balanced ecosystem requires the death of some plants, animals, and people to make room for others, and even a loving, joyful, empowering expression of sexual power-to can result in unintended pregnancy, sexually transmitted diseases, AIDS, and broken hearts.

The distinction between power-over and power-to calls into question several metaphysical problems of free will, causality, and cosmology that are beyond the scope of this article. For our current purposes, the distinction can be considered as a difference of attitude that one takes toward the people and objects that one seeks to influence. Attitudes have substantial normative impact, for a posture of empowered humility will encourage us to ask different questions, emphasize different aspects of a situation, employ different moral vocabularies, and ulti-

mately reach different moral decisions than we would from an attitude of control.

Reproductive power-over is exhibited in the literal destruction of offspring through embryo disposal, abortions, and infanticide. Procreation can also be approached from a power-over attitude in which offspring are created on schedule, genetically altered, and molded through childhood to suit the parents' wishes. I suggest that conception, continued pregnancy, and parenting are better attempted from an attitude of power-to, because the continued existence and growing independence of the child demonstrate that the parents are enmeshed in a larger life cycle over which they have only limited control. Not only have the reproductive technologies failed to provide the control we desire over conception, but the parents of any toddler or teenager will attest that parental control is largely a fiction. The child's innate energy may be channeled toward productive rather than destructive pursuits, but striving to change the child's nature usually results in misery for everyone concerned.

We tend to think of reproductive power as purely productive and thus positive, but this is a limited—and false—description. Like the rains that fall in the spring, we have the power to create and nurture new life and also to destroy it. Destruction need not involve the brash intentionality of asserting power-over by disposing of embryos, fetuses, or infants, however. Reproductive power-to can lead to genetic abnormalities, teratogenic birth defects, prematurity, severe neonatal illness, and grave physical risks for the mother. In addition, procreating in a miser-

able psychosocial or economic environment may threaten the well-being of the child, the mother, and entire families or communities. Reproductive power-to is thus not unidimensionally positive. Some pregnancies are clearly disastrous, destructive situations.

Because the power-to of procreation can be both productive and destructive, depending upon the circumstances, it must be guided in an active manner that both anticipates and responds to those circumstances. The practical implications of adopt-

The practical implications of adopting a power-to rather than a power-over stance toward reproduction are substantial, and extend far beyond infertility treatment. The practice of medicine would have to be restructured to downplay technological intervention.

ing a power-to rather than a power-over stance toward reproduction are substantial, and extend far beyond infertility treatment. The practice of medicine would have to be restructured to downplay technological intervention. The current emphasis on illnesses as crises to be managed would be exchanged for an emphasis on fertility protection, disease and injury prevention, and education about how our bodies function. When infertility could not be prevented, treatments would emphasize less invasive techniques. For example, IVF can be done in the course of a natural cycle, in which the one

egg normally produced each month is monitored and retrieved, thus avoiding the risks of ovarian hyperstimulation. Canada's Royal Commission rightly concluded that IVF ought to be offered only to women with complete blockage of both fallopian tubes. There is no evidence to indicate that IVF is effective for any other diagnosis, some evidence that IVF is counterproductive for sperm abnormalities and idiopathic infertility, no evidence that any of the variations of IVF are effective at relieving every cause

of infertility, and no plausible biological mechanism by which the techniques would work for most causes of infertility (1993:519).

An emphasis on prevention rather than dramatic intervention would redirect our attention to the larger social and environmental determinants of health and fertility, and individuals (both men and women) would have to recognize their individual procreative potential and assume responsibility for managing it throughout their lifetimes. At all three levels of influence—medical, social, and individual—people must work together to prevent malnutrition, smoking and drug use, exposure to radiation and many chemicals, conception at advanced or immature age, and several underlying diseases or disorders that are known to cause birth defects, complications of pregnancy, and infertility. Abstinence and contraception prevent many pregnancies under negative circumstances, and abortions in some cases can prevent disastrous births. Given the inherently destructive power of an abortion, however, it should be viewed humbly as a last resort to avert a greater disaster rather than a right of fertility control to which one is entitled. Prenatal care is essential to prevent later health problems, and emotional preparation is required in order to parent effectively. The nature of one's physical health and reproductive options, as well as the nature of any child who results, must be understood and respond-

ed to in an active attempt to direct reproductive capacities in positive rather than negative directions. The directing of reproductive capacities must be gentle, however, to prevent the backlashes of contraceptive-induced (or IVF-induced) infertility, physically or emotionally damaged children, and careless, destructive abortions.

Birth control is thus better understood as procreative guidance or management within limitations than as a form of power-over our bodies and reproductive destinies. Assertions of rights to reproduce (or not to) generally flow from a power-over attitude. Individuals or partners assert control over the process of reproduction to determine its outcome. While choices must be made and activity is required to direct reproductive capacities, the gentle activity expressed by *wei wu wei* is a much better description of the relationship we bear to our bodies, our partners, and our offspring than is the striving *yu wei*, which tends to confound our plans and show us again that "birth control" is largely out of our control. I suggest that significant medically induced harms may be avoided, and many social problems might be prevented, by refining our controlling, autonomous, rights-based, power-over notion of reproduction with a vision of procreative power-to and with the humble responsibility that such an enormous power entails.

NOTES

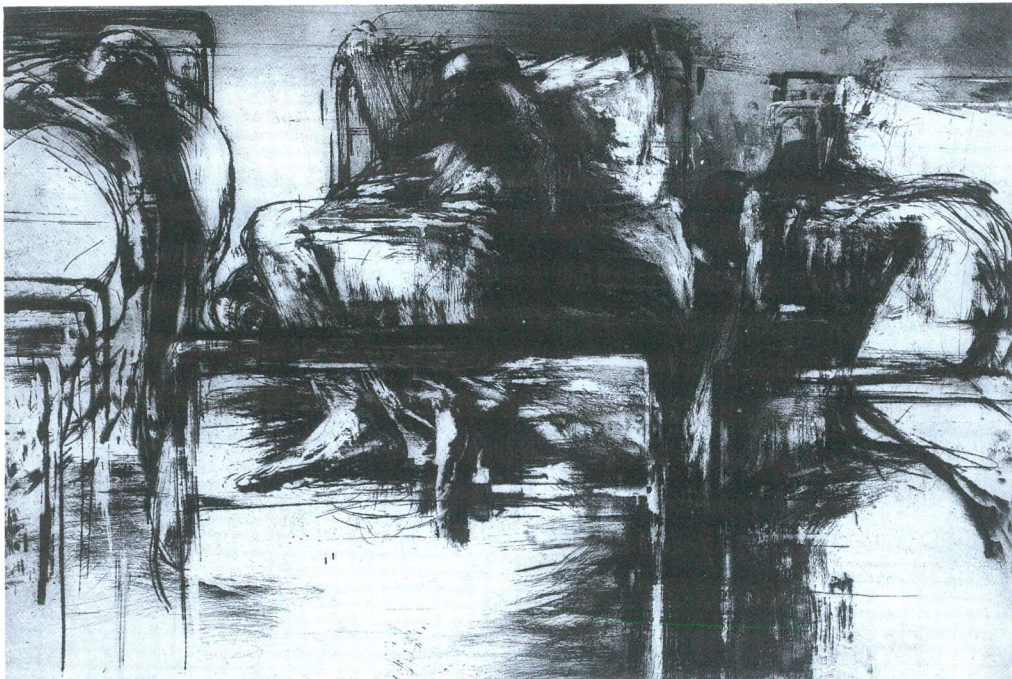
1. Personal communication and interviews in June of 1990 with Heather Pollock, nursing coordinator; Keith Harrison, head scientist; and other members of the Queensland Fertility Group.
2. Chuang Tzu is believed to have lived in the time of Meniscus, around the fourth century B.C.E. He developed Lao Tzu's teachings with rigorous logic, humor, and poetry, much as Plato did with the teachings of Socrates. Chuang Tzu's fables and stories emphasized the transcendental aspects of Taoism rather than its mundane implications and established a link to what would become Zen Buddhism. See Gia-Fu Feng and Jane English (1974), James Legge (1959), Thomas Merton (1965), and commentary in many secondary sources. Because most of these beautiful stories are somewhat lengthy, I have not quoted Chuang Tzu directly.

Citations to the *Tao Te Ching* give a chapter number and the initial of the principal translator. In this essay, two translations are used: G = Gia-Fu Feng and Jane English (1972); W = Arthur Waley (1958).

3. Some commentators view the *Tao Te Ching* primarily as a manual for government because of its frequent observations about leadership. This emphasis on politics was likely an attempt to restore social harmony during the unrelenting Warring States period in China (771–221 B.C.E.).

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Closed Ward: The Three Beds.
Etching and aquatint by Michael Mazur.

Philadelphia Museum of Art: Given by the Print Club, Philadelphia.

AIDS, Judaism, and the Limits of the Secular Society

Andrew F. Shorr

Introduction

THE EMERGENCE OF THE ACQUIRED immunodeficiency syndrome (AIDS) pandemic has simultaneously forced society to grapple with new moral dilemmas while necessitating the revisiting of several old ethical conundrums. Two specific ethical issues have received much attention—the duty to treat those infected with the human immunodeficiency virus (HIV) and the duty to warn those who share needles with or are sexual partners of people who harbor HIV. The secular discussion of these questions has been heated and acrimonious, often evoking passionate controversies. Nonetheless, as we proceed through the second decade of the AIDS pandemic, the debate over these topics essentially remains unresolved.

Judaism offers a unique approach to understanding the ethical dilemmas posed by the spread of HIV. An examination of the Jewish analysis of

the duties to warn and to treat not only reveals that Judaism has much to contribute to discussions of bioethics in a secular society but also offers a response to those who believe that Jewish tradition cannot speak to those outside the Jewish community.

One value of the Jewish approach lies in its ability to serve as an alternative paradigm for medical ethics that differs sharply from many current models. Absent from the Jewish rubric, for example, is the rights-talk that now pervades most discussions of morality and medicine and which, as some commentators acknowledge, weakens these secular efforts (Glendon 1991). Jewish law also establishes an ethic of duty and shifts the focus of the analysis away from the doctor-patient relationship. Instead of viewing the interaction between physician and patient as creating special duties, a Jewish paradigm for medical ethics attempts to apply to the practice of medicine the rigorous standards of ethical conduct required in all aspects of daily life. In short, Jewish law contains a coherent model of medical ethics, and one need not be a religious Jew to acknowledge and to accept either the values embedded in this view or its rationality. Similarly, by serv-

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ing as a contrast to other theories of medical ethics, the Jewish approach forces secular writers to confront issues and concerns that they might have otherwise ignored. This, in turn, enhances the quality of the ethical discourse and aids in the fashioning of an approach to medical ethics that can have force in a pluralistic society.

The Duty to Treat

EARLY IN THE AIDS PANDEMIC IN THIS COUNTRY, orthopedic surgeon Lorraine Day loudly exclaimed that she was not required to treat those infected with HIV (Daniels 1991). Multiple surveys of physicians have demonstrated that many share her view. In one study, nearly 50 percent of primary-care physicians stated that, if given a choice, they would not care for those suffering from AIDS. Another poll found that only 10 percent of internal medicine residents had a strong commitment to providing care for those infected with HIV, while 25 percent had a definite aversion to HIV and intended to plan their careers around avoiding HIV-seropositive patients (Daniels 1991). In response, the medical board of New Jersey mandated that “a licensee of this Board may not categorically refuse to treat a patient who has AIDS.” Even at this level in the medical hierarchy, however, there is no consensus regarding the existence of a duty to treat. In Arizona, for example, the state medical board adopted the position opposite that of their colleagues in New Jersey and argued that physicians had no obligation to treat. Similarly, the American Academy of Orthopedic Surgeons has expressly rejected the notion of a positive duty to treat HIV-infected patients.

The American Medical Association (AMA), a source of professional ethical guidance for physicians, has also had difficulty grappling with this issue. In 1986 the AMA argued that individual doctors were not required to provide medical care to those with HIV if they were “emotionally unable” to

do so (cited in Daniels 1991:37). By 1987 the AMA had amended its statement on AIDS and declared that a “physician may not ethically refuse to treat a patient . . . solely because that patient is [HIV] seropositive” (AMA, Council on Ethical and Judicial Affairs 1988:1060). This duty, though, was only based on the need to prevent “illegal or invidious discrimination,” and the AMA continued to maintain, in a rather contradictory manner, that its Principles of Medical Ethics acknowledged that physicians have the freedom to choose whom they serve.

There have been two general approaches to resolving the confusion surrounding a duty to treat HIV-infected individuals. Some scholars argue that a duty to treat emanates from the concept of medicine as a socially sanctioned profession, while other commentators believe that this obligation is inherent in the virtues of medicine. Each of these efforts, though, suffers from a number of limitations that only further perpetuate uncertainty in this area.

Ezekiel Emanuel writes that a duty to treat “is derived from the concept of medicine as a profession and from the profession’s role” (1988:1686). By becoming a doctor, one enters into a form of social bargain with the community in which he consents to treat the ill. For the secular world the attractiveness of the social bargain model rests on its appeal to notions of consent, autonomy, and justice. This model, however, has several flaws. First, a duty to treat grounded on the implicit consent of professionals is necessarily circumscribed. Second, the often enumerated restrictions on the duty to treat (for example, obligations to other patients) further limit the duty’s moral authority. How should the physician weigh conflicting duties to other patients? When do the doctor’s responsibilities to her family trump her duties to HIV-seropositive patients? Third, the social bargain paradigm, even though couched in the language of consent, is essentially incapable of providing a response to those who trumpet the autonomy and rights of the physician.

Other members of the secular community who support the duty to treat emphasize physician virtue. For example, Zuger and Miles ground a duty to treat on a conceptual analysis of the ends of medicine (1987). They argue that the practice of medicine centers around healing, and thus physicians, by being members of the medical profession, are obligated to care for the sick. Zuger and Miles find historical precedent for their approach in the writings of ancient physicians, including Scribonius, and conclude that physicians who refuse to care for HIV-positive patients “fall short of an excellence in practice implicit in their professional commitment” (1987:1927). John Arras, on the other hand, expressly rejects this approach (1988). Rather, he states that a duty to treat can be gleaned solely from the historical record. By examining the behavior of past physicians felt to be virtuous, it is possible to envision the model practitioner.

Although relying on the virtue model to find a duty to treat those suffering from AIDS avoids many of the problems inherent in the logic of the social bargain model, it also has limitations. The conceptual paradigm implies that the *only* end of medicine is a comprehensive form of healing. This goal, however noble, is unrealistic—frequently the physician cannot cure her patient but can only provide compassionate care (Daniels 1991). Moreover, virtue-based arguments face a more general challenge. Is failing to meet the standards of an ideal of virtuous conduct a basis for social condemnation? By not giving charity, most people fail to live up to common notions of the ideal citizen. Yet those who do not give to the needy or to organizations that serve them face no particular public sanction. Finally, historical constructions of virtue fail to

acknowledge the true record. In the past, many physicians neglected their patients and fled from cities infested with plague. Even the noted anatomist and medical philosopher Galen abandoned Rome as the plague approached (Fox 1988:7). More recently, in the United States both during the yellow fever outbreak and later during the cholera epidemic, numerous medical professionals either left their homes in order to avoid exposure to contagion or simply refused to visit the sick (Fox 1988:8). In

short, the historical evidence of medical behavior does not provide a clear source for modern ethical guidance. Thus, a duty to treat based on virtue models is, as John Arras acknowledges, “fragile” (1988).

The Jewish approach to the duty to treat, in contrast to secular attempts, is unique. Modern Jewish commentators state unequivocally that physicians are obligated to care for persons infected with HIV. Similarly, ancient Jewish writers, including both

Jewish law contains a coherent model of medical ethics, and one need not be a religious Jew to acknowledge and to accept either the values embedded in or the rationality of this view.

Maimonides and one of his most cogent critics, Nahmanides, have argued that the Torah requires physicians to care for the ill. The origin of a duty to treat is found in several biblical commandments. First, one may “not stand idly by the blood of your neighbor” (Lev. 19:16). The Talmud comments that fears of either significant expense or danger to self do not limit the obligation to participate in life-preserving endeavors. Second, the Torah mandates the returning of lost objects to their proper owners (Deut. 22:2). Maimonides argues that, since the Talmud extends the notion of ownership to encompass one’s body and health, this passage creates a powerful duty to treat. In other words, Maimonides feels that the biblical commandment “And thou shall return it to him” establishes a duty incumbent

upon physicians to restore the health of patients.¹ One finds a third Torah-based source for a duty to treat in the notion of “providing for his healing” (Exod. 21:19). Nahmanides uses this concept to develop an argument for an obligation to treat that differs substantially from Maimonides’ efforts.² For Nahmanides, as David Novak notes, healing is “more than an ordinary obligation but an act of *imitatio Dei*” (1992:112). Nahmanides, moreover, believes that the obligation to treat the ill arises from the broad commandment “to love thy neighbor as thyself” (Lev. 19:18).

More recent Jewish scholars have drawn from both Maimonides and Nahmanides in order to codify the duty to treat. Joseph Caro (d. 1575), in his seminal compilation of Jewish law, writes, “The Torah gave permission to the physician to heal; moreover, this is a religious precept and it is included in the category of saving life. If the physician withholds his services it is as if he is shedding blood.”³ Potential risks to self do not mitigate this duty. For Caro, one is required to “expose himself to possible danger” if necessary for the saving of a life. For Jews, the discussion of a duty to treat does not concern the existence of the duty. Rather, the ethical discourse concerns the source of this duty and its theological underpinnings.

The Jewish perspective on the duty to treat patients harboring HIV also demonstrates the contribution that Judaism can make to secular bioethics. As Louis Newman observes, embedded within Jewish religious law are “principles with broad applicability” (1993:562). Put another way, the moral precepts that underlie the duty to treat are intelligible outside the realm of Judaism. One need not be an observant Jew to realize that these concepts merit serious consideration. Several other factors recommend the Jewish approach. Adopting a Jewish model allows one to avoid rights-talk and its accompanying limitations while also shifting the focus of the analysis by highlighting the moral relationship between individuals. Furthermore, unlike

virtue-based arguments, which historical evidence essentially undermines, the historical record of Judaism both elucidates and reinforces the obligation to treat people with AIDS. Jewish physicians during the plague were religiously obligated to treat their patients, as modern Jewish doctors are duty bound to care for HIV-seropositive persons. Jewish physicians *did* treat plague-infected patients (Jakobovits 1967:106–9). The passage of time has neither theoretically nor practically weakened the force of this duty. The Jewish position can serve as a point of comparison for differing secular theories of medical ethics. The existence of the Jewish view challenges those opposed to a duty to treat to re-examine their beliefs and assumptions in order to respond to the concerns and values that form the basis of the Jewish model.

The Duty to Warn

THE JEWISH RESPONSE TO THE DEBATE over the duty to warn also demonstrates the contribution Judaism can make to secular bioethics. Historically, contact tracing, the process of identifying individuals at risk for infectious disease (particularly those sexually transmitted) based on their exposure to an index case, was a well-accepted public health practice. When employed in earlier eras of epidemic venereal disease, few saw any ethical difficulties inherent in this procedure (Bayer and Toomey 1992). The AIDS pandemic, however, has led clinicians, public health officials, policymakers, and the public to reconsider this position. Furthermore, the clinical impact of this problem has been significant. Survey data reveal that many persons who are aware that they carry HIV opt not to notify their sexual contacts of this fact. In one study, 36 percent of blood donors who had been told they were HIV positive had not shared that information with their sexual partners more than one year later (Williams et al. 1988).

Those who allege that physicians have no obligation to warn focus on three issues: the confidentiality rights of the individuals, the realities of doctor-patient relationships, and the potential for discrimination against persons with AIDS. First, they argue that respecting patient confidentiality requires that clinicians accept the wishes of HIV-seropositive individuals who do not desire to notify their partners. Notions of autonomy entail doctors' not breaching the duty of confidentiality they owe to their patients. One can trace this duty back to the Hippocratic oath, and, over the last 50 years, the concept of respect for patient confidentiality has developed as a response to and a check on the paternalism often encountered in the clinical setting. Commenting on confidentiality, the AMA Council on Ethical and Judicial Affairs states: "Information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree" (1986: section 5.05). Betraying confidentiality egregiously vitiates the privacy rights of patients. As one ethicist expresses it, violating confidentiality in this instance would do significant "damage to the patient's rights and civil liberties" (Winston 1987:22). Most gay-rights activists denounce the duty to warn as a profound intrusion on privacy; and it raises "Orwellian fears," because partner notification creates the potential for the development of registries that list homosexuals, bisexuals, and their partners.

Second, opponents of the duty to warn believe that such obligations will undermine the doctor-patient relationship. Confidentiality is the basis for an effective doctor-patient relationship. It puts the patient at ease and allows her to reveal information of clinical import that she might otherwise keep secret. If physicians must notify others of the HIV status of their patients, patients will be less likely to disclose certain aspects of their clinical history. This, in turn, will impede the delivery of efficacious medical care. More important, foes of the duty to warn

fear that if HIV-positive persons know that their doctors will betray their serostatus, infected persons will simply stop seeking medical attention. As the director of the Lambda Legal Defense Fund once put it, "Doctors ratting on [HIV-positive individuals] . . . will undermine efforts" to care for HIV-infected patients (Bayer and Toomey 1992:1161).

Third, those who oppose the creation of a duty to warn worry that persons with HIV will face increased discrimination under a scheme of obligatory partner notification (Lo 1992). In the past, those infected with HIV have faced discrimination in many areas of public life. When third parties found out about their HIV status, some AIDS patients lost their jobs and others had difficulty finding adequate housing. Even in settings where there is essentially no risk of viral transmission, such as the classroom, HIV-infected individuals have faced stigmatization and physical isolation. Although recent legislation, most notably the Americans with Disabilities Act, has outlawed such practices, infected individuals may still face discrimination, although it may be less overt than it would have been in the absence of such legislation.

Several professional societies have embraced the preceding analysis of the duty to warn and officially oppose partner notification. The American College of Obstetrics and Gynecology, for instance, has articulated a set of ethical guidelines that state that the desires of the patient take precedence over other concerns. Organizations composed of public health officials, such as the Association of State Health Officials and the U.S. Conference of Local Health Officials, have specifically rejected mandatory partner notification. Five states now expressly prohibit the disclosure of the identity of infected individuals (Bayer and Toomey 1992).

Secular advocates of a duty to warn, in response to concerns regarding confidentiality and the physician-patient relationship, assert that privacy rights are not absolute and that one must view the doctor-patient relationship more broadly to encompass

duties to third parties. Bernard Lo writes that the principle of beneficence serves as a basis for the duty to warn (1992). He limits, however, the moral authority of beneficence in this situation. Since a duty to warn essentially deals with prevention and not treatment, it is weaker than claims grounded on the principle of nonmaleficence. State courts have been less equivocal. In *Tarasoff v. California Board of Regents*, where a clinician knew his patient planned to murder a former girlfriend, the California Supreme Court asserted that the physician should warn innocent third parties. The court wrote: "The protective privilege ends where the public peril begins" (1976:553). Correspondingly, the AMA, the American Academy of Family Physicians, and other subspecialty medical societies embrace the duty to warn, and most states currently allow physicians to notify the partners of HIV-infected individuals, irrespective of patients' objections (Bayer and Toomey 1992). The fact that physicians may, under law or guidance from their professional society, breach confidentiality does not imply a duty in the strict sense, that is, a requirement that they must violate patients' wishes in order to prevent harm to others. The duty to warn, in actuality, might more accurately be called an "opportunity to warn." Moreover, this concept, as currently conceived in the secular society, offers no guidance as to when a physician should disclose a patient's serostatus, to whom he should reveal this information, or how to evaluate concerns about the resulting consequences for the patient.

As one can see, the secular debate over the duty to warn remains unresolved. In contrast, following a Jewish approach to this question leads to a strong duty to warn the partners of patients infected with HIV. One can find the origin of this duty to warn in four separate areas of Jewish law and theology. First, the biblical commandment "not to stand idly by the blood of your neighbor" (Lev. 19:16), discussed with regard to a duty to treat, also applies in this situation. This dictate obligates a physician to notify

innocent third parties if one of her patients poses a threat to their health. The dilemma of the *rodef* (pursuer) demonstrates the significance of this concept for Jewish thought. The Talmud (*Sanhedrin* 73a) contains a lengthy analysis of an individual's duties if he sees someone chasing after a person to kill her. The Talmud states that in this situation one must rescue the potential victim even if it necessitates the use of deadly force: "He who pursues after his neighbor to kill him must be rescued [from transgression] at the cost of his own life." The case of an HIV-seropositive patient who refuses to warn his sexual partners is analogous to the situation of the *rodef*. In each instance, a third party faces a potentially mortal threat that some other person becomes aware of and, as a result, may eliminate. That the Talmud shapes the duty to stop the *rodef* as obligatory and not merely as permissible signals the moral importance of this notion. Thus, unlike many secular conceptualizations of the duty to warn, which essentially frame this duty as optional, in Jewish law one does not have a choice whether he should prevent harm to another. The Jewish analysis of the duty to warn unequivocally creates an obligation to intervene.

A second source for the duty to warn rests in the prohibition against "placing a stumbling block before a blind man" (Lev. 10:13). It may not seem that this mandate pertains to a discussion of a duty to warn, but in Jewish law this proscription has often been broadly interpreted. More generally, the prohibition illustrates and reinforces the concept of respect for persons. In other words, it serves to prevent the unscrupulous from exploiting another's weaknesses, disabilities, or diminished capacity. With regard to business ethics, Jewish scholars have interpreted this passage to require full disclosure for the completion of complex transactions and to dictate that the parties to a contract enter into an agreement free of coercion. In the clinical setting, one can envision the wife of an HIV-infected individual as the proverbial "blind man." She is unaware of the

threat her husband poses to her health. To maintain a sexual relationship, her spouse wishes to keep his serostatus secret. The physician who is aware of the situation has the opportunity to remove the veil of ignorance from the wife. Therefore, in order to remove the “stumbling block,” the clinician, under Jewish law, must warn the wife.

Third, in the *Sulhan Arukh*, the authoritative codification of Jewish law from the sixteenth century to the present time, Rabbi Joseph Caro argues that if a physician knows that someone is going to die, he must inform him of this fact. Again drawing on Jewish beliefs about respect for persons, Caro states that the physician must disclose this information so that the dying individual can seek forgiveness both from those he has wronged and from God. To deprive one of the opportunity for such moral introspection, for Caro, is to fail to acknowledge the person’s moral status. Similarly, because AIDS is essentially a terminal illness, not disclosing the serostatus of an HIV-positive patient to his partner is akin to not notifying her that she may face a deadly pathogen. Failure to notify her deprives her of the chance to put her life in order. Many secular ethicists acknowledge the importance of this claim. For example, Sissela Bok writes that “a terminally ill person who is not informed that his illness is incurable . . . cannot make decisions about the end of his life” (1978:244). Secular discourse about this issue, however, rarely addresses respect for the victim directly.

Fourth, in addition to theoretical analyses, some sources in Jewish law include examples of

problems normatively similar to a duty to warn. An examination of these dilemmas helps to elucidate the Jewish perspective on the duty to warn. For instance, the commentaries of the noted Rabbi Israel Meir HaCohen (also known as the Chofetz Chaim) include a discussion of the questions presented when a person learns of a fact that disqualifies another from becoming married (Freedman 1990). Should

one reveal this information to the intended spouse? Generally, under Jewish law one would be obliged to keep this knowledge confidential so as not to violate the commandment against gossiping (*lashon bara*). The Chofetz Chaim, however, concludes that one must provide such potentially embarrassing information to the future spouse. Likewise, although an HIV-infected patient may fear that divulging his serostatus would result in others gossiping about him or would ruin his marriage, the writings of the Chofetz Chaim indicate that the possible harm to the patient do not trump an individual’s duties to a third

party. Additionally, the Chofetz Chaim provides several specific guidelines describing how one should, when required, reveal facts that might embarrass another. He would require that (1) the information to be exposed be accurate; (2) no other means to prevent the danger exist; (3) disclosure would, in all likelihood, prevent the harm; and (4) the information not be presented in an overly dramatic form. Before revealing a patient’s serostatus, therefore, the clinician would have to ascertain that the diagnosis was correct and that the patient himself was not willing to warn his partner. Moreover, one could

Distinctly Jewish views on specific ethical conundrums can serve as examples of how moral principles might be evaluated or applied differently while simultaneously forcing secularists to confront beliefs that call into question their fundamental assumptions.

reveal a patient's HIV status only to those at risk for transmission. As one can see, Jewish tradition not only contains a type of case law that embodies the duty to warn, it also, in contrast to secular ethics, specifically presents a mechanism for revealing information that others would prefer to keep confidential.

For non-Jews, the value of the Jewish perspective is that it allows one to shift the focus of the debate. In the secular paradigm, the ethical analysis emphasizes the physician-patient relationship and the special obligations and duties incumbent on the members of this partnership. What would be supererogatory in other personal interactions is seen as obligatory in the context of the physician-patient relationship. Judaism, however, does not place such emphasis on the doctor-patient encounter. The duty to warn, for example, obligates all members of society to prevent harm to third parties. Similarly, the duties not to gossip and to protect confidentiality not only pertain to the communications between physician and patient but also affect broader social interactions. Rather than hold the doctor-patient relationship to a "higher" ethical standard, Judaism places strict ethical duties on all members of the community.

Because of this distinct focus, one can see that the Jewish tradition contains mechanisms for promoting and reinforcing the basic foundations of society. Since all members of the community face similar ethical duties and obligations to their peers, there is less confusion regarding moral relationships between individuals. Thus, even secular humanists might wish to adopt the Jewish perspective on the duty to warn in order to, as Newman writes, "pre-

serve the basic institutions of our society" (1993:562).

Conclusion

MUST PHYSICIANS TREAT PATIENTS infected with HIV? Do clinicians have an obligation to notify the sexual partners of persons who harbor HIV or those who share needles with them? The ethical controversy surrounding these questions remains unresolved. Jewish tradition, however, clearly compels the physician both to treat HIV-seropositive patients and to warn innocent third parties. These issues demonstrate that Judaism has much to contribute to modern discussions of ethical dilemmas found in medicine and show that Jewish tradition can effectively appeal to persons outside the Jewish community. Not only does the Jewish approach acknowledge moral norms that speak to and of the human condition generally, it also emphasizes values that are intelligible and persuasive to those who do not necessarily adopt the theological beliefs that underlie them. As the Jewish view of the duties to treat and to warn highlights, one might embrace Jewish principles simply for pragmatic reasons, including the need to adopt moral standards that are beneficial insofar as they support the ethical growth of society. The importance of Jewish law for the secular world rests in its ability to serve as a contrast to other, non-religiously based approaches to ethics. Distinctly Jewish views on specific ethical conundrums can serve as examples of how moral principles might be evaluated or applied differently while simultaneously forcing secularists to confront beliefs that call into question their fundamental assumptions.

NOTES

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1. Maimonides, *Mishneh Torah*, *Hikhot Rozeab* 1:14.
2. Nahmanides, *Torat Ha'Adam: Kitvay Ramban* 2:41–43. The *Mishneh Torah* (literally, second Torah) was written by Maimonides in 1180 after nearly a decade of work. It represents a seminal effort at organizing and interpreting all the biblical and talmudic writing until that time.
3. Joseph J. Caro, *Sulban Arukh*, *Yoreh De'ah* 336:1. The *Sulban Arukh* is the authoritative codification of Jewish religious and civil law from the time of Maimonides until the present day. In terms of jurisprudence, it can be considered the “controlling” law.

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The Little Deer.

Oil on canvas by Frida Kahlo, 1946.

Collection of Carolyn Farb, Houston.

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

The Case **Dawn Runner**

Lois M. Verbrugge

THE UNDERWEAR ON FIRST, then the white sleeveless top and shorts with aqua trim. Big safety pins at the shoulders to hold the jogbra in place, short socks, and the red-white-and-blue shoes that had run so many miles so well. The sun was rising in the midwestern sky at 5:30, a fine running time before June's heat filled the day. Since it was Saturday, there wouldn't be much commuting traffic from the far suburb to downtown—a nice feature. I left the door of my parents' house unlocked rather than take a key; I was visiting them for three days.

Then those fleet feet took me into the dawn along long flat county roads, always a joy because I could see so far and run so fast. The sun that morning was coming up as a rose ball, and I started due east to watch it rise. Though I no longer lived here, I knew the roads well. Turning to the west, I saw the dawn in a different dewy way. I passed through a town and saw a man out early watering his flowers; his garden was colorful with abundant blooms.

Otherwise people were sleeping in, and I was alone on the road. Few cars passed. Cool, no wind; I moved with ease and grace. Running was the thing I loved to do most in life.

With no particular course planned, I turned north to find another long east-west county road and took the right side margin. Hearing a car slow down behind me, I glanced behind and realized the driver was letting me pass the neighborhood street just ahead and would then turn in. He did. I ran on, thinking of the day's main event—the fifteenth reunion of my high school class and the friends I'd see.

I heard it again, slow and paced with my running. Looking back, it was the white car. He was following me. His nearness yet distance was odd; maybe he was just curious. Time drew out, and I ran on. He sped up a little, passed me, and was soon gone. The next turn was the east-west county road, and I went right.

Where did he come from? Behind me, slowly, staying a fixed distance, not very close and not very far. It was ambiguous and strangely malevolent. If he was just cruising and interested in watching the dawn runner, he was now too persistent. If he intended harm, he was keeping his distance. Should

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I run into the field? (But he might have a gun or knife and follow me, and then I would be away from the road where other cars might pass.) Should I run to a house and bang on the door to wake people? (But that might not succeed, and he would have enough time to reach and hurt me.) Should I continue running? (But he might stop me and force me into the car.) It was hard to know, and his behavior gave no good clues. The car accelerated and passed me in a burst of speed. Relieved but uneasy, I ran on.

Again. Behind me, with measured pace. He had turned into a school yard and waited until I passed. Quickly I crossed the road to run on the left side. Still keeping his distance, he crossed the road to the “wrong” side and followed. I turned around and gestured for him to move off, to go away. The car’s pace quickened a little, then slowed as he passed me, inches from my body. The window was down; he said nothing. He did not reach out to touch, just drove those slow inches from me. All at once, he zipped away. I decided to head for my parents’ home a mile away as fast as possible and turned the corner south. The car wasn’t in sight.

Loud and fast. I heard the car tear around the corner behind me, tires screeching and kicking up gravel. Turning quickly, I saw him aimed straight at me. Speeding up.

I thought, “This doesn’t happen.”

And then, “I’m dead.”

The weapon was his car. He hit me at about 50 miles per hour. My memory is empty from those two sentences to the realization of being alive in the ditch. Picking myself up, I knew nothing of the injuries. I thought only of reaching my parents’ house across the long open field. I tried.

I no longer know his name, the man who took a different route to work that morning because he decided to buy doughnuts for his co-workers on the way. Coming south, he saw an exhausted runner. Then the way she moved caught his attention and suggested something worse, that she was in trouble. Stopping, he crossed the road and found me in the

field, picked me up, and carried me toward his car. As he was figuring out which door to open and how to get me in, I heard it.

The white car was coming back at terrific speed; I knew the driver was returning to “finish me off.” I screamed and the Samaritan understood. As the car careened by, he tried to read the license plate. He took me home.

I do not know how I stumbled to my parents’ bedroom, knocked, and said, “Dad, Mom, I’m in trouble.” Dad came out. I will never forget my father wanting to wash me, seeing the blood everywhere and hoping to make his daughter whole by washing it away. They are all unforgettable—the police arriving, the Samaritan leaving, the emergency room, the nurses and radiologist, the orthopedists, the detective, and my father always there. My mother, not keen on blood or trouble, kept a bit apart but cared.

I never got it more right than during those hours lying in the emergency room. My first impression, when there was quiet around me and I could think, was of a hunter and a deer. He had stalked me. He was attracted by the freedom and beauty of the deer, but he hated the deer’s having them and decided to take them away. He watched, he followed, he destroyed.

Now I know what shock is. I tried to normalize the day—giving the detective as many details as I could recall, talking with my husband by telephone and saying he didn’t need to come, convincing my father I really could go to the reunion, and appearing there with a temporary leg cast and crutches, escorted by him. It is amazing that any of it happened. My husband came. My friends never forgot that evening. My father was a changed man.

The white top and shorts, new the Saturday before when I placed high in a long race, were thrown away by my mother or father. My shoes were not thrown out; those cherished road-worn companions were set aside and later taken and put away by my husband.

I flew back to my home city with my husband. On Monday morning, I saw the city's best sports orthopedist and was hospitalized immediately. The left knee tendons and ligaments were torn off the bone; the right knee cartilage was damaged; wounds and bruises covered my body head to foot; and there were other somatic secrets still to come. The decision was made to repair the left knee and to leave the right knee alone for a while, and surgery was performed several days later.

That summer was filled with anxiety, hope, sadness, anger, and other emotions of magnitude. The cast was on for many weeks. All the usual regimens and devotions changed abruptly. The orthopedist said I would probably run again. When the cast came off, I learned how to walk, did physical therapy with dedication for many months, and gradually took up swimming. My father feared I would limp (maybe because his sister had had crippling childhood polio, limped severely and painfully thereafter, and was sexually attacked as a teen while riding home from school in the horse carriage), but soon the limp was gone.

Things didn't happen the way the orthopedist expected. Chronic pain entered both legs, and the gains made in ambulation eroded. I had never known that such nonstop demonic pain could exist. Oddly separate from that, and very distinctive, was a gnawing dark ache inside my right knee. My temperature system was awry; I could not tolerate moderate heat, and my hands, feet, and face turned bright red in normal settings. My body burned inside clothes and shoes, and I sweated frantically.

My endocrine system skidded to a stop or else took a somersault and stayed upside down. I could scarcely continue my job and gradually became effectively homebound. The orthopedist gave up (he had fixed me, and there should be nothing wrong now) and sent me to a physiatrist, who reestablished a low-level physical therapy program that proved impossible to carry out.

Grieving, I threw away the red-white-and-blue running shoes. Drugs to stop pain and inflammation failed, and elastic knee braces provided relief while on but terror when taken off. I read about pain, vasospastic disorders (but the articles focused on coldness and its making body areas white, not heat that made body areas red), depression, and psychosoma interactions. When the pain climbed toward my hips, I turned desperate. I was afraid about my future.

One winter day, my next-door neighbor brought a book to me about a meditation approach called biogenics, an autogenic technique for dealing with pain and chronic ill-

ness. I decided to try it. I had to; there were no other options. I began with dedication and despair pitted solidly against each other. Each day, I spent long times on the floor with arms and legs stretched outward in repose. In the midst of dense, caroming pain, it seemed hypocritical to repeat silently to myself "My body is free of pain. My mind is at peace. I am full of health." I hated the sentences. Sometimes tears rolled down my cheeks while I voiced them soundlessly. I railed against this meditation nonsense but continued and sought to believe. Three weeks later, there was a day that the

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He had stalked me.
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and decided to
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He watched, he followed,
he destroyed.**

pain backed off during the meditation. Then it happened again, and again. Three months after starting, I had periods of day and night without pain when not meditating.

The sentences expanded and took on confidence. I visualized my hypothalamus as a yellow flower and my pituitary as a pink one, and I made sentences for them. "I am a cool yellow lily." "I am a deep pink rose." I imagined the pain sparks and thunders as ugly little creatures hiding behind a door and shouting so as to seem monstrous, and I told them to pack up and leave. "The pain is small and powerless. I release the pain." There were sentences about being safe (I was afraid of the sound of cars and walked in the neighborhood only if my husband was along), about goodness (it was unavoidable but horrible, the thought that I had enticed the assailant and was responsible for what had happened), and about trust (in my body and in strangers). After five months, I was virtually free of pain. Nevertheless, I went to a week-long clinic conducted by the inventor of biogenics. I was happy to be going for reaffirmation rather than salvation; my companions at the clinic were not so fortunate. I maintained the daily meditation program. Gradually the vasospastic disorder lessened so that I was just rosy rather than beet-red in standard heated places. But I did not menstruate (that had ceased before the assault because of leanness), and I had no libido.

Full of hope, I bought running shoes and tried to run. The answer was a devastating no. Pain and instability said that my running days were over. I was a swimmer, not a runner.

There were deeper somatic and psychological secrets that took longer to find their way out. I mention three. First, with a more sedentary life, concerns about weight and food increased and took powerful hold. Calories were counted, daily charts filled out, weight checked several times a day. Five years after the assault, alone for a month in the mountains, I saw a frighteningly low number on the

scale one day. Something inside saved me; I put on my jacket, drove to the nearby town, bought pastries (napoleons with custard and crust made in heaven), and ate them with delight. I simply changed; a year later I weighed 30 pounds more, not by conscious design but by the body's quiet necessity. It was difficult to change my entire wardrobe and to adjust to roundnesses, but I did and now think the change wonderful. I have not weighed myself for almost a decade, and food is a great friend. Second, the prolonged stresses of physical pain and career interruption may be the underlying cause of a problem that started six years after the assault. I now have the syndrome called multiple chemical sensitivities, or MCS. It took me a year of awful symptoms and malaise to figure it out, eventually by reading. I live quite free of petrochemicals and volatile organic compounds, have some social limitations in order to reduce exposure to them, regret the impact those limitations have on my husband, and am regularly overwhelmed by business trips because they increase exposures so greatly. Third, I did not recognize the assault's deep impact in making me distrustful of my womanhood. The uncovering of this issue and its resolution came by a circuitous route. A physician specialist whom I consulted for MCS (his strong aftershave did not enhance our discussions) suggested I had psychological problems instead. I challenged him to find the very best psychotherapist and said I would give it one last try (prior experience with psychotherapy left me dubious). Indeed, the best psychotherapist for me came into my life, and with his help I found love for and safety in being a woman that I had never believed possible.

Do people know how far and long the damages of assault go? How much courage and faith it takes for the victim, who has little reason to possess either, to come back from one precipice and then another and another?

For my lifetime, I will be proud of releasing the chronic pain, proud of welcoming my womanhood, and proud of choosing again to live with some risks.

CASE STORIES

I learned that both the body and the mind strive toward healing, toward homeostasis. In the presence of driving illness and despair, it takes almost impossible bravery to change one's perception from "body as nemesis" to "body as friend," from "mind as betrayer" to "mind as ally." You must talk yourself into it at first.

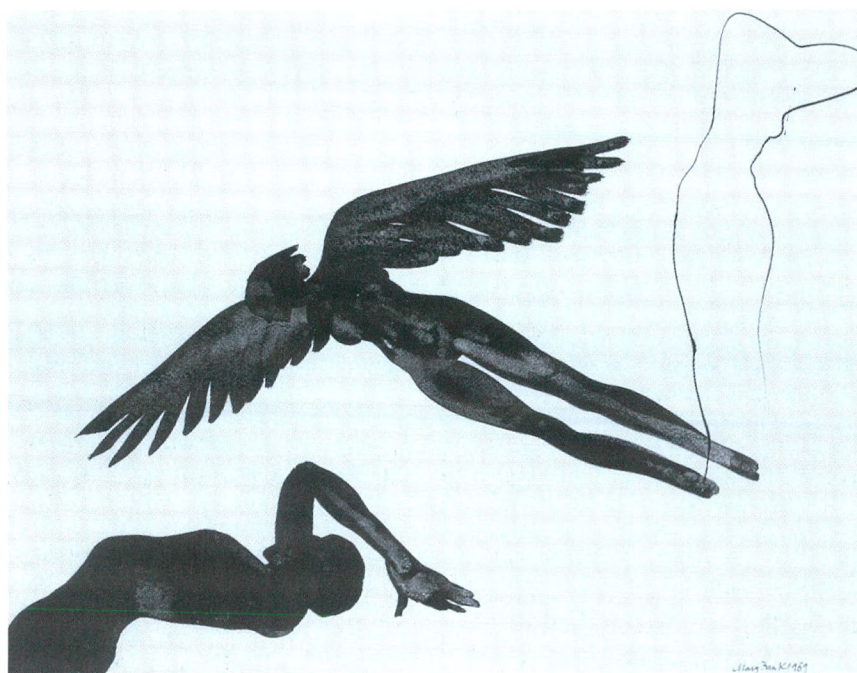
THE CAR AND ITS DRIVER WERE FOUND late that Saturday. The scrambled numbers seen by the Samaritan, plus my recollection that the car was a white Mustang, were submitted to the state's motor vehicle department. Several candidates were identified and checked. When police officers visited him, they dusted the car and found my handprints on the hood. He confessed. I have forgotten his first name but not his last; I'll call him Kline here. I never saw him again. A criminal court case for the felony (attempted murder) was scheduled. Prior to the trial, the judge requested that I provide personal testimony to him, and I traveled to the city, still in the full cast, to do so. During the trip, I was also evaluated for neurological and psychological deficiencies by an insulting and incompetent physician, hired by the defense. By the judge's plan, I did not attend the trial. My parents did. Kline had just turned 18 years old; he had a juvenile record of drug abuse and a disrupted family life (his mother had died a few years before). This was his first adult offense, so prior ones were ignored. He refused to speak to examining psychotherapists before the trial. He would not answer their question about why he had done it. The closest he came was in court; in response to the judge's question about whether he

knew what could happen to the runner, he shrugged and said, "I didn't care." In his closing statement, the judge said, "Why didn't you just go jump in a lake!" Kline's public defender plea-bargained (guilt was admitted for assault with a deadly weapon), and Kline was sentenced to 10 years in the state penitentiary, down from the judge's stated wish for 25. He was released after two years. That is all I know about him.

I am alive because from far within, instinct brought my arms and hands forward when I saw the car coming toward me. My hands met the hood, and I was thrown over the car rather than dragged under. I recall none of that. I thank instinct.

I learned that the court system coddles the criminal and scarcely notices that there is a victim. Neither I nor my husband will ever serve on a jury; our attitudes are unfit. I have a nagging right knee that was never repaired and a big staple in my left knee that sings sharply when touched. I learned how greatly my father loved me—not right away, but over years as his opinions were voiced and retirement plans (to help troubled youths) were made. I found the beauty of my womanhood and restored my sense of safety. Seven years after the assault, with more pounds on my frame, I started menstruating. I was awed and have been happy about it since. Eight years after, with those same buttressing pounds, I tried running again.

I am a swimmer, mostly. Once a week, I run, more slowly but with the inimitable joy of wind in my hair and birdsong in my ears. Right now, my shoes are purple-white-and-rose, the underwear is lavender, the top is white and shorts purple, and they all make me fleet of mind.



Woman with Bird-Shadow and Man.
Ink by Mary Frank, 1969.

Private collection. Reproduced by permission of Midtown Payson Galleries, New York.

Commentary

Running to the Sun

Ellen Flookes

THE CHILLING TENSION IN LOIS VERBRUGGE'S story of her personal assault was almost too familiar. Hit the remote. But this time, the visceral tightening inside was not the result of a television producer pumping up the thrills of random violence for family entertainment. Before me was the very real story of a woman who left the house early one morning for a run and returned a short time later shattered by a brutal assault.

It seems I have been primed all my life to accept violence and some vague notion of its inevitability. In the 1950s, the steely echo of *Dragnet's* hammer of justice hitting the anvil three times with solemn finality sent me flying into the arms of my mother. One taste of violence, and the shock of my own vulnerability raced through my body like an electric current. Now I sit passively flipping through screens of hideous human tragedy in shows like *Top Cops*, *The FBI: Untold Stories*, and

The Detectives with an embarrassing lack of sentiment. I blast them off the screen not only because watching them could be construed as tacit approval but because I mistrust the false sense of relief these shows induce. When the violence ends, I am supposed to feel lucky that this horrible thing, whatever it is, didn't happen to me, but the implicit message is that it might. Eventually, in order to function I must retreat into the less hostile, potentially more dangerous world of unknowing and convince myself that I am at least reasonably safe. However, two facts tap on the window of my illusion: I am a woman, and I am a "truster."

The reality that I can be physically overpowered by most men, even men without weapons, means that on a very basic level, the physical level, I can be beaten. This is not easy for me to accept. But the fact that I can be physically dominated and forced into submission is integrated into the core of my being a woman. I must remain aware of my vulnerability but not so aware that I shrink from ordinary pleasures by subscribing to a lifetime of fear. However, the truth that I can be physically dominated determines consciously and unconsciously the course of many of my actions and sets limits on my

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ability to participate fully in society. As the true crime shows illustrate in sickeningly graphic detail, any lapse of vigilance on my part could have drastic consequences. In the cop-show lingo of *Hill Street Blues*, I must "be careful out there" and accept this tiresome responsibility of constant watchfulness. However, this forewarning may not be sufficient advice for women who are trusters.

Former police chief Anthony Bouza of Minneapolis, Minnesota, states, "Many victims of crime are people who like to beat the odds . . . they are easy trusters, open people with others" (quoted in Flannery 1992:17). This statement makes me very uneasy. Not only do my chances of becoming a victim of crime increase because I am a woman, but Bouza is intimating that I am unwisely playing the odds if I trust other people. Trust is an integral part of my moral and ethical modus operandi. Yes, I can be prudent, but if I break down and discard basic trust in my fellow human beings, I would live in a frightening isolation on the dark side of life. Many women, and certainly some men, live this way, daily choked by fear and apprehension.

Venus Flytrap

TRADITIONALLY MEN HAVE PLAYED A LARGE ROLE in determining where women can go and what they can do and even in helping women form ideas of themselves. Stories in which women are perceived as adjuncts of men filled with special evil powers reach as far back as Adam and Eve. In the creation account

in Genesis 2, Eve was shaped into existence from one of Adam's ribs. It was Eve who bit the apple from the tree of the knowledge of good and evil; it was Pandora who lifted the lid of the jar and spread plagues into the world. "Control women" was the moral that weathered the centuries. Whether or not men enjoyed influencing and directing women's

lives, they exercised this power as a matter of course. Today, however, the opportunities to do this have been sharply reduced by women themselves, many of whom decide their own course of action. This change has disappointed some men and made other men very angry. If women are to protect themselves from violence, they must take into account that the struggle of women for self-direction and equal human rights has fueled a generalized anger toward women which has precipitated incidences of random violence against women. The murder

of 14 women in the University of Montreal's Ecole Polytechnique in 1989 is one example.

Strangely, when many women are free for the first time to leave the home to compete in the male world for success, money, status, and upward mobility, women have at the same time become more obsessed than ever with their bodies. The personal discipline that brought Verbrugge the rewards of a successful academic career also took her to the isolated road where she was attacked that early morning. Successful women must not be fat. Cultural images show us that successful women are thin, very thin. Thin women have bodies that represent the control, self-denial, and discipline of the competitive male world.

In order to function I must retreat into the less hostile, potentially more dangerous world of unknowing and convince myself that I am at least reasonably safe. However, two facts tap on the window of my illusion: I am a woman, and I am a "truster."

Our ideal of the female body has undergone drastic transformation. The Greeks showed us their conception of a full-blown femininity: Venus de Milo, full-breasted and lush with fertile fat, represented the ideal woman's body and the perfect place for creation of life. Renaissance painters rejected the shame and concealment attached to the body in Gothic times and proceeded to redefine the body as a site of life-giving energy and sensual pleasure. But the thick thighs and domed bellies of the women in Botticelli's *Three Graces* couldn't be further from the body image many women desire today. Our ideas of femininity have narrowed to a thighless, hipless, breastless version of a childlike body with an associated childlike innocence. The childlike bodies of powerhouse gymnasts like Olga Korbut, Nadia Comaneci, and Cathy Rigby doing handsprings on balance beams fascinated audiences and inspired an entire generation of half-starved young female athletes, many of whom battle anorexia and bulimia in their quests for nymphlike thinness.

Statistics tell us that actually very few women are born with the thin, leggy body type we admire so much today.¹ One out of every two women is on a diet. In fitness centers women, and men, stand in front of giant full-length mirrors and search their bodies for fat, with the intensity of grooming baboons. Our obsession with body type and thinness has set women up to be perpetually unhappy with perfectly normal, healthy, sometimes fat, female bodies. As a partial result, women have gained the capacity to disappoint anyone (including themselves) who holds an idealized concept of the female body. In a sense, women's bodies have become Venus flytraps. Being lured into the velvety interior of a Venus flytrap may mean falling prey to an element of mistrust on a primal level—a woman's mistrust of her basic femininity. The price of disillusionment is high.

Face to Face

IN 1989, JOURNALISTS PUZZLED BY THE STRANGE antisocial behavior of a gang of teenagers who raped a jogger in New York's Central Park coined a new term. *Wilding* described the particularly energized anarchy teenagers displayed as they spun out of control. After arrest, they demonstrated no remorse or shame, and when questioned, none reported feeling enraged or even angry at the time of the crime. The absence of any moral sense of their actions prompted one writer to characterize them as "psychic amputees." Getting high on violent acts and the relentless pursuit of self-gratification was a new lifestyle based on uncultivated consciences.

As urban crime has increased, so has our fascination with it. In 1957 Leonard Bernstein romanticized urban street culture in his musical *West Side Story*, in which one character satirizes his hostile behavior by describing himself as being "depraved on account of being deprived." This rock-bottom, go-for-broke mentality is interesting in much the same way that graffiti scribbled on subway walls is compelling and energizing. It is hard to ignore graffiti; it signals to us the subculture of "wilding" life, an out-of-control expression of the antisocial self.

But face to face with the braggadocio of a person walking the edge with nothing to lose, "wilding" signals danger loud and clear. For millennia, self-preservation has rested on our assumption that we can call for help, summon our fellow human beings to our rescue, but we can't count on that anymore. We can't assume that our connectedness, one to another, will help us if we are in danger. Because we cannot presuppose ethical and moral action, we are shoved into a Kafkaesque drama in which reality is redefined in terms of moral mistrust grounded in fearful isolation.

Possibly we are more aware of violence and the daily threat of assault than our behavior might lead us to believe. Paul Tournier, in *The Violence Inside* (1978:16), states, "Our unconscious proves to be

more aware than our conscious of the harsh laws of life." If violence rests in the realms of passion, as Herbert Marcuse suggests, then our unconscious registers our first awareness of danger.

Particularly startling in Lois Verbrugge's account was her early awareness of a violation occurring in the distance between her and her attacker. Her unconscious perception of her attacker's unnatural control of speed and distance was her first signal of danger. As the tension of the threat increased, she was required to assess on the conscious level her assailant's emotional state. At this point, the perceptual field narrows, and the victim enters what Freud terms a state of "perceptual vigilance," in which dangerous stimuli are selected for processing and other perceptual elements are filtered out (Yarmey 1979:51). The physical appearance, gestures, speech, posture, and most significantly, facial expression give clues to the attacker's underlying emotions. If we can identify the emotion, we can presumably better predict intent (Bassili 1978; Galper 1970). We are skilled at an early age in identifying emotions on the human face and distinguishing these emotions from other forms of remembered visual stimuli. Many witnesses of crimes in action cannot identify their assailant but often can recall the emotions they read on their assailant's face for many months, even years, afterward.

Not only was Verbrugge physically assaulted, she was forced to acknowledge the fact that her assailant was well acquainted with human cruelty. Identifying the face of human cruelty is a shattering experience; it is not an easy face to forget. Painful emotional truths emerge which require separation from objective truths. Unlike Perseus, Lois Verbrugge did not have Athena's shield to prevent her from looking directly at the head of Medusa.

The Boneyard

WHEN HER ASSAILANT'S CAR TURNED THE CORNER and headed straight for her, Lois Verbrugge thought she was going to die. And at the very instant when denial of death could no longer be maintained, she was in a sense dead. In the deepest center of her soul, Lois Verbrugge witnessed her own death. It is a long way back from the boneyard.

Witnessing human cruelty and looking directly into the face of death is more than any of us bargains for. It seems reasonable to want to put an experience of this magnitude behind us as quickly as possible. However, it is difficult to dam up an interior flood of holy terror when little pieces of inner certainty continue to break off and float downstream. During this period of fragmentation, and very slowly, life is transformed by a separateness, an apartness from the previous order of life. When set apart by transforming experience, life is sanctified, a word that shares the root of "apartness" and "separateness." It is made holy.

The very act of witnessing implies personal transformation. In doing so, we are forced to attest to a new set of realities and to own uncommon experience on intimate terms. In early Judeo-Christian culture, the testimonies of Christian witnesses were highly valued and not always easy to obtain. In the abrupt ending to Mark's Gospel, the women went to the tomb carrying oil and spices to anoint Jesus's body, but incredibly, the stone was rolled away and his body gone. "Trembling and bewildered, the women went out and fled from the tomb. They said nothing to anyone because they were afraid" (Mark 16:8). Attesting to the truths of new realities was recognized by Jesus as an uphill battle all the way, and he exhorted Christian witnesses of his day to persevere with the courage to seek the spirit of truth (John 15:26; 16:13).

To attest to the truth of an experience as shattering as Lois Verbrugge's would be no easy task. To own the reality of your own death and the reality of

evil in one breath would be inviting personal devastation. It is no wonder that the shorts and top Verbrugge wore when she was attacked were thrown away. They represented a transforming experience too terrifying to acknowledge.

Somewhere in the description of Lois Verbrugge's father wanting to wash the blood from his daughter's body was the sense of life being reduced to its barest bones. Returning to a hope-centered life from the reality of blood is a painstaking process. The cost of reintegrating the parts of the whole is high; there are no guarantees. If the physical and emotional pain is of long duration, sadly we can predict rejection by those persons, both friends and professionals, who are frustrated and rendered powerless by our persistent cries. We can act on moral indignation and demand that justice nail holy terror to the door of the boneyard in retribution, if not restitution. Of one thing, however, we can be certain: the aftershocks along spiritual and emotional fault lines will continue to reverberate long after the wheels of justice have turned and medicine has exhausted ways to treat the pain.

The Lois Verbrugge presented to medicine for reconstruction was a holy woman, a woman set apart by the transforming experience of personal violence, a woman who had looked into the face of Medusa. The serpents on Medusa's head are symbols of our worst fears, and the venom of evil serpents represents the power to transform into death. This same venom can be transformed into an antidote, a protection against certain death.

It was the serpent that adorned the staff of Aesculapius, the deity of healing, and it is this symbol of transforming power that is used today by the medical profession.

In alarm, Pandora closed the jar, but one spirit remained; it was Hope, which failed to escape with the other furies. From the

very center of herself, Lois Verbrugge asked repeatedly for wholeness and freedom from pain through daily meditation. Slowly she summoned from within herself the hope for a reintegrated life and the rediscovery of the mystery, and beauty, of being a woman. She ran once again toward the sun.

**In the deepest center
of her soul,
Lois Verbrugge witnessed
her own death.
It is a long way back
from the boneyard.**

NOTE

1. "The Famine Within," a documentary film by Katherine Gilday, 1990, available through Direct Cinema Limited, Santa Monica, California 90410. ISBN 1-55974-389-5.

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Conceição Aparecido (Apparent Consciousness).
Ceramic by Mary Frank, 1970. 12 x 11 x 9¹/₄ inches.

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Can a Healer Be Too Wounded to Heal?

Maxine Glaz

IT HAS BEEN A REASSURING PREMISE of theologian Henri Nouwen's work in *The Wounded Healer* (1972) that experiences of loss and pain can be facilitators of ministry. They can make the minister or caregiver more receptive to the struggles of others, more aware, more human, more humane. Far from being perfect people or superior priests, we as wounded laypeople and clerics can help others precisely because we understand their need.

But are there wounds so serious, so troubling, that they confound us and tangle up our lives so that we live out the past in our ministry to others? Can these wounds make it so hard for us to reach others that we turn people off as often as we are able to reach out? What of the now common revelation that a candidate for ministry was once abused? Is the pain of abuse so harmful that it is inevitably crippling? When do we say that a healer may be too wounded to heal?

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I am the director of a program of clinical pastoral education (CPE) in a tertiary-care medical center and have also been a seminary professor of pastoral care. My observations of students and colleagues in both settings lead me to believe that there are, in fact, limits to the usefulness of suffering as a potential source of strength and empathy in a caregiver. Those among us who have endured abuse may acknowledge the experiences of violation in our past and recognize that we are wounded but still misunderstand how the power of the past impinges on current pastoral relationships. Many such students and clergy assume a defensive position toward self-review as an aspect of preparation for ministry, while many educators are not well equipped to manage the complexities of clinical learning, especially the problems about learning which may follow abuse.

Certainly people with serious character problems (some who have been abused and some not) exhibit such negative patterns of involvement with others that it is easy to argue that they should not be ministers. Through the ages the church has attracted a share, perhaps even more than its share, of the devious, the depressed, and the vengeful into its ranks and hierarchy.¹ It has been difficult, and con-

tinues to be difficult, to weed out ministers who are dangerous to others. But leaving aside these severely deviant persons, how can we understand the effects of abuse on persons who become ministers, and more constructively select and educate them for pastoral service?

Many life experiences (including my own professional development as a minister [who grew up in an abrasive, even abusive, family, with parents whom I both loved and feared], years of teaching seminarians, and participation in advanced training programs in the Denver Psychoanalytic Society) have led me into this discussion, as I have considered the impact of abuse on persons who become ministers and thought about how best to respond as a pastoral educator. Even with my experience and education, I would caution the reader that all issues of violence may raise concerns that must be taken seriously. Given the nature of abuse, its destructiveness to the person who endures it, and the understandable modification of personality that may result, the problems I describe inevitably touch on the ineffable and the sacred.

Those who have been abused are seeking to manage the past, and they display traits that are unavoidable, both adaptive and maladaptive to the present, and quite often beyond conscious control. They are a by-product of the natural order of creation because they reflect the depths of human nature and experience, our inescapable, even God-given vulnerability, our potential for destructiveness, and our awesome humanity. Whatever I have to say about abuse should be viewed against the reader's own experience and insight.

Abuse and the Post-traumatic Stress Disorders

A PSYCHOLOGICAL PERSPECTIVE on post-traumatic stress disorders (PTSD) is an informative beginning point for discussion (Marquardt 1991). In general, trauma disorders are brought about by events that lie beyond the range of usual experience and would be considered very distressing or disturbing to anyone. Initially PTSD diagnoses were associated with war and traumatic loss. More recently mental health professionals have recognized that extreme stress is a normal and predictable reaction to trauma of many kinds. Whether induced by battle, disaster, crisis, or violence, the emotional state of the victim is similar in every trauma and carries a similar symptomatology. The victim revisualizes the traumatic event and repetitiously reexperiences the associated affective state. The trauma becomes a depressing and absorbing preoccupation that interferes with daily tasks. It intrudes

into consciousness, whether wanted or not.

Information about post-traumatic stress disorders has emerged from many sources—through knowledge gained in work with war veterans and Holocaust survivors, victimology, bereavement and disaster psychology, substance abuse (which is very often an effort to self-medicate and numb trauma), rape, and child abuse. Studies in every area converge to suggest a pattern of human response to repeated violence. A catastrophic event is hard to manage or assimilate. The mind goes back to it, repeating the

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sensations and visualizing the events until the related affects are diminished. But when the trauma is severe, recurring, or sustained, so that it is hard to reestablish a feeling of normalcy, the initial sense of being startled, hurt, and overwhelmed begins to merge into a gestalt including persistent states of readiness or arousal in which one is always anticipating, always prepared for, the worst (see Derr 1991; Herman 1992:35–39).

Among the diagnoses of PTSD the association of trauma and childhood abuse is the most recent to be considered, in part because of our horror that such catastrophic events occur within the family. Society tends to deny the reality of parental violence as much as a child may need to deny it, and normalize it, in order to survive. It has not been easy to achieve an understanding of the destructive consequences of abuse or to intervene appropriately with children who are abused. It is also hard to consider how we may need to manage the aftermath of abuse in ourselves and in others.

Symptoms of Abuse

THE SYMPTOMS OF PHYSICAL AND SEXUAL ABUSE among persons who were abused as children are intrusive and recurrent recollections of the event in dreams, hallucinations, or dissociative and flashback episodes or intense psychological distress when exposed to events that recall the trauma; a heightened sense of excitation and emotional stimulation when anxious; acute distress on learning of the suffering and victimization of others; wariness when acknowledging feelings associated with the past for fear these feelings will again be devastating and might include the associated pain and the intolerable sense of being out of control; numbing or avoidance of stimulation associated with the past; depression; amnesia for aspects of the event; personality splitting; diminished interest in significant activities; detached or estranged and cold responses to others; reduced empathy for others; and a restricted

range of affect. Additional symptoms include difficulty falling or staying asleep, irritability, outbursts, temper tantrums; vengeful rage which may be turned against the self or others; difficulty concentrating, hypervigilance, an exaggerated startle response; and an array of psychophysiological changes which can include episodes of illness, physical symptoms or ailments, and psychotic reactions (Herman 1992:35–39).

The two polarities, broadly categorized as arousal and numbing, are efforts to maintain equilibrium in the face of the continued overwhelming sense of threat. Taken in this context, the symptoms are not abnormal but are mechanisms for managing the overwhelming in human experience. They are protectively adaptive for the individual who strains to shelter the self in the midst of continuing crises.

The Aftermath of Abuse: Vulnerability and Adaptation

EVEN WITH SIMILAR BACKGROUNDS OF ABUSE, persons who have been abused assimilate experience differently. Differences in age at the onset of violation, in gender, or in the form or intensity of abuse, and in the relationship of abuser to victim, mean that no two survivors have the same trauma or the same outcome, even though similarities in the victim's behavior suggest some common concerns.

The symptom profile described above does not, in itself, tell us much about the impact of violence on an individual or about his or her motivation. Not everyone who has been abused will abuse. Some who have not been abused do abuse, but abuse creates a peculiar vulnerability to panic anxiety and to strong, disorganizing feeling. Physical and sexual abuse torment, harm, bruise, and physically rip the victim. As abuse first violates physiologically, it floods the victim with sensory stimulation by traumatically engraving the memory. It spoils and inundates normal thresholds of sensitivity, flooding the

victim with input. When abuse is repeated, it predisposes the child, and later the adult, to be agitated or to disconnect from others in an effort to manage and control new stimulation.

Abuse is also intentional behavior on the part of another rather than an accidental event. This reality adds to the trauma and confounds the victim's thinking about the self and others. Naturally the victim wonders, "What did I do to cause this abuse?" before realizing that he or she was truly violated and was violated without justification or provocation. A victim is therefore uniquely susceptible to feeling re-stimulated (not simply in a sexual sense, although the re-stimulation may at times involve sexual feelings), to panicking in the face of anxiety, and to being terrorized by his or her conscience.

Once internally disorganized, a victim may find it difficult to distinguish the past need to react from an appropriate action in the present. At these times the belief that one is a victim and is about to be attacked, or has already been attacked, can fuel a sense of urgency so great that one deflects aggression in stony walled-off silence or with force. And either withdrawal or aggression in response to the excitation may provoke yet more intense exchanges between one's self and others. Those who thus dread and anticipate violence may behave with violence, even when it is not their intention, because they believe the situation warrants such action.

Just as problematic, a state of calm may seem so foreign, so laden with the felt potential for a new calamity that it too becomes unbearable. A victim can act precipitately, even provocatively. We incorrectly assume that the motivation or intention is masochistic, designed to repeat the past or recreate harm. The seemingly masochistic behavior appears provocative but may be an effort to manage what is felt as inevitable. Provocation thus becomes a way to control the onset of aggression which is felt to be certain to come; organizing it for a time and place when the victim is more prepared to master rather than succumb to violence.

A colleague of mine was accused of psychological abuse and told he had overstepped important boundaries after he had asked a new parishioner, "Do I see a tear in your eye?" She had met with him to speak about becoming a minister and had obliquely told him about the pain in her life during the course of their conversation. The parishioner later referred to his question as confirmation that he was hopelessly intrusive and crude. During their many conversations the minister learned from the parishioner that she had often been left with neighbors as an infant and had suffered repeated sexual abuse. She had recently entered psychotherapy to discuss her experience when the minister asked her about her tears. He had meant to reassure her and invite her to say more, if she wished. He felt her tears expressed her strength. She felt his question expressed his voyeurism.

In consultation, the minister began to see that this woman was keenly sensitive to any emotional involvement with a relative stranger. As a victim whose abuse began when she was very tiny and continued until the age when she could clearly remember what had happened to her, the woman now felt emotionally stirred and overwhelmed by the minister/stranger's interest. She was therefore furious with him. I believe she was equally furious with herself that she had exposed herself to the interest and concern of a stranger who could brutalize her. She had meant instead to impress him with her ability for pastoral service. Her reaction, which on the surface seemed to the minister defensive and paranoid, made it impossible for him to connect with her through such an openly curious inquiry. Painfully, the sting of her fright and her conscience was used as an attack and reproach against the minister who himself began to understand what it might be like to be a victim of abuse.

Initially this parishioner had come to talk to the minister about her interest in ordination. She believed the church was a place in which she would have a safe opportunity to care for others and give

witness on their behalf against abuse. In a situation where she could more clearly feel her own authority and adulthood, she could possibly avoid acting on her acute sense of threat. In the minister's role her capacity to care for others could conceivably buffer her sense of helplessness and provide a motive and means for remaining calm. Doing for others, instead of being done to (with all the implied threats of reliving the past at the hands of a hurtful aggressor), could conceivably mitigate her sense of danger. As an inquiring candidate for ministry—a suppliant, as it were—however, she did not and could not feel safe.

Some survivors of abuse achieve realistic self-perceptions and integrate an awareness that they have been violated with a balanced perception of the abuser(s) and of others. An effort to come to terms with the past yields self-awareness; symptoms subside, and they can assume a more normal life. These survivors may become fine caregivers, for they are peculiarly and courageously able to identify with others in their suffering, to pursue justice, and to stand up for those who are also dejected. Persons diagnosed with PTSD are often deeply religious, inclined toward nonmaterial values, and have great respect for religious or spiritual aspects of life. With maturity they can struggle honestly with their use of passivity and aggression in their attempts to manage the past and maintain current relationships with others.

But not all survivors are so fortunate. For some the sense of victimization continues and is a part of their identity, a special status. They believe that past abuse haunts and inhibits them or that it may entitle them to exceptional treatment and compensation now. The less fortunate of the abused do not secure a balanced perception of their personal histories, or of those around them. They see themselves as scapegoats who valiantly fend off aggression and hostility. At the same time they may defensively deny their own healthy, and unhealthy, aggression and hostility. In the worst instances, perhaps because of the form or severity of the abuse or because they cannot come to terms with the past, victims of abuse may

pursue justice vigilantly and take justice into their own hands, demanding vindication in worthy or selfish causes, and justify their own mean-spirited actions as those of a defender of virtue. Words and actions are validated by their perception of others' abusive or malicious intentions. These victims requite perceived evil with attacks and accusations of evil and with self-righteous superiority toward others who, in their view, are not also underdogs.

Victims who behave without much self-understanding can continue to behave as victims, or they may act in a mode of rage and opposition so intense that an observer will feel they are far more abusive and like their abuser(s) than otherwise. They may acknowledge their past helplessness to fend off violence but continue to live by fending off violence others don't intend. This psychological defensiveness, however understandable, is expressed either in extreme withdrawal and anxious self-preoccupation or in presumptuous counterattacks.

One CPE student who had been abused expected to be able to come and go from her training center without alerting anybody. She was indignant that her supervisor or other students expected her to negotiate absences with them. With intense self-preoccupation she always referred later to these absences, which were often for more than a day at a time, in the language of the necessity for self-care. She wanted each colleague to be to her a "kindly and pastoral shepherd" (the words she used to describe herself), no matter how provocatively she behaved. "I went to get my driver's license renewed, and then I was so weary I just stayed home. Why should I have talked to you about that?" she demanded. Her supervisors and her colleagues were not even to ask what was going on. Furthermore, she could not comprehend that her implicit criticism of those around her might damage her relationship with them. She believed that she was merely calling them to a higher duty.

This illustration helps to show how the residue of dissociative behavior can affect professional activ-

ity. In every case observers of this behavior identify the actions as eccentric and spacey. They may be bewildered, even lost, as they try to understand, and they frequently respond with their own anger. The victim of abuse remains more or less unconnected, living in his or her own world, and relatively oblivious to the effect this may have on others. When observers are distressed by these awkward voids in contact, the abused victim may not recognize the distress as legitimate. As victims, they believe they are innocent and seem unaware of any other intentions. They respond in an effort to stay out of harm's way, numbing themselves in order to shut down feelings of fear and anger and helplessness; they may find it hard to believe that anyone else could regard these actions as threatening or provocative.

The Mitigating Effects of Alternative Relationships

HOW DO WE ACCOUNT FOR THESE DIFFERENCES among persons who appear to have lived through similar experiences? What allows some victims to manage the past productively and, even with a similar initial constellation of symptoms, to serve community by fostering concerns for justice and for the empathic understanding of victims? What predisposes others to live in ways that continue their humiliation and that cause pain to themselves while antagonizing people around them?

Many factors contribute to differences among persons as they manage a history of abuse. Children who are very young when the abuse begins cannot so readily draw on their own capacity for regulation of affect that is learned and internalized as parents soothe and comfort their infants and toddlers. If the abuse begins while one is yet very young, the mechanisms for managing terror and other intense feelings will be lacking or sorely tested, and the youngster is inevitably more vulnerable. Similarly, how

does one trust the consolation of a parent who but moments ago was violent? Other social support may help to restore the lost calm, but probably the perpetrator cannot. If one's own parent is the primary antagonist, daily life becomes more chaotic than when the violator is a neighbor or an uncle, someone more removed from the home. The violence of a peer or an older sibling may not be as devastating as that of a parent or another adult. Yet the severity of the abuse may modify all the issues of proximity and relationship described above.

The sadistic quality of the abuse also makes for great differences in what the child, now an adult, must manage. The mother who gets out of control as she attempts to discipline may be abusive and not much of a model for handling strong feelings, but the child who is sadistically whacked for eating breakfast, or dragged from bed while asleep, will have a harder time finding logic in the parent's behavior. The father who is angry with the child with cause, however exaggerated, may be hated, but he is also demonstrating feelings a child can understand, while the father who has no cause to target the child can only be an object of terror.

With these differences in mind, certain other life experiences help mediate the effects of abuse. For many abused children there is someone, or several others, who help soften, manage, or contain the blows of the aggressor even when they cannot prevent the attacks. One of my former students had a paternal grandmother who intervened as best she could in her granddaughter's life. Though her son had not married the girl's mother, she offered gifts and summer vacations away from home that helped the child believe there was a safe place in an unsafe world. However awful the abuse, children who have others available to provide comfort and consolation are left with fewer dangerous residual effects of abuse.

A clinical pastoral education supervisor, talking about herself, gave this account:

My father was a combative autocrat who easily got out of control with us children. A glass of spilled milk at the dinner table sent him into a tirade which was too often followed by a beating for the offender. Crying only made him more furious. My brother and I were often sent from the table without supper. My mother was very distressed by Dad's outbursts and would try to intervene, but most often that made matters worse. Later in the evening she would slip into our bedroom with food and words of comfort. I know that my mother thought about leaving my father, because she told me so, but also that she felt it just wasn't practical in the late forties when women were encouraged to be at home. Perhaps my father felt some remorse for his behavior; I don't know. I do remember Mom holding me and telling me it was not my fault, which helped me to cry and pull myself together after his assaults.

These traumatic incidents predisposed the supervisor to anxiety and depression which, by her own admission, complicated life choices and personality development. These made it harder for her to achieve a level of personal comfort, but the trauma alone did not predict an outcome for her. While she could be expected to be angry that her mother did not do more to protect her from her father, she recognized the inherent complexity in her mother's situation and was grateful for what her mother could and did provide. Among her several stints in therapy to address the effects of an abusive past, she recalls especially this comment by a psychologist about her mother: "She couldn't always protect you, but she saved you." Some within her large extended family subtly acknowledged the inappropriateness of her father's rage, and others (one a family doctor) worked to contain him. All these people, she reasons, were helpful because they confirmed that others too saw him as a problem, and because their interventions over time rechanneled his rage.

I have learned that for many who were abused, empathic siblings, caring aunts and uncles, friends, or even a kindly intervention from a neighbor or church member protected them from the full impact of violent aggression. One young man told me,

My mother (who was, in fact, psychotic) slept with a knife under her pillow. The best times of my childhood occurred after I could ride my bike out to the bay and sit all day, away from her, watching the water. Otherwise, when she was mad at me, which was often, she would chase me around the house threatening me with a knife. It was a great relief for me the day we visited an aunt of mine and she reached over, patted my shoulder, and uttered, "You really are a good kid. She isn't crazy because of you. She's just crazy!"

This man was sensitive to anger and relatively unable to deflect or otherwise protect himself from his partner's harshness. He tended to choose relationships in which his expectation of criticism would be fulfilled. But he also possessed a capacity for inner self-regulation in the face of stress or adversity, and with support he could learn to evaluate his choice of friends. An aunt and his sisters and brothers had helped him to cope, even though his own father had been too unavailable to protect him. He realized that these other family relationships meant almost as much to him as did the chaotic mothering he endured, for they provided him with an alternative view of women and calmed his distress when his mother's attacks stirred him up so that he felt out of control.

A founding clinician of the Kempe Center in Denver, Colorado, suggests that childhood victims who are able to conclude that the abuse they endured was not merited are better able to manage the aftermath of abuse.² A victim who believes that the perpetrator is troubled, psychotic, immoral, or in some other way the real problem, and that she or he is not, is more resilient than one who cannot dis-

count the abuser. A victim is less marked by what has happened and more able to recover from the violation when she or he is told, or somehow recognizes, that the violence is not of the victim's doing. A seminarian said to me,

I would kneel in my pew at church and consider what I heard of God's goodness and justice. Through the veneration of the saints I learned that others had suffered too but were honored and had a special place for what they innocently endured. It was not much to go on, but I suppose I still identify with that notion. I felt keenly that a good God would not approve of my father's actions. Without saying so, the church assured me that my father's violence was wrong! I strongly believed, and in a larger sense still do believe in the positive rewards for virtue, if not in this life, then in the life to come. I don't understand how the liturgy and teachings of Catholicism helped with all that our family suffered, but I know that they did.

More than finding someone who will believe the accounts of the abuse after the fact, as important as that may be, the victim needs someone who believes in his moral decency and acute vulnerability at the time it occurs. Without this external advocacy or some prior inner conviction on the part of the victim regarding his own historic innocence, a victim is subjected to a terribly recriminating conscience. As I understand it, this involves a viciously aggressive superego induced by the violence and hostility perpetrated against the victim, coupled with a frantic impulse to escape from or retaliate against any stimulation that hints of the past. This deep self-blame is then deflected in projection and animosity toward others.

A second life experience that mitigates the effects of abuse is the opportunity for the victim afterward to have a substantive and nonabusive relationship with a person of the same sex as the perpetrator.³ Such a relationship again allows the victim

to assess the perpetrator more realistically, to view him or her as the problem, and to escape the conclusion that all men or all women are to be mistrusted.

One of my students, an ardent feminist, had an abusive father. Her brother, however, was several years older than she, and he provided a sheltering and close relationship. Because her brother was also abused by their father, and sometimes more harshly than she, she sees violence as a universal issue and doesn't sympathize with the position that violence is primarily a gender problem or that men inevitably execute harm.

Several men have told me about a special neighbor, female relative, or sister who cared for them when their mother was prone to rage and violence or when a mother condoned her husband's violence. These victims were grateful for a relationship with a caring person who was the same sex as the violator. The other women in their lives provided a broadened view of women that prevented them from seeing abusiveness as a characteristic of all women. Similarly, I have heard many stories about a wonderful junior high coach or a fine youth leader who, without knowing it, allowed a victim the opportunity to have an experience with a caring male. Each of these stories confirms the impressionable resilience of children and the devastating and destructive power of another abusive relationship. There is a plasticity and openness to relationship that remains in the worst human experience until re-violation shreds the potential for comfortable connection with others.

If the intensity and form of abuse are not too great or if the mediating experiences described above do occur, the child can grow as a person who can keep the past in perspective and contribute to the care of others. Without these interventions to help modulate affect, to reappraise the cause of abuse, or to broaden experience with healthier relationships, the outcome for the victim can be dismal.

For victims who have not yet learned to man-

age the terrible burden of psychological threat, overstimulation, excitation, and reaction, problems with people are inevitable. They may relive experience so that they are perpetually at odds with the world. Their ability to understand others' motivations or actions as benign is limited. The normal limitations of others are denied or exaggerated as the present is continually interpreted through the lens of violence. These people need special consideration, may expect immediate and knowledgeable attention (in order to be reassured), or they may project their own internally denied sense of violation and corresponding aggression—in effect, re-enacting the historic reality of injustice. Without inner equilibrium and a capacity for managing and calming a sense of threat, it is difficult for victims to maintain equilibrium in current relationships.

Assessing Abilities for Ministry

THE EXPERIENCES AND VULNERABILITY of a victim of abuse inevitably influence the person's capacity for ministry, sometimes positively, sometimes not. When I assess a candidate's potential for ministry or an application for one of the clinical programs in my medical center, I make some judgment on this balance. At the same time, I must evaluate my own or our staff's ability to manage the potentially negative residue of trauma. I believe that as increasing numbers of ministerial candidates can acknowledge an abusive past, the church, our seminaries and educational programs for ministers, and our judicatories are obligated to be more intentional about the selection and ordination processes of those who have been violated. At the same time, we need to avoid candidacy and admissions procedures that re-violate the abused or create caricatures of them that underestimate their potential, and ours, for redemptive involvement. I am reminded of this text from St. Ignatius, a first-century teacher of the church who seems to have dealt with many difficult students:

By the grace which you have put on, I urge you to press forward in your race and to urge everybody to be saved. Vindicate your position by giving your whole attention to its material and spiritual sides. Make unity your concern—there is nothing better than that. Lend everybody a hand, as the Lord does you. “Out of love be patient” with everyone, as indeed you are. Devote yourself to continual prayer. Ask for increasing insight. Be ever on the watch by keeping your spirit alert. Take a personal interest in those you talk to, just as God does. “Bear the diseases” of everyone, like an athlete, in perfect form. The greater the toil, the greater the gain.

It is no credit to you if you are fond of good pupils. Rather by your gentleness subdue those who are annoying. Not every wound is healed by the same plaster. Relieve spasms of pain with poultices. In all circumstances be “wise as a serpent,” and “harmless as a dove.” The reason you have a body as well as a soul is that you may win the favor of the visible world. But ask that you may have revelations of what is unseen. In that way you will lack nothing and have an abundance of every gift. (Richardson 1952:118)

The kindness and patience of Ignatius are admirable, but they demand a great stretch of faith for most of us. I try to blend his Christian vision with the reality of what I know about myself and hope to evaluate about the minister's potential.

I consider a number of issues when reviewing materials and interviewing applicants for an admittedly complex and stressful medical center program of clinical pastoral education. I want to know the following:

Does this applicant remember but minimize particular traumatic experiences, or does he or she seem adamantly focused on having been a victim? I expect some minimization and regard it as normal. A psychotherapist may take note of this minimizing

in a different way and may wish to have an abused client attend to the reality of abuse and not discount its importance. As an educator I want to know that an applicant can diminish his or her attention to the past in order to attend to the present. Thus I am not overly alarmed by an applicant's understatement, especially if I learn they have had psychotherapy, and I am alert to intimations of good, sustaining personal relationships as a part of the candidate's profile.

If a candidate does tell a story of abuse in the application process, however, I assess the person's capacity to acknowledge its abnormality. Either through a reasonable evaluation of the account or an appropriate affective response, I want to know that the candidate realizes that what she is talking about was abuse. If the macabre is presented too masterfully or if affect is totally absent from the description of these events, I worry about how conscience-burdened that candidate may be and how she may manage her conscience in the context of clinical learning.

A final concern, much harder to anticipate, has to do with the candidate's potential to become disorganized under stress. I believe this has occurred in several of my students, and it does create difficult problems in the clinical context, particularly in on-call coverage. In one instance, a student had a serious car accident on the anniversary of a traumatic on-call assignment. Another student who was weary and fearful of the

dangers of call coverage had no recollection of being called, although a page log indicated that he was called. Possibly the student or minister who already understands his personal history and knows that he may become disorganized is more able to manage trauma and to use supervision to debrief. Nevertheless, when I become aware of the potential

for a student to disconnect from events around him, I anticipate that the student, the student's colleagues who often do not understand what is happening, and the program staff may experience his deflected trauma in the course of our work together. One wonders if the risk is worth taking.

I also try to anticipate something of the mix of intellect, affect, and action the candidate normally uses to manage experience. Is one of these used more often than others or to the exclusion of any one of the three? Does intellect predominate? Is intellect used to support affective reflection or to deflect and defend against it? Is the person overly analytic? How has intelligence been used in other work-related activities? Are emotions expressed or not? Does the candidate appear numb or frozen? Or easily flooded with feeling and prone to explode? How

volatile is this individual, and when does he have temper tantrums? Does he mask affect with self-righteous superiority? How much is this person inclined to take action? Does he perhaps act without thinking, or is he immobilized and unable to take action when needed? Both written materials and an

**Some survivors of abuse
achieve realistic
self-perceptions and
integrate an awareness
that they have been
violated with a balanced
perception of the abuser(s)
and of others.**

**These survivors may
become fine caregivers,
for they are peculiarly and
courageously able to
identify with others in
their suffering, to pursue
justice, and to stand up
for those who are also
dejected.**

interview offer the opportunity to develop a profile of the candidate's usual way of responding.

Next, I want to learn something about the tilt under stress. When this candidate is anxious, how does she cope? What does she avoid when taxed? I may ask for a description of a particularly difficult time in her life and ask for her observations on how she managed. What I want to discern is whether this individual will be able to get onto the hospital units (on the job) and be able to conceptualize something of her experience using her own inner states to help her learn. Similarly, a candidate's committee would want to know how this minister is apt to go about her work and respond to stress. When the going gets rough, what will this person do? What has she done in the past? Does this person show adaptive strengths?

In evaluating persons who have been abused, I try to consider the extent of impairment for pastoral service. Is anxiety used as a signal for self-regulation and reflection, or does the candidate become panicky, flooded with emotion, frozen? What is this person's attitude toward himself and his own bodily sensations and urges? Does the person find his own feelings and wishes acceptable or threatening? Is he altogether too angelic, heretically inclined to live as a disembodied soul? And what of the balance of passivity and activity? Is this someone who copes or someone who absorbs experience and events, swallowing all their negative reactions rather than considering them or, on the other hand, resisting all but the most easily managed? How does this candidate manage aggression? Can she live with ambivalence? How idealizing is she of others and self? How does she attempt to portray her history and self? What is the capacity for empathy? Is the capacity for understanding the experience or situation of others—for example, my situation and needs as an interviewer—impaired? What has her social experience been? Who has she been attached to, and at what ages and stages of life did these attachments occur? How did she relate to others in school, especially as a preado-

lescent and adolescent? Is church then viewed as an escape from human contact and overly spiritualized, or is it a way and means of deepening involvements?

Ultimately I look to see what I can predict, a tenuous endeavor at best. Nevertheless, the effort prepares me for what may come and helps me assess whether I and others who will be involved with the candidate will be able to manage and assist the student as needed. Similarly, I believe churches, seminaries, and judicatories have a responsibility to anticipate what difficulties the minister may have without imposing those perceptions on a candidate already burdened by the past. At times we must say “no” or at least “not yet” to those who are apt to be re-violated by an experience with us, or who may violate us in the midst of the anguish that already overwhelms them.

Clinical Learning as a Context for Professional Development

CLINICAL PASTORAL EDUCATION is often used by judicatories as an evaluative tool of committees for assessing clergy candidates and by seminaries as a means of pressing difficult students toward self-review. I do believe in the value of the experiential education offered in programs of CPE, but I acknowledge that surviving a clinical training program does not assure that clergy candidates are going to serve well in the parish or that they will be more self-reflective as a result. The task of the CPE supervisor is to provide an educational context and experience that allows students to learn from patients (and secondarily peers) about their role and about themselves as clergy. Clinical pastoral education will not accomplish in ten weeks (or even in a full year or more of training) a significant degree of self-understanding and personality change to help a candidate manage a lifetime of abuse. The goals of training are not primarily therapeutic, nor are they

to make an assessment of the student's capacity for ministry.

My own assessment of a candidate leads to admission (or not) for a limited educational program in a particular setting. Once a candidate is admitted, it is not my job but the student's task, as she or he is able, to consider her or his personal strengths and limitations and style of involvement with others. A judicatory, it seems to me, might ask a candidate to address the question of personal history in his or her own self-evaluation (perhaps including a final CPE evaluation), but a CPE supervisor is not at liberty to address or disclose such personal information about a student within a final evaluation. A candidate's committee should know that evaluations are now written with the Limits of Information Act in mind. This protects the student and perhaps the supervisor but may not protect the judicatory or the church. A supervisor will try to intimate the student's problems but may feel constrained from outlining them, although he or she also may have spoken to the candidate about these issues privately.

Quite aside from making these assessments, I've had to ask myself as a supervisor how I am to conduct a training program which sometimes includes persons who have been abused. Do I modify my goals, intensify or relinquish them, because of the emotional contours and limitations of the student? Perhaps I've become a better teacher as I have reconsidered my task in this light. I am certainly more aware of what I am doing and why I am doing it.

First and foremost, I want to help all students think about the pastoral care of others, their needs in crisis, and the stress of hospitalization. The patient, therefore, remains the best teacher and is the focus of my concern and my efforts to assist the student. When I ask about a student's response to a patient, it is not meant as an invitation for the student to doubt herself and second-guess her own work but as a means for her more deeply to understand the patient and the patient's use of her. While

some anxiety may facilitate learning, the clinical context itself provides more than sufficient anxiety for learning to occur. Students who have been abused remind me that few, if any of us, need an educator who sees his or her task as one of creating self-doubt. Verbatims, conferences, and supervision are therefore means to identify *what* is happening and perhaps *how* it is happening between the patient and the chaplain, thus increasing the learner's sense of competence in the midst of ambiguity. "Why" questions that explore a student's personal history as it connects to a pastoral relationship are invasive and are rarely asked. Personal history is not usually dealt with in supervision. Concerns about the past do come up, often at the student's initiative, and answers may be tentatively formulated following the student's direction, but supervision does not dwell on the past. Such insights are valuable but are best fostered and worked through in the privacy and contained environment of a psychotherapeutic relationship.

Just as I avoid creating new anxiety for a student, I avoid overwhelming and aggressive confrontation as a means to achieve insight. I often ask the student to help me understand how or why an event or situation occurred as it did as I try to help him determine how realistic or unrealistically he may have responded. These gentle reappraisals are frequently successful and reduce rather than encourage anxiety. When needed, I may also make an administrative determination about what must be reconsidered, or what must change, though I may not try to change a student's mind or explore his reaction and experience in response. I try to remain as benign an authority figure as I can be, knowing that any authority figure may be viewed far more negatively and as being far more powerful than I understand myself to be.

When an abused student is involved, the most difficult part of managing a clinical learning program such as CPE may be to manage the aggression the student generates, particularly among peers.

Components of the learning program, such as group life, which are peer oriented, used for support and feedback, can easily get out of hand. In this context the abused student is not protected by the security of being the caregiver or of being the cared-for supervisee. Apparent mutuality and multiple relationships complicate the fragile sense of connection to others. The situation may quickly feel unsafe. Invitations to intimacy based on revelations of abuse re-expose the learner to feeling overwhelmed and misunderstood, to feeling violated and violent in response. Furthermore, learning of another person's trauma, valuable as that can be, may rekindle one's own trauma and suffering, generating responses that take time to understand and assimilate. In this context, feelings can easily become volatile and require expert handling. The supervisor must consider when and how to contain the expression of feelings as well as how students may be invited to express themselves, offering options for students to consider in an interpersonal realm.

None of these approaches to the education of the abused violates the integrity or the experiential components of clinical pastoral education. Instead, they are efforts to make use of what I have learned from those who have been abused about the delicacy of human experience; our vulnerability, our wariness when we feel overexposed to others and perhaps

violated; and our almost universal ineptness in assessing another's motives rather than projecting our own responses onto him or her. Those of us who will be involved in educating the next generation of clergy will have to practice the guidance of the New Testament and of St. Ignatius; to be "gentle as a dove, and wise as a serpent." Perhaps such wisdom will allow us to contribute to the mission and ministry of the church. It presses us to develop a pastoral theology that includes the learner in learning, the wounded and the means of healing as we learn, that incorporates knowledge from human experience and psychology, that does not confuse projection with empathy or intuition with impulsivity, and that does not betray that which is entrusted to us in ordination.

Some who have been abused may be too wounded to be healers. Some who have been abused have considerable potential to help others in and through a ministry of caring, but caring must be taught, especially with the most difficult of students. Education for those who have been abused requires that we reconsider how to and when to "lend everybody a hand, as the Lord does you," not because it's comfortable or easy to extend ourselves but because it is the basic impulse of the gospel to learn how to share the acceptance and grace which are ours.

NOTES

1. Perhaps the church draws more than its share of the abused because of the haunting quality of trauma and the need for images, equally compelling and equally powerful, to contain these disturbing and eerie phenomena. See Derr 1985.
2. Brandt F. Steele, conversation with author, fall 1988.
3. Brandt F. Steele, conversation with author, fall 1988.

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Shadows.

Oil and collage on canvas by Benny Andrews, 1992. World Series.

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Population, Ecology, and Women

Christine E. Gudorf

THE 1994 *STATE OF THE WORLD REPORT* of the Worldwatch Institute (1994) recounts a very troubling global trend: a massive slowdown in the growth of food. For example, yields from the globe's 17 oceanic fisheries reached their peak in 1989, after increasing more than fourfold since 1950. Nine of the 17 are clearly on the decline. Second, the global demand for fresh water is pressing hydrological limits, slowing the use of irrigation. Thus, since 1981, there has been no increase in the amount of land used to grow grain, and the increase in rice yields in Asia has slowed, with production falling below consumption for the last three years. The costs of using technology to increase yields has caught up with the human community in the form of erosion and the pollution of land, water, and air. Worldwatch's conclusion is that though there may still be food gains in individual areas, they will be balanced by food losses in others; thus, success in combating hunger and the disease and premature death that result from

malnutrition must come primarily from population stabilization, not increased food production.

Even more compelling is the evidence concerning the dangers of pollution of air, water, and soil around the globe, as the Rio Earth Summit made clear. In September 1994 the United Nations International Conference on Population and Development (ICPD) met in Cairo to develop a plan of action for achieving population levels that the earth can sustain. At that conference, women made two major breakthroughs. First, they were highly visible not only among the national delegations but even more at the NGO forum, where the nongovernmental organizations that fund and implement many health, population, and development policies in developing nations were represented. Second, the Cairo Programme of Action focused on providing the conditions under which the world's women would voluntarily limit their fertility. The rhetoric of this conference was about enabling women to be

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human subjects, rather than treating them as tools to be used in reaching population targets.

Levels of food production are not a conscious factor in the reproductive decisions of most of the world's women. Most women—like most men—are ignorant of the global trends outlined by the Worldwatch Institute. But ecological education alone will not introduce global ecological concerns into their reproductive decisions. Very few women in our world, and certainly not all men, are free to consider global population trends or global ecology in making decisions concerning reproduction. Poverty in developing nations and in minority racial and ethnic communities in developed nations as well as social and economic trends within women's local communities and families more directly influence many women's choices. The trends that critically affect women's decisions about birth limitation in most of the world include the rate of infant and child mortality, the educational level and status of women, the availability of economic roles and credit for women, and women's level of participation in social organizations. Among women whose decisions are directly affected by policies of population limitation or ecological concerns, most are coerced, usually by governments—as in China's one-child policy or as in decades of coerced sterilization in many parts of the developing world as well as among subgroups in developed nations, including, in the U.S., Native American women, Puerto Rican women, and black women.

Institutional religion influences the reproductive choices of women in two ways: (1) through success in getting passed civil laws that prohibit the use of some forms of birth regulation, such as steriliza-

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tion, abortion, and even some forms of contraception (as in, for example, much of Latin America, Poland, and other largely Catholic nations) and (2) through pressure on the communal culture regarding sexual mores, age at marriage, and gender roles in marriage. While religion is influential, it is only one of many determinants of the broader cultural situation

that affects the sexual and reproductive behavior of individuals and communities. Religions of the world lobbied both in the preparatory committee (PrepCom) process leading up to Cairo and at the Cairo ICPD itself. The Vatican took the lead, but later, delegates from all the world religions took positions on abortion, contraception, family planning, adolescent rights, and family unification.

To understand better the role of religion in sex and reproductive activity, let us look at a historical example. The demographer Ryan Johansson contends that the sexual behavior prevailing in Western Europe between the late fifteenth and the early eighteenth centuries was unique compared to behaviors in other parts of the world (Johansson 1992). In Europe, sexual activity was almost universally restricted to marriage, 10–15 percent of the population never married, both men and women married late, and there was no evidence of infanticide or divorce. Moreover, within marriage there were many restrictions, including bans on contraception, late abortion, and infanticide, all of which were freely practiced outside Christian Europe. Sexual activity in Christian Europe was understood as an obstacle to spirituality and was severely restricted in terms both of when couples could have sex (for example, not on holy days, during Lent, before Holy Communion, during pregnancy) and of the sexual acts and positions for heterosexual

coitus (Ranke-Heinemann 1990: chaps. 20–21).

This sexual code was understood as Christian, and the Christian church was understood as responsible for its teaching and enforcement. Investigation of birth, baptismal, and death records for illegitimacy showed that there were relatively few violations of this sexual order (an illegitimacy rate of only 2–7 percent). But investigation also suggested that the virtual universal acceptance of this sexual order had a more complicated foundation than reverence for church teaching alone.

During these centuries, the average age of menarche in women was between 15 and 17, compared to 12 today. In addition, menopause set in 5–10 years earlier than today. Both of these differences stemmed from the generally poorer health of the population because of less adequate nutrition and greater incidence of infectious disease. This same lower level of health, combined with extended nursing of offspring, ensured that most married women did not conceive again until almost three years after a birth.

Infant mortality rates were very high, and deaths of older children from epidemics were common. The peasant and yeoman classes, which constituted the overwhelming majority of every society, relied on an adult son to take over the homestead and his father's work and support his elderly parents. Even among the small socioeconomic elites, the preservation of family property and power depended upon the production of a male heir. To assure having a male heir survive to adulthood, families had to aim for two sons to survive infancy. Since half the children born and half the surviving children were likely to be girls, the average family needed four children to survive infancy. Given infant mortality rates, that meant they needed six to seven live births. If all four survived, birth order often determined the adult children's fates: the heir inherited, the "spare" son went into the army or a monastery, one daughter was given a dowry so she could marry, and if there was not enough for a sec-

ond dowry, the second daughter went to the convent. Following the sexual code of European Christianity from the fifteenth to the eighteenth centuries produced in the average family the desired six to seven live births, three to four living children, and two or three adult children.

It was this relation between the results of following the Christian sexual code and the reproductive needs and constraints of families in their specific biological-social-economic situation that was responsible for the long and revered life of the Christian sexual code. By the early nineteenth century the decrease in infant mortality, better control of epidemics that killed children, and the increased health of women (which lowered the age of onset of menarche and raised menopausal age), along with the loss of convents and monasteries as depositories for excess children in Protestant lands, all combined to undermine allegiance to the Christian sexual code. Families, even if they adhered to the ascetic sexual practice mandated by the Christian church, began to have more children than they could economically place in the world. Moreover, with increasing urbanization, the raising of excess children became very expensive.

As the death rate of infants and children decreased, parental attachment to children also increased, as historian Philippe Ariès (1962) demonstrated, with the result that parents began asking themselves questions about the justice of sacrificing the interests of all other offspring to the interests of the heir. Families began to attempt to limit the number of children to those they could successfully establish in the world, and contraception slowly began its ascent to moral respectability in society and in the churches.

Just as the early Christian sexual code was undermined by larger social forces, indigenous religion and its morality has suffered a similar fate in many parts of the world brought about by the pressure of Christian monogamy and modern mobility and urbanization. In West Africa, for example, in

traditional polygamous societies, spouses were usually forbidden sexual congress from late pregnancy until the child was weaned some two or three years after birth. While these cultures were intact, such rules kept down the birth rate, allowed the new mother time to heal and bond with the child, and allowed the husband sexual congress with another wife. Tribal authorities enforced such rules just as they enforced rules prohibiting adultery.

But even with the deterioration of these traditional societies, religiocultural insistence on the ban on postpartum coitus persists (Orubuloye 1993). But husbands, historically encouraged in their cultural tradition to feel a right to sex, now most often have no other wives, and so often obtain sex commercially. Not only is the cost of commercial sex incurred at the expense of the men's families, but also, under present epidemiological conditions, many of these husbands contract HIV from such commercial encounters. Moreover, a much smaller but significant proportion of wives, feeling the general economic distress in sub-Saharan Africa in addition to the economic burden of their husbands' sexual expenditures, hitchhike to distant towns to become anonymous part-time commercial sex workers in order to feed their families. They, of course, also risk bringing home the AIDS virus and other sexually transmitted diseases (STDs).

These examples suggest that it is naive morally or religiously to absolutize any standard of sexual and reproductive behavior. In setting communal standards for such behavior, people should look not only at the practices that prevailed in their communities in the past, the sacred texts passed down, abstract considerations of human nature and the dignity and worth of individuals, or the religious meaning of marriage, though all these are important. Religious communities also need to consider the social and reproductive consequences of sexual behavior in a given historical setting and time, and the relevance of those consequences to all of human society.

Religion and Women

FROM THE PERSPECTIVE OF WOMEN it is extremely dangerous for either religions or governments to take up issues of population and ecology. It is only a little over three decades ago that many nations and national agencies became concerned about overpopulation as an obstacle to development. Their concern led to policies that worked against the interests of many millions of women. In one area of the world after another, poor women have been rounded up and sterilized. In 1983 in Bangladesh, the army rounded up thousands of women in the north for compulsory sterilization. In the next two years following the disastrous floods of 1984, women were routinely denied their share of emergency food unless they showed a certificate of sterilization, no matter whether they were grandmothers or young girls not yet married. In the first half year following the flood more women were sterilized in Bangladesh than in the previous ten years combined. In fact, the percentage of women sterilized increased from 25 to 41 percent of the 45 percent of women using any form of birth regulation (Hartman 1987:214-17).

In India, angry popular response to the government's shift from army-imposed compulsory sterilization of women to army-imposed sterilization of men in the north in the late seventies brought down the government of Indira Gandhi. In many other parts of the developing world from West Africa to Malaysia, women have been implanted with IUDs by itinerant medical teams, with no possibility of follow-up care and no help for perforations or pain. In Indonesia, government population officials successfully negotiated with the elders of many villages to trade the placement of contraceptive devices in the village women for agricultural credits, bribes for the elders, or political honors (Hartman 1987:74-83). In such cases, the wishes of individual women mattered not at all, whether they already had four or five children, whether they were newly married and childless, whether their only



Images of Mexico.

Oil on canvas by Jesus Guerrero Galvan, 1950. 39½ x 49½ inches.

Dallas Museum of Art, Dallas Art Association purchase, 1951.102.

child had just died, or whether continued childlessness would cause their husbands to divorce or abandon them. Furthermore, a number of studies of these national contraceptive programs by outside agencies pointed out the virtually universal lack of follow-up care in such campaigns, the all too frequent failure to abide by counterindication warnings (for example, in implanting IUDs into young unmarried girls or prescribing hormonal contraceptives to women with hypertension), the frequent absence of informed consent (especially regarding the permanence of sterilization and the availability of other forms of contraception), and even the absence of

sterile technique in some cases, all of which inevitably produced an unnecessarily high rate of deaths, medical complications, and clinical depression in women.

There is a very real danger that religion, like these governments, will decide that (1) there is a population crisis that threatens the whole society; (2) the birthrate must be lowered; and (3) controlling women's bodies is necessary to lower the birthrate. For despite the marvelous contributions of religions of the world to human culture, to aesthetics, to morality, and to intellectual life, religion has seldom defended, and has often collaborated in the

abuse of, women's bodyright. (The term *bodyright* means that the integrity of a person includes the integrity of his or her body, so that respect for personhood entails people having clear primary control over their own bodies.) In fact, for months prior to the Cairo ICPD and during the conference itself, some religious leaders, notably the Vatican and some segments of Islam, teamed up to condemn attempts to improve and expand the health, status, education, and reproductive options of women (Cowell 1994:1; Crosette 1994:1). Their argument was that expansion of these opportunities was not moral, since some women would use them to limit the size of their families through contraception or even abortion, contrary to the teachings of their religions. The plea of these religions was for the ICPD to support the traditional family—which is not seen as compatible with the improvement of the health, status, education, and reproductive options of women. Religions have all too often accepted patriarchy's instrumental view of women: that women's dual purposes are the reproduction of the species and the service of men, which often includes their sexual gratification. None of the major world religions has defended in any systematic way a woman's right to make basic decisions about her body, such as whether and whom she will marry; whether, how, when, and where she will have sex; whether she will conceive or give birth; and how and by whom she will allow her body to be touched (Gudorf 1989). Least of all have religions of the world defended women's right to pleasure in sex. According to the latest research of the Population Council, between 85 and 130 million women living in our world today have suffered genital mutilation, aimed at controlling or eliminating female sexual pleasure. Given the brouhaha in the U.S. over the Bobbitt case,¹ it seems safe to doubt that the religions of the world would be silent if over 100 million men had had their penises removed as children.

What have women ever done that makes men appear more capable of responsible reproductive

decisions than women? Is their record for parental nurturance and support, of subordination of their own concerns to the needs of children, so much better? Are they more sensitive, better role models, more devoted to life, than women? While it would be dishonest to claim for women any natural or unfailing parental nurturance, rates of paternal abandonment, paternal abuse and neglect, and paternal failure to pay child support, compared to those of women, devastate any male claims to superiority with regard to being concerned and responsible about child nurturance.² Furthermore, what data we have suggest that when male partners agree to birth regulation, culture assigns to women the responsibility for both implementation and consequences. Research also suggests that both male opposition to and female support for contraception are much higher when women provide most of the income for supporting children, because men who do not exercise economic control over families rely more strongly on sexual and reproductive potency as proof of their manhood.

Women's Bodyright and Reproductive Responsibility

HOW CAN RELIGION HELP EFFECT A REDUCTION in world population and in environmental threats without increasing the unjust burdens of women? The Cairo Programme of Action is correct: the only way to make progress in these directions without further victimizing women is to make the transformation in the status and role of women a primary goal of the population and ecology movements. What the developing world heard at Cairo is also correct: transforming the status and role of women within society is itself an integral part of a wider social revolution directed at more equitable distribution of the resources of the world and greater democratization. The ecological crisis requires both drastic reduction of overconsumption in the North

and lowered rates of population increase within a process of economic and social development in the South.³

There are many risks and temptations that religious communities run in espousing such a transformation of the role and status of women. Here I describe two briefly, discuss a third at some length, and conclude with a fourth.

First, even basic movement toward justice for women in the world will require a massive transfer of resources and power to developing nations and to deprived racial and ethnic minorities in the developed world. This is not merely a matter of depriving rich elites of things, although that is hard enough. This is also a matter of the privileged dealing with new and frightening feelings of powerlessness. Interdependence will feel like dependence to those accustomed to domination. Even middle-class religious women in the developed world who understand themselves as committed to religious ideals of loving and sharing with neighbors and to solidarity among women will find it difficult to support such transfers.

Second, many religious communities who attempt to promote this transfer of resources will be strongly tempted to understand this effort in traditional religious terms—as an embrace of religious asceticism. This is very dangerous for women, especially but not exclusively in the West, where asceticism has been understood as physical and psychic deprivation: fasting from food, drink, sex, and bodily pleasure, inducing bodily pain, and voluntarily accepting dependency associated with poverty and homelessness. These ascetic activities have often

been encouraged for men in religious rituals or vocations that exclude women as participants or observers. Such exclusion may include taboos on menstruating, pregnant, or nursing women or be based on a view of women as obstacles to the asceticism demanded of men. Women understood as reminders of both male lust and householder status and its distractions become religious problems. Consequently, a shift toward asceticism will

inevitably call into question the virtue and worth of women (and men) who seek a greater share of resources and power. For women especially, the ascetic ethic of self-sacrifice and service for the family has constituted the core of the religious ideal of woman. To accept either equality or power—much less to demand it—is to lose status in an ascetic ethic. Rather than asceticism, we need to stress democratization in promoting transfer of resources and power to women and other deprived and powerless groups.⁴ Democratization must be transformed from a

secular to a religious process and made central to both religious moral teaching and spirituality.

The third risk in pursuing a transfer of resources for transforming women's role and status in the world is that religions will succumb, in the same way that international organizations have so often done, to arguments that the status and role of women are culturally determined and that to interfere in any way is cultural imperialism. According to this argument, religions must remain neutral because they exist in many cultures and thus must respect all cultures and favor none.

All cultures contain valuable insights, values,

Studies show that in societies where women know other women who have been beaten for suggesting the use of contraception, they themselves are unlikely to bring up the issue with their own spouses, even if they have never been beaten.

and practices; but all cultures also have moral blind spots that developed for particular historical and geographical reasons. Respecting each other's cultures must entail accepting criticism of harmful aspects of one's own culture as well as appreciating different and beneficial aspects of the other culture. Furthermore, there is no reason why women, sex, and marriage should be the only areas of culture exempt from moral questioning. Nations and religions of the world have had no problem censuring or even intervening to end slavery, foot-binding, Hindu suttee, clan raiding, excessive militarism, promotion of drug use, torture, genocide, or other activities rooted in cultural traditions. All religions of the world should condemn practices such as child marriage, abortion for sex selection or as a primary method of contraception, female infanticide, female genital mutilation, and domestic violence, including marital rape—all practices that undermine just and equitable development of persons. Religions need to demand respect for the bodyright of women, because we have compelling evidence that repeated violation of bodyright, whether in child sexual abuse, domestic battery, or marital rape, conditions women to accept the dictates of abusers: "You do not control your body or your life; I do!" Such experiences diminish a person's capacity for moral agency—for responsible relationship with oneself, with other persons, with the rest of creation, and with divinity itself. Experiences of repeated abuse also determine that the healing process will be long and painful.

The Cairo Programme of Action is based on research indicating that voluntary efforts at reducing the birthrate in most of the world depend on reducing infant mortality not just overall but in each specific community. When couples can be assured that most of their existing children will survive to adulthood, they usually voluntarily reduce the number conceived. In societies where development allows families upward socioeconomic mobility through limitation of family size, the birthrate

then continues to fall. New social roles and status for women are an integral aspect of economic development and lowered birthrates. Women need access to education and training, employment, old-age assistance, agricultural and commercial credit, and social status. To the extent that women have access to all these, they are less inclined to measure their worth by the size of their families and are more able to seize control of decision making in their own lives.

Western religions have issued innumerable statements about the dignity and worth of women and about their rights in society but have been notoriously slow to support specific measures that would give top priority to many of these goals in practice. A necessary first step for religions in supporting such an agenda is promotion of forgiveness of the external debt of most developing nations. The vast majority of developing societies will continue to lack discretionary funds to apply to any alleviation of poverty for women, children, or men unless there is debt forgiveness on a large scale.

Religious preference for words over action is perhaps clearest in the case of violence against women. Western religions preach love of one's neighbor—even one's enemy—and insist on the moral superiority of peaceful means of conflict resolution. Yet violence against women, and even against children, has never been understood as a major problem. Nor is the situation better outside the West. Violence against women is the common though not universal pattern in our world.

In terms of domestic violence, a series of studies done in nations around the globe between 1986 and 1993 reported women claiming (and in a number of paired studies, men confirming) a staggering incidence of violent abuse by their sexual partners.⁵ In separate surveys taken in both Barbados and Antigua, 30 percent of women report being beaten as adults, and 50 percent of both women and men report that their mothers were beaten by husbands. In Uganda, 46 percent of women report being phys-

ically abused by a partner; in Kenya, 42 percent report being beaten regularly; in Tanzania, 60 percent of women are beaten by partners; in Belgium, 41 percent of women report domestic violence, of which 3 percent was very serious, 13 percent moderately serious, and 25 percent less serious; in Norway, 25 percent report being seriously beaten or sexually abused by a partner; in the Netherlands, 20.8 percent of women report experiencing violence in a heterosexual relationship; in Zambia, 40 percent of women report being beaten; in Papua New Guinea, 67 percent of rural women, 56 percent of urban low-income women, and 62 percent of urban elite women report being beaten; in Sri Lanka, 60 percent of women report being beaten; in Korea, 42 percent report being beaten, 37.5 percent in the previous year; in India, 75 percent of lower-caste men and 22 percent of upper-caste men admit beating their wives; in Malaysia, 39 percent of women report being beaten in the last year. In a Japanese study open to volunteer bias, 58.7 percent of women respondents report being physically abused, 65.7 percent report emotional abuse, and 59.4 percent report sexual abuse. In Costa Rica, 54 percent of women report being beaten; in Guatemala, 49 percent of women report being beaten; in Mexico, 56.7 of urban women and 44.2 percent of rural women report experiencing interpersonal violence; in Ecuador, 60 percent of women report being beaten; in Chile, 60 percent report physical abuse, with 26.2 percent reporting severe abuse beyond pushes, slaps, or thrown objects. In Canada, four different surveys report between 27 percent and 36.4 percent of women have been beaten, with between 11.2 percent and 17.8 percent beaten in the last year. In the U.S., three different surveys indicate that between 28 and 40 percent of women report abuse by a partner; two of the studies showed 31 percent of respondents reporting physical abuse.

Statistics on rape between 1987 and 1993 tell a similar story. Among college-age women in Canada, New Zealand, the United Kingdom, and

the U.S., between 11 and 18 percent are victims of completed rapes, and 19–25 percent are victims of attempted or completed rapes, excluding rape by husbands (for U.S., see Koss, Gidycz, and Wisniewski 1987; for all other countries, see Heise 1993). While we have less international data on child sexual abuse, existing studies show 33 percent of women in Barbados, 25 percent of women in Canada, and slightly more than 25 percent of women in the U.S. report childhood sexual abuse (for U.S., Finkelhor et al. 1990; for other countries, Heise 1993). (Sexual abuse of boys is also common, although at lower rates: 10–11 percent in the U.S. and Canada and 2 percent in Barbados.) We can infer from other data similarly high rates of child sexual abuse in other places. For example, a 1988 study in Zaria, Nigeria, showed that 16 percent of female patients receiving treatment for STDs were children under the age of five (Heise 1993). A 1977 study in Ibadan, Nigeria, found that 22 percent of female patients at an STD clinic were children under 10 (Heise 1993). In a study at the Maternity Hospital in Lima, Peru, 90 percent of the younger mothers (those 12–16 years old) had been raped by their father, stepfather, or another close relative.

Religions of the world must take up the issues of domestic and sexual violence and must become involved as defenders of victims and accusers of perpetrators. In the absence of a religious perspective based in the dignity of the individual human person, the very real alternative is that sexual and domestic violence may be treated only as a legal issue, which is a very limited advance. Governments can force men to limit physical violence out of fear of prosecution but may well fail to convert them to respect for women, who will continue to be abused in more subtle, but equally damaging ways. Law cannot teach love or respect—it can only discourage physical harm.

Changing Women's Situation

IN FEMINIST BIOETHICS THERE IS GENERAL agreement that new reproductive technologies must be regarded as both powerful and neutral; that is, depending on the circumstances, they can be used either for or against the interests of women, and who controls the technologies is a critical element (Farley 1985; Sherwin 1992). At present, women do not control reproductive technologies, which tend to be owned and operated in the interests of corporations, institutions, and partnerships controlled by men. Some women may benefit from specific technologies, but the primary function and purpose of the technology is to earn a profit for its owners. If it ceases to be profitable, it will no longer be offered.

Similarly, population policies can either empower women or coerce them. There is little middle ground. It is a mistake to think that lowering birthrates automatically serves the interests of women. Similarly, education in population programs can encourage respect for women's exercise of responsibility for their own bodies, or it can reinforce women's dependence on others for interpreting and caring for their bodies. Women want help in controlling their own fertility; they do not want to pass control of their fertility on to others.

What women need from their religious communities is recognition of themselves as integral persons, capable of exercising responsibility. They need to be supported in making responsible decisions about their bodies, including decisions about whether and whom to marry, about engaging in sexual activity, about what education they will receive, about whether to use contraception and what kind,

and about the kind of work they will do to support themselves. Women need support in making decisions about the number, health, and education of their children. Women need support and protection from violence of all kinds, including sexual violence, domestic violence, and the violence of female genital mutilation.

Movements for both global health and population regulation need the involvement of women to

be successful, but activists have begun to realize in the last decade that many women are not free to participate. Those who staff and implement population programs know that one important reason Norplant and, before Norplant, IUDs, were so popular with married women in many parts of the developing world was that they required neither the cooperation nor the knowledge of the husbands. These contraceptives, therefore, did not put women at risk of violence in the

many parts of the world where recourse to contraception is understood (especially by men) as supporting promiscuity and adultery. Clinic after underutilized clinic around the world has found that eliminating a policy of requiring spousal consent for contraception caused clinic use to soar. The role of responsible religion in such communities—of which there are some in the U.S.—is not to condemn the women who, for fear of being beaten, do not consult with their husbands but instead deceive them about contraception. The proper response of religion is to condemn the use of violence against wives that causes them to fear introducing the subjects of contraception or sterilization and to encourage both men and women in mutual decision making.

Widespread domestic violence poisons not

If population issues are truly to be based in ecological responsibility, then it becomes necessary to insure that lowering the birthrate is not accomplished through continued or increased injustice to women.



The First Born.

Bronze sculpture by Hugo Robus, 1951. 17.5 inches high.

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only the marital relationships in which it occurs but other marital relationships in the society. Studies show that in societies where women know other women who have been beaten for suggesting the use of contraception, they themselves are unlikely to bring up the issue with their own spouses, even if they have never been beaten. This is true even where significant proportions of their husbands respond to surveys that they do not want more children and would agree to the use of contraception if their wives brought it up. Fear of violence inhibits communication and encourages deceit.

AIDS education programs around the world rely heavily on promotion of condom use. Efforts aimed at teaching women, including wives, casual

female partners, and prostitutes, to insist on condom use have been notoriously ineffective. The general failure of the campaign cannot be attributed to women's lack of concern about their own health or about passing AIDS on to their children. Nor is the failure related to women's inability to understand the risk involved in unprotected sex. The major reason for the failure of condom promotion among women is the powerlessness of women in relation to men and the use of violence to maintain female powerlessness. Wives, girlfriends, and commercial sex workers report violence as a common response to the suggestion of condom use. Men are angered that the sexual object they have purchased dares to make demands of them. Husbands are angered by the

implication that wives either think them unfaithful or are critical of their lack of fidelity. Their anger is based on the understanding that wives do not have the right to be critical or demanding. Where violence is already a possibility or even a constant reality in a relationship, suggestions, much less demands, for condom use from women often trigger violent attack.

It has long been suggested that, in Western thought, attitudes toward women and nature have been linked. Carolyn Merchant (1980) made a convincing case for this link in the shift from classical and medieval to modern philosophy in the West, and eco-feminist thinkers continue their fruitful probe of this theme (see, for example, Adams 1993). To assert this link is not to take an essentialist, non-historical view of women or nature. It is only to say that our culture has linked women and nature in our thought in ways that make it unlikely that we can rethink one without the other or move to respect one without the other. It is highly unlikely that effective ecological consciousness is possible without both the transformation of the role of women in the world and a complete social purge of patriarchy. If population issues are truly to be based in ecological responsibility, then it becomes necessary to insure that lowering the birthrate is not accomplished through continued or increased injustice to women. Continued abuse of women as instruments in any otherwise worthy cause is unlikely to coexist with

acceptance of human codependence with the rest of creation.

The Fourth and Last Temptation

MOVING TOWARD RESPONSIBLE POPULATION and environment policies that include commitment to greater justice for women will not be easy for religions. The constant temptation for religious communities dealing with women, as well as for many women themselves, is to succumb to victimism. The injuries to women are so great and so long-standing that it is easy to understand women as either inevitably or essentially victims. To succumb to victimism would mean failing to insist to oneself or other women that we have the capacity and duty to heal from victimization. It would entail the churches obtaining better treatment for women victims but failing to empower them to speak for themselves. Victimism produces, in short, more benevolent forms of subordination for women.

If there is a central theological task for the religions of the world here, it is to insist that God⁶ did not create women to be victims, is seriously offended by the victimization of women, and is, in fact, eternally available to nurture and support victims past pain and suffering to recovery and integrity.

NOTES

1. Lorena Bobbitt was tried for cutting off her husband's penis while he slept and throwing it on the street—after he had beaten and raped her. The jury accepted her defense and sent her to a psychiatric hospital for treatment rather than to a fixed prison term.
2. About 10 percent of domestic abuse is initiated by women, and 90 percent by men (Shupe, Lacey, and Hazelwood 1987). About 95 percent of sexual abuse of girls is committed by males, as is 80 percent of sexual abuse of boys (Poling 1992:13). Studies show that child support payments after divorce are often unreliable; one study showed that only 22 percent of divorced fathers fulfilled all the financial obligations to children set by the court, while 50 percent fulfilled none at all. In two out of three Aid to Families with Dependent Children cases there are no set obligations to which fathers could be held (U.S. 1977). About 50 percent of the children in the U.S. spend a significant part of their childhood in a female-headed household without a male adult; one in four children in the U.S. is born out of wedlock (Hekman 1992).
3. I use "the North" to refer to the industrialized countries of the world and "the South" to refer to the poorest, least industrialized countries of the world.

4. I use *democratization* here for its greater clarity. In religious traditions this political ideal invokes language about sharing and community, the brotherhood and sisterhood of children of God, and compassion.
5. The following statistics are taken from a paper by Lori Heise (1993), formerly of the Douglass College (Rutgers) Center for Women's Global Leadership, now of the Pacific Institute for Women's Health. For each of the 34 studies, Heise names the author, date, sample size, sample type, the findings regarding violence against women, and related comments. She notes that some of the studies asked women whether they had ever experienced certain acts by sexual partners (e.g., being hit with a fist or an object; being thrown, slapped, or kicked), while others asked women whether they had been beaten or abused. Clinical research suggests that allowing women to self-define abuse results in underreporting of abuse. For example, in Zambia, 17 percent of the women surveyed responded that physical and mental abuse were a normal part of marriage, as did 22 percent of the Malay women.
6. This is, of course a very parochial (Christian) usage. Nontheistic, polytheistic, or religions in which there is no creator who remains involved with the world would use alternative language, perhaps: harmony in the universe is violated by the existence of violence against women and can only be restored by eliminating this disruption.

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REFLECTION

Moonlighting in May

Michael P. Honan

"CODE BLUE, 12 TOWER. Code blue, 12 tower," the operator's voice shrieked from the ceiling speaker. I jumped up from my chair, cursing under my breath. If the code had happened only five minutes later, I would have had this history and physical exam finished—my fifth of a still-early night. Sometimes this moonlighting job was all right, and other times, like tonight, it wasn't worth all the money in the world.

I hit the stairwell at half-speed, fully realizing I had the seven flights of stairs to go. For just a second, I considered going and waiting for one of the terminally slow elevators, but recalling the apocalyptic story of the senior resident who had used the elevator during a code quickly brought me to my senses. That resident, the story goes, had to wait for a slow elevator; when he arrived in the room several minutes late, he was shocked not by the fact that the code was unsuccessful but by the fact that the patient was a friend's grandmother!

I dashed through the last stairway door into the 12 tower corridor. Unasked, a nurse's aide pointed

toward room 1251. I raced through the hall, filled with customary trepidation. No matter how many times I had been code team leader, I still feared down deep that my instantaneous actions would be the sole determinant of whether a person lived or died. When a code failed to save a patient, the attending physician and the advanced cardiac life support (ACLS) instructor would try to ease the stress by saying "the patient was already dead" or "all you can possibly do is improve the situation." Somehow these words were less than comforting.

Some residents sought protection in the numbers, quoting mortality data on codes. They contended that the vast majority of codes were unsuccessful, and therefore it didn't matter what we as residents did. I never knew whether to interpret those statistics with relief or even greater fear. Was it true that what we did in a code did not matter? Or were only a few of us doing the "right thing" and ultimately saving those few survivors. In any case, I was experiencing a fear well known to residents yet seldom discussed outside professional circles because it would not be "physician-like."

Once in the room I instinctively reached for a pair of latex gloves. Another senior resident often joked about this, saying it was my way of granting myself absolution for any mistakes I was about to make. It was probably more of a leftover from intern days when I actually had to touch the patient! As a

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senior resident, my contribution to the code team was almost completely cerebral. Most of the nursing staff had been so well trained that I often wondered if anything different would happen if the residents didn't even show up for codes.

The only electrical activity on the monitor was caused by the intern's compressions on the patient's chest.

"What do we have?" I asked.

"Asystole since we hooked him up," one of the senior R.N.'s answered, knowing immediately the specific information I wanted.

"Not good . . .," I muttered, yet in the same breath I directed the team to administer 1 milligram of epinephrine. (Although usually ineffectual, this "heart starter"—as one senior resident called it—occasionally gave life to the dead.) I proceeded through the ACLS protocol mechanically, knowing full well the expected outcome.

"Do you want an ABG [arterial blood gas]?" the enthusiastic intern queried.

"Sure," I halfheartedly replied.

"Watch yourself," the floor nurse cautioned, as she recorded the timing of medications without looking up from her clipboard. "He's HIV positive."

Only then did I look to the head of the bed. I was surprised to see how young this patient was. He looked vaguely familiar, but then so does everybody in a hospital gown, I thought.

As we continued our deathwatch, one of the other senior residents went to call the attending while I reached for the chart.

"That's all the epi," said the crash cart nurse wearily.

"How much longer?" asked another.

"Pastoral care is with the mother down the hall in the family conference room," remarked a third. "She was in here when the code was called," the nurse continued, explaining. "She said she was holding his hand when she felt it going limp. She got an

aide who came and got me, and I called the code."

Still taking in the commotion in the room, I opened the chart and glanced at the nameplate to see how old the patient was. "Garcia, Jose. 28, Hispanic male." I realized then that I *had* taken care of this patient before. I had admitted him about two months ago, during another horrible moonlighting night. In fact, I had admitted him to the adolescent ward, because all the adult medical wards were full.

My thoughts drifted to that cold spring night when Jose was first admitted. I had learned then that Jose had moved to Hollywood when he was 23 to follow his dream of becoming an actor. Several years later, while working as a waiter, he collapsed at work from excruciating abdominal pain. His

medical workup revealed that he had a rare small bowel tumor—and that he had AIDS.

Jose's father had refused any active participation in his care because of the AIDS diagnosis. In fact, Jose's mother had reported with some disgust, he had reduced contact with his son to brief cordialities.

Jose had been treated in California until four weeks ago. After his roommate died from complications of AIDS, Jose had moved back to the Midwest to be with his mother. He was now in the hospital for recurrent abdominal pain. His mother had related all of these facts with great expedience, given her broken English. I remember thinking what a brave woman this was as she played the roles of mother, father, friend, and caregiver. It was humbling to watch this grown man fall into the shelter of his mother's nurturing care as he succumbed to this terrible disease.

I ended the deathwatch and prepared myself mentally to speak with Mrs. Garcia. While the staff prepared the body for viewing, I thought of what I would or should say. I thought back to our first meeting, remembering her big green eyes and how they were filled with apprehension as she hung on every word I spoke. I wished I had been more dedi-

**No matter how many times
I had been code team leader,
I still feared down deep that
my instantaneous actions
would be the sole
determinant of whether
a person lived or died.**

REFLECTION

cated in the short course in medical Spanish I had signed up for the previous fall. I had dropped out because of too many call schedule conflicts.

I walked the long hall to the family conference room and pushed the door open gently. Mrs. Garcia was sitting at a table talking in hushed tones with the chaplain. She appeared older and more tired than I remembered. Her eyes were red and slightly swollen as though she had been crying for a long time.

"Mrs. Garcia," I softly interrupted. As she rose from the table I could see she was sobbing quietly.

"I'm sorry," I said as if that were enough.

She let out a loud cry as she fell forward into my

arms. Her embrace seemed to last forever as she alternated between moaning and sobbing. I felt uncomfortable holding and consoling this woman, but, at the same time, I knew it was the right thing to do. My discomfort gradually eased, and I felt a sense of sadness replace it. I felt empathy for this mother who had lost a son. I made a quick mental note to hug my son a little longer and harder when I got home the next evening. Seconds changed to minutes and my eyes searched the room to fixate on anything to distract my thoughts. I latched onto the clock and could see it was 11:45 P.M. It was still Sunday. It was still Mother's Day.

NOTE

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ISSUES & CURRENTS

The Reign of Autonomy: Is the End in Sight?

Ron Hamel

AUTONOMY'S REIGN AS THE DOMINANT PRINCIPLE in medical ethics may be coming to an end. For the past 25 years, autonomy has not only shaped medical ethics in this country but also controlled ethical decision making about patient care. At times, it has been the sole consideration in resolving ethical conflicts; more often, it has been the decisive one, trumping all other considerations, principles, and values. Autonomy has verged on being tyrannous.

This statement may sound like blasphemy in a nation that prizes, indeed nearly worships, autonomy and self-determination. And it may sound somewhat bizarre after the expenditure of so much energy over the past quarter century, by medical ethicists in particular, to redress the abuses of physician paternalism. Such corrective action was undoubtedly necessary. And the emphasis on patient autonomy has contributed significantly to enhancing the status of patients in the therapeutic relationship. This has occurred, however, at a price, which only recently has become apparent. Increasingly, in health care institutions and in the academy, at conferences and in journals, one hears rumblings about the need to dethrone autonomy (as it is commonly understood in medical ethics) as the reigning principle, though not to banish it.

For centuries, physician beneficence maintained supremacy in the physician-patient relationship. But in the mid-sixties, autonomy emerged as the first principle of medical ethics. As Thomas Murray observes, "autonomy emerged as a powerful protest against evil or thoughtless researchers and paternalistic physicians. It found deep ideological resonances within American popular, legal, and political culture: our celebration of the individual, our anger at infringements by others, our constitutionalized protections of personal liberty, our faith in markets as fair and efficient methods for distributing social goods" (Murray 1994:32). Autonomy has come to mean the ability to follow one's self-chosen norms free of external constraints or coercion. It is a bulwark, a moral and legal defense, against any and all who would usurp one's right to make decisions for oneself and one's life or who would impose their values upon the individual. The concept of autonomy was appropriately used to address the problems that bioethics faced in its beginnings. But it is now starting to show wear. Clinicians and medical ethicists, in particular, are becoming increasingly aware of its limits and are calling into question its continued reign as the supreme principle. Why is this happening? What is problematic about a medical ethics based on autonomy? A couple of scenarios may help to illustrate some of the difficulties.

Mr. Davis is a 51-year-old man with a relatively

rare autoimmune disease that progressively destroys muscle tissue. The treatment for the disease has contributed to his contracting pneumocystis carinii pneumonia. He is placed on a ventilator to assist him in breathing. Very high settings are required, risking damage to his lungs. He shows no improvement over a three-week period; in fact, his situation deteriorates. He develops Adult Respiratory Distress Syndrome and multiple pneumothorax. The damage to Mr. Davis's lungs is irreversible. The chance for recovery is nil. Four weeks after he is placed on the ventilator, Mr. Davis's family is approached about a do-not-resuscitate (DNR) order and discontinuation of treatment. In the opinion of everyone caring for Mr. Davis, further treatment is futile. The attending physician and all the consultants meet with the Davis family to explain the patient's prognosis and to offer their recommendation. Because Mr. Davis does not have decision-making capacity or an advance directive and is terminally ill, he falls under the provisions of the Illinois Patient Surrogate Act. His wife is his legal proxy. She vehemently insists that she is "the legal decision maker" and wants "everything to continue to be done." Mr. Davis has a right to the best health care available, even a lung transplant (which, in fact, she pursue). He is a fighter, she says, and will come out of this.

The health care team backs off. Further attempts to get a DNR order and to withdraw treatment are unsuccessful. Mr. Davis survives another three weeks with maximum treatment until his life can no longer be sustained.

Or take another case. Mr. Matthews, 64 years old, has a history of diabetes and suffered a stroke five years ago from which he has recovered, except for the existence of a slight limp and a bit of difficulty with his speech. For the past few months, however, he has not been feeling well and has found it increasingly difficult to get around because of swelling in his legs. He tells his family that he thinks his death is not far off.

Mr. Matthews is admitted to the emergency room because he has been found by his wife to be confused and combative. He is given oxygen, which does not remedy his condition, and so he is intubated. Approximately 36 hours later, Mr. Matthews's family insists that the patient be extubated. They

maintain that Mr. Matthews had said he never wanted to be on a ventilator. Furthermore, his quality of life has been deteriorating and, in all probability, if he survives this episode, will worsen. Members of the medical team are opposed to extubation because they do not yet have a clear diagnosis. They believe, however, that his condition is likely to be reversible. The team tries to buy a few days' time.

On the first day that the possibility of extubation was raised, Mr. Matthews had marginal decision-making capacity. When asked if he wanted to be extubated and if he realized the possible consequences, he replied yes on one occasion and shook his head no when asked later. The following day, however, Mr. Matthews had increased mental clarity and indicated both by shaking his head and in writing that he wanted to be extubated. The family was more adamantly in favor of discontinuing treatment than they had been previously. Against his and others' medical judgment, the attending physician finally acquiesced: ventilation was discontinued, along with antibiotics and IVs. Mr. Matthews survived and was in better condition when he left the hospital than when he had entered.

Both cases demonstrate problems with enshrining patient autonomy. The problems are both theoretical and practical. The latter are more obvious, so I would like to begin by raising some of the former. One theoretical problem concerns the way in which we understand the human person. Autonomy does not do justice to who we are. It offers only a very thin interpretation of what it means to be a human being. Autonomy tends to reduce the person to a decision maker. But we are more than decision makers. We are more than our freedom and our ability to choose. These alone do not sufficiently describe or define us, though they are undoubtedly a constitutive element of what it means to be human. Defining the person in terms of autonomy or focusing on autonomy as the key characteristic of the person does violence to our identities.

This distortion is compounded by autonomy's depicting human beings atomistically, as isolated entities unrelated to others, as sovereign or nearly sovereign selves. The fact is that we are not mere individuals. Human beings are essentially social beings, in relationship to others and dependent upon

others. Sociality is not a choice; it is a fact of existence.

Placing an undue emphasis on autonomy distorts not only our self-understanding but also our patterns of relating to others and our sense of responsibility for others as individuals and as parts of a whole community. The assertion of individual rights and the pursuit of self-interest almost always supersede an acknowledgment of obligations to others and to the social whole and a willingness to sacrifice for the well-being of others and for the common good.

These are some of the theoretical problems with autonomy, roughly sketched. What are some of its practical shortcomings? One is that our focus on autonomy leads us to become overconcerned with procedures—informed consent, advance directives, decision-making processes, use of surrogates, and the like—to the neglect of other crucial moral dimensions of patient care. We establish procedures and structures to ensure the free exercise of autonomy in various situations and in order to respect a pluralism in values, beliefs, and practices. A focus on autonomy and procedures allows us to overlook differences. This is appealing in a pluralistic society. While we probably can't agree on what values or norms should guide us, we can more easily agree on procedures. Respecting mechanisms or procedures becomes more important than affirming and respecting the particular values, beliefs, and practices of individuals and groups.

A case in point. Many faith-based health care facilities have largely abandoned their religious heritage in the domain of health care ethics. It is not their religious traditions that inform policies related to forgoing treatment, for example, but the concept of autonomy, namely, the patient's right to refuse treatment (even if it be lifesaving treatment). To obtain an informed decision by an individual with decision-making capacity is all that matters. In an attempt not to offend those who do not share the religious convictions of the institution, those convictions are allowed to play little if any role. This is undoubtedly a difficult problem, but the solution—adopting an ethic of autonomy—seems a betrayal of the identity of these institutions. The emphasis on autonomy poses, or should pose, problems at least for faith-based health care institutions and for people of faith within the Jewish, Christian, and Muslim tra-

ditions. While these traditions vary, none supports the understanding of autonomy embodied in American medical ethics. Each has a strong tradition of viewing the individual in relationship to community and to a sovereign God. The individual in these traditions does have the capacity and the responsibility for self-determination, but that is not an "auto-nomous," absolute, and individualistic self-determination. In these traditions, decisions about oneself and one's life must be made while considering one's relationship to God and to others. It is ironic and quite sad that most faith-based health care institutions and people of faith have bought into the Enlightenment rendering of autonomy now enshrined in American culture and American medical ethics. So many have abandoned the richness and the insights (and in this area, the balance) of their own traditions for secular accounts that actually do violence to their traditions. Something has gone wrong; religious communities have failed somehow adequately to form their members in their traditions.

A second problem is that autonomy tends to be adversarial. The individual is a law unto him- or herself and alone determines what is in his or her best interests. The assertion of autonomy places one over against others. It says to others that one does not want them to interfere with or infringe upon how one lives one's life. Autonomy is a claim to non-interference. There is something defensive about it. This is perhaps most clearly seen in the physician-patient relationship. Autonomy frequently has the effect of pitting the patient and/or surrogates against health care providers. It is a way of asserting or exercising power over against physicians, in particular. This was perhaps necessary given the excessive physician paternalism of the past. But it is ultimately destructive of the physician-patient relationship or the healer-patient relationship. It pits will against will. It fosters mistrust.

Furthermore, by emphasizing the autonomy of the patient and by allowing patient autonomy almost always to trump, we have neglected the autonomy of physicians and other health professionals. We have diminished their moral agency and assaulted their professional integrity. This is exemplified in the two cases recounted above. In both instances, health care providers acted against their

best medical judgment in deference to the claims of autonomy. The scales were tipped in favor of autonomy. Their professional judgment (and particular beliefs) had little or no moral weight. While we have asserted the right of patients to act upon their own values and beliefs, we have not encouraged or permitted the same for health professionals. Physicians are expected to acquiesce to the wishes (and, occasionally, the demands) of their patients even against their professional judgment. Patients or surrogates call the shots; they almost always win out. Health care providers often don't feel free or comfortable expressing their own values or beliefs because of the fear of "violating patient autonomy." They harbor perhaps an even greater fear of litigation which harkens back to the adversarial nature of the physician-patient relationship.

The exercise of autonomy by patients can violate professional integrity in still other ways. Patients who execute advance directives, particularly durable powers of attorney for health care, sometimes check a box indicating that they do not want life-prolonging treatment employed. There is no further explanation. They may even have communicated this wish verbally to family, friends, or relatives. But it is sometimes not clear how this exercise of autonomy is to be interpreted. Is the surrogate to refuse life-prolonging treatment in all situations or only in those in which the life-prolonging treatment is non-beneficial or excessively burdensome? A literal interpretation of the patient's expressed wish to have no life-prolonging treatment may result in forgoing treatment that is reversing or assisting in reversing the patient's condition and restoring the patient to his or her previous quality of life. Surrogates sometimes demand, against the medical judgment of health providers, that the patient's expressed wishes be followed literally (as in the second case described above). This can be harmful, indeed deadly, to the patient and may also violate the professional integrity of the care providers.

Requests or demands for medically "futile" treatment, as in the first case, can also assault professional integrity. Such requests challenge the health professional's medical judgment, call into question his or her expertise, eliminate the latitude necessary for discretionary judgments, and ultimately reduce

the health care provider to an instrument of the patient's or surrogate's wishes. The patient's moral right to autonomy must be balanced by respect for the autonomy of the physician and of other health professionals. Their capacity to make choices, to follow their consciences about what is good medicine and what is morally appropriate in the situation must also be respected. Autonomy is not a unilateral right.

For some patients or their surrogates, autonomy has become a burden, not a blessing. For patients, treatment decisions even in the best of circumstances can be overwhelming, confusing, or frightening. In addition, illness is likely to compromise patients' decision-making ability, even though they appear able to make decisions. The anxiety, discomfort, pain, anger, and other emotions associated with disease, patients' absorption with their bodies and their disease, the disruption of their identities, effects on mental functions due to fever, medication, shock, or dementia may lead patients to make decisions they would not otherwise make. For surrogates, such decisions can be psychologically traumatic. Some believe that by what they say, they are causing their loved one to die, a decision they are not able to make or willing to live with. Others find it difficult to separate their own preferences and needs from what the patient would choose. Their inability to let go of the patient or of their own guilt, or their anger toward caregivers leaves them unable to make appropriate decisions for the well-being of the patient, yet their decision prevails on the basis of patient autonomy and surrogate decision making. Impasses between surrogates and health professionals can sometimes be resolved when the caregiver relieves the surrogate of the full burden of the decision. What appeared to be an insistence that "everything be done" can be, in fact, an inability to accept responsibility for a life-and-death decision.

Perhaps the most extreme expression of autonomy is the demand for the practice and legalization of assisted death—whether brought about by oneself with the assistance of another or entirely by another. The rhetoric associated with the debate over physician-assisted suicide and euthanasia is the rhetoric of rights—particularly the right to die. People believe that they have the "right" to choose the time, manner, and place of their death.

All of these examples are simply to make the point that patient autonomy is an inadequate concept upon which to base a medical ethics. Not only is it inadequate, it can also be harmful—to the well-being of patients themselves and their surrogates, to the identity and integrity of health professionals, to the relationship between patients and physicians, to the common good, and to religious identities of health care institutions, communities, and individuals. I do not mean to advocate a return to the days of physician paternalism nor totally to repudiate autonomy. But autonomy as we know it must be modified, which means, at least in part, that it must be contextualized. Two contexts are primary. The first is the relationship between patient and caregiver. The second is the relationship between the patient and his or her family, associates, community, and society. For people of faith, there would be yet a third primary context—their religious community and the Deity to which they profess faith. None of these does away with autonomy, but these contexts do make autonomy and its correlative, self-determination, less individualistic and more relational, less absolutist and more responsive to other values, interests, and considerations. Beneficence and justice certainly must come into play as a balance to autonomy. But many other values and virtues are also integral to being human, to being a member of a community, and to participating in a healing relationship.

Alternatives to the autonomy model do exist. One such example is the work of Edmund Pellegrino and David Thomasma, particularly their book *For the Patient's Good: The Restoration of Beneficence in Health Care* (Pellegrino and Thomasma 1988; see also Callahan 1987, 1990; Brody 1992). They wish to ground medical ethics in the very nature of medical practice itself. The goal of medicine is not to promote autonomy but to respond to the need and plea of the sick person for help. "The obligation to help the sick . . . is grounded in the claim that comes from the vulnerability and suffering of a fellow human" (Pellegrino and Thomasma 1988:32). They call their approach "beneficence-in-trust." The principle of beneficence (not to be identified with paternalism) unites a concern both for the well-being of the patient and for the patient's autonomy. By beneficence-in-trust, they mean that "physicians and patients hold in trust the goal of acting in the best interests of one another in the relationship." What that requires differs for each. What we begin to see in this approach is a focus on the healer-patient relationship, on the goals of the practice of medicine, on relationality, mutuality, partnership, and dialogue—correctives to some of the shortcomings of the autonomy model. There is promise in this approach. If nothing else, it begins to forge new ways of thinking and offers elements of a new paradigm. Development of that paradigm is the current challenge of bioethics.

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NOTEBOOK

Of the 597 respondents in a New Hampshire Medical Society survey,

- 310 said that if it were legal, they would prescribe or administer a lethal dose of medication to a terminally ill patient who requested it. Another 19 percent, or 113 physicians, said they would do so even if it were illegal.
- 45 percent said they thought physicians should legally be able to give terminally ill patients, upon request, prescriptions for lethal doses of medication; 32 percent said physicians should not have this right; 21 percent said they didn't know.
- 30 percent voiced support for the physician's right to administer a lethal injection to a patient in the same circumstances; 40 percent were opposed.
- 99 reported having received requests for lethal injections, and 11 said they had complied; 113 said they had had patients ask them for lethal doses of medicine to be self-administered, and 22 said they had complied.
- The majority (70 percent) reported they felt "pain" was the most important reason patients seek "aid-in-dying."

Ironically, Ezekiel J. Emanuel, M.D., after studying several polls on the issue and reporting on them in the September 12 issue of the *Archives of Internal Medicine*, says that "the main reason for

wanting euthanasia . . . is not pain. The main concern of patients seems to be being a burden."

(*American Medical News*, 10 October 1994)



The U.S. health system is still by far the most expensive in the world, and the spending gap with other major countries is widening, a new study indicates. The U.S. spent \$3,094 per person on health care in 1992, or 13.6 percent of its gross domestic product, according to figures compiled for the Organization for Economic Cooperation and Development. Most of the other 23 countries spent less than half as much. A report published in the journal *Health Affairs* said the U.S. had the fifth-highest infant mortality rate—after Turkey, Portugal, Luxembourg, and Greece—and the highest percentage of low-birthweight babies. But it was near the top in life expectancy for senior citizens.

Canada spent 10.3 percent of its gross domestic product, or \$1,949 per resident, on health in 1992; Finland 9.4 percent, \$1,363; United Kingdom 7.1 percent, \$1,151; Japan 6.9 percent, \$1,376; and Turkey 4.1 percent, \$156.

Americans spent less time in the hospital than people in most other countries.

(*Chicago Tribune*, 6 October 1994)

■

The vast majority of American doctors—88 percent—believe too much emphasis is being placed on length as opposed to quality of life, according to a recent poll. Eighty-seven percent of the respondents also felt society had gone too far in using technological advances to keep a person alive.

(Chicago Tribune, 4 October 1994)

■

Participants in the recent United Nations International Conference on Population and Development in Cairo were unknowingly speaking three different languages, said William F. Vendley, executive director of the World Conference on Religion and Peace, who was an official nongovernment representative at the meeting. The result, he contends, was sometimes a broadening of perspectives and sometimes sheer Babel.

The first of these languages, he said, was the empirical language of demography, public health, and international agencies, a language heavy on quantification and immediate problem-solving. It was the language in which many of the meeting's preparatory documents were drafted and initially discussed. The second language was that of religious traditions, a language of moral norms rooted in some larger vision of the common good. It was the language of the Vatican, the imams, and many other religious leaders at Cairo. The third language was that of specific situations, of sad instances—rape, destitution, absent or unsafe medical care—that seemed to challenge the applicability of the existing norms. It was the language of many feminists and religious dissenters at the meeting.

Vendley recalled a session that illustrated his thesis about the different languages. When several distinguished Muslims presented their tradition's teachings on abortion as perfectly clear and settled, women veiled in traditional fashion ardently questioned the male leaders from the back of the room. The women challenged the leaders to discuss situations where bearing children meant courting death or devastating shame or family ruin. He suggested that religious traditions could be enriched by these

“voices refusing to allow the moral discussion to stop with the declaration of a norm.”

Vendley added that the religious and situational forms of discourse “cannot enrich one another unless people become aware that they are both legitimate but quite different.” He is more confident, however, that the world's religions have the language to articulate comprehensive visions of social development and the human good that can augment and correct the “somewhat impoverished language” of much economic and population planning.

(New York Times, 24 September 1994)

■

British doctors attacked the ethics of an American clinic that was offering to sell the eggs of human donors. The clinic had advertised in British newspapers for childless women to fly to the U.S. for treatment. (British law prohibits the sale of eggs, which means that women often have to wait years for a donor.)

Also in Britain, the use of eggs from aborted fetuses to treat childless women was banned by the panel that regulates human fertilization procedures.

(Economist, 27 August 1994, 23 July 1994)

■

Genentech Incorporated, one of the biotech industry's largest, most profitable players, is quietly using a marketing tactic that is raising eyebrows: It is funding a nonprofit group that identifies “short schoolchildren who may only have a cosmetic need for a high-priced Genentech growth drug.”

In 1993 the company took in \$217 million on sales of its human growth hormone, Protropin; some of the hormone was used to treat children suffering from hypopituitary dwarfism. But the drug has been controversial for years because the malady is hard to diagnose, a year's dosage costs about \$20,000, and critics say some doctors prescribe it for children who are short but otherwise healthy.

Genentech is also by far the biggest donor to the Human Growth Foundation, a tiny nonprofit education and research group in Falls Church, Virginia. In 1993 the company contributed more than

\$100,000, or about 25 percent of the charity's budget, to pay for screening 35,000 kids in Atlanta grade schools for growth abnormalities. The charity trains gym teachers to measure students using highly accurate devices and to plot them on charts delineating abnormal growth; the devices and charts are supplied by Genentech at no cost. Parents of children who rank in the chart's bottom 5 percent receive form letters from the charity urging them to contact their physicians or the charity, "if you are concerned about your child's growth or weight." The letter makes no mention of Genentech, which is based in San Francisco.

(*Wall Street Journal*, 10 August 1994)



Smoking is the leading cause of premature death in the industrialized world, and half a billion people alive today will be killed by tobacco if current trends continue, scientists warn in a new global survey.

"We are expecting to see a tidal wave of mortality from the developing world," said Dr. Alan Lopez of the World Health Organization. The report, published in September by scientists at Britain's Imperial Cancer Research Fund, WHO, and the American Cancer Society, says that smoking will have accounted for 60 million deaths in the 50 years between 1950 and 2000. Smoking kills one person in the world every 10 seconds, but if trends continue, that figure will rise to one death every three seconds, the report warned.

Although the epidemic of smoking deaths in the U.S. has abated, it is expanding sharply in the former Soviet Union, Eastern Europe, and the developing world, the researchers said. In Western Europe, where more than 500,000 people die each year from smoking, the trend also is upward.

"Smoking is like no other hazard," Lopez said. "It will kill one in two smokers eventually."

Even though U.S. death rates from smoking are declining, the report said "12 percent of the entire male population of the U.S. aged 35 will be killed by smoking before reaching 70."

(*Chicago Tribune*, 20 September 1994)



Although the benefits of pastoral care in hospitals may be difficult to quantify, mounting evidence that chaplain visits aid in patient recovery is causing health care providers and insurers to sit up and take notice.

A two-year study of 700 coronary patients at a Massachusetts Veterans Administration hospital, for example, found that a group of patients who had daily visits from a chaplain were released from the hospital an average of two days sooner than were a group of patients who saw a chaplain an average of three minutes during their entire hospital stay. The director of the study, Dr. Elisabeth McSherry, noted that while the cost of the daily chaplain visits was "no more than \$100 per patient," the Veterans Administration saved as much as \$8,000 if a patient spent two fewer nights in the hospital. The former group also had fewer complications after surgery, the study found.

Such data are of obvious interest to insurers, who are faced with rising costs and increased efforts to reduce the length of patient stays without jeopardizing the quality of care.

(*Chicago Tribune*, 27 November 1994)



Most of the mainline Protestant denominations in the United States are facing financial difficulties as contributions from local churches decline, according to the *New York Times*. "In some cases, the result has been reductions in church staffs that echo the wrenching dismissals in the corporate world," writes Gustav Niebuhr, religion reporter for the *Times*. Niebuhr says the downsizing trend "has cut across ideological and theological lines, affecting the conservative Southern Baptist Convention and the liberal-leaning United Church of Christ." Annual giving to the Southern Baptist Cooperative Program fell by about 3 percent (more than \$4 million) from 1990 to 1993, for example, and in the same period the United Church of Christ (UCC) reported a reduction in contributions of about 6 percent, or \$850,000.

When the amount of incoming money decreases, budgets and staffs are cut as well. The Episcopal church has reduced the size of its workforce at the New York denominational headquarters by a

third—to about 200—over the past three years, and the Presbyterian Church (U.S.A.) has cut its national staff by a quarter.

Church officials point out that lower contributions to denominations don't reflect less giving at the local level; in fact, donations to member congregations of some mainline denominations are at an all-time high. Both the Presbyterian church and the UCC reported record giving in 1993.

Why is less money finding its way to the national headquarters? Observers have several theories. Younger churchgoers (particularly baby boomers) have fewer denominational loyalties; some studies have shown that denominational affiliation is relatively often far down the list of considerations when boomers are "shopping" for a church. Others note that while total giving is up, donations as a percentage of members' disposable income are down, and some blame churches for appealing to members as "consumers" looking for a bargain rather than as disciples who are challenged to give more to the poor and the needy. A third explanation is that local churchgoers perceive that more of their money actually goes to the poor and needy when the funds are spent locally—on Habitat for Humanity projects or soup kitchens, for example. "Nobody wants to explain to their congregation, you've got to cut out that feeding program—when you're feeding 200 people per week—because you've got to give that money to the national church," according to Episcopal bishop George Hunt of Rhode Island.

(*New York Times*, 25 September 1994)



ABC News is the first network to hire a full-time religion correspondent, according to a report in the Associated Press. Peggy Wehmeyer, a local TV reporter in Texas who had been putting a "spiritual spin" on some of her news stories, was selected by anchorman Peter Jennings to add a "new dimension" to ABC's nightly national "World News Tonight." Since her promotion to the post in January, Wehmeyer has done stories on school prayer and anti-Semitism and has interviewed President Clinton on his faith (he considers himself "a person who has sinned as a child of God, sought forgiveness,

sought for redemption, and is . . . struggling to find the guidance of God in this job").

Wehmeyer, 39, describes herself as a conservative Christian but denies that she'll be biased in her coverage. "I have no agenda or need to convince people that my view of the world is correct. If you're a good journalist—whether you're an atheist, a born-again Christian, a Muslim, or a Jew—you should be able to cover religion well. And I would say that someone who has faith has a good chance of doing it well."

Although media observers agree that religion is generally underreported by the major networks in proportion to its importance in American life, explanations for this discrepancy vary. Robert Wyatt, a journalism professor and author of a Vanderbilt University study of media coverage of religion, sees "more ignorance about religion than bias against it" in the average newsroom, although the study also found that American newspapers and broadcasters "largely refuse to take religion coverage seriously." More conservative watchdog groups claim that the underreporting is a factor of a "liberal/secular bias" in the media: the Media Research Center, a conservative group, claims that "only 211 of 18,000 network news stories in 1993 dealt specifically with religion." Not surprisingly, many inside the media have other explanations. Peggy Wehmeyer's boss at ABC, producer Sally Holm, says that religion makes for "tough television"; many religion stories, she feels, don't lend themselves to traditional television formats. "Clearly, you can't take pictures of angels," Holm says.

(*Chicago Tribune*, 30 September 1994)



Many doctors and medical ethicists are criticizing the increasing number of "method patents," which grant inventors exclusive rights for new diagnostic and treatment methods. The U.S. Patent Office has recently approved patents on methods for administering insulin, diagnosing heartbeat disorders, and operating on cataract patients with a self-sealing incision that doesn't require stitches. When the holder of the patent on the cataract incision, Dr. Samuel Pallin, filed a suit against a physicians'

group for performing hundreds of surgeries using his procedure without paying him royalties, he was roundly condemned by some colleagues. "A violation of the Hippocratic oath" and "improper for an ethical physician" were two of the criticisms leveled at Pallin in letters to the editor of an eye surgery magazine.

Critics of Pallin contend that physicians have an ethical obligation to share their discoveries at no charge in the interest of public health. Calling such sharing of information "the hallmark of a profession," the president-elect of the American Medical Association, Lonnie Bristow, argues that physicians' role "isn't to secrete information anyway." In the past, it would have been difficult for method patent holders to track unapproved use of their procedures without, for example, examining patients' scars, but

insurers' and providers' requiring more detailed recording of specific procedures performed makes it simpler to monitor such data.

Patent law advocates point to the incentive value of licensing and royalty privileges granted to patent owners and maintain that without such protection medical progress might be delayed. Thus, despite efforts by the AMA and some physicians' groups to ban medical method patents (which are not permitted in many countries), advocates say the number of such patents will only increase. "[Patents are] where the money is," explains eye surgeon Pallin's attorney. "[That's what] encourages people to sit down with a glass of scotch and think up new ideas."

(Wall Street Journal, 11 August 1994)

BOOKS

Finding One's Way through Illness: A Map of the Journey

Edwin R. DuBose

Marc Ian Barasch, *The Healing Path: A Soul Approach to Illness* (New York: G. P. Putnam's Sons, 1993), 428 pp.

TO SPEAK OF THE SOUL in the same breath with illness and health raises the hackles of many in medicine. The boundary between care of the soul and care of the body has been clearly defined for centuries in the Western world, originating with Cartesian dualism in the seventeenth century. Modern medicine's biomedical model has become the dominant paradigm for understanding health, illness, and healing. Based on a mechanistic causality that applies only to the body, in which mind, health, and spirituality have no common ground for interaction, the model reduces medicine to physiology. This medical paradigm is so pervasive that it determines not only how we interpret what we see but even what we see. It is so embedded within our psyche that few of us are aware of how determinative it is of the way we think about health and healing. According to this model, illness is "an attack on the body by heredity, a virus, a toxin, an oncogene; a statistical bad hop; an ordeal . . . sponsored by the Blind Forces of Nature" (p. 48). Not only does this emphasis on specific disease causation obscure important dynamics of the physician-

patient relationship as a factor in healing, it also encourages patients to think of their bodies as objects and themselves as passive followers of physicians' determinations.

There are signs, however, that this perceived bifurcation between mind and body is being questioned. Recent studies in mind-body interaction (for example, biofeedback) are forcing medical scientists to reconsider the adequacy of the biomedical model. In addition, the tremendous growth of public interest in complementary therapies (such as natural healing, herbal medicine, acupuncture, massage, yoga, or reflexology) derived from a variety of alternative medical models (such as Tibetan medicine) seems to indicate a recovery of an appreciation of the relationship among mind, body, and spirit.¹ With such an explosion of interest, it is helpful to have an account that surveys the landscape, while offering a particular map of the terrain. Such a book is *The Healing Path: A Soul Approach to Illness*, by Marc Barasch.

Barasch was the editor of *New Age Journal* when he was diagnosed with cancer. On one level an autobiographical account of his struggles with his illness, *The Healing Path* is also an exploration of the complex nature of illness as a catalyst for profound inner experience—"a marauding destroyer but also an agent for change" (p. 51). Illness, like any severe crisis, may destroy even the most entrenched strategies

for living, from work to personal relationships. It strikes at the very core of normal identity, fragmenting our carefully constructed images of ourselves, forcing attention and awareness in unaccustomed directions. For many people, illness is a shattering experience, leaving them vulnerable, angry, frightened, dependent. The vulnerability of the ill leads to desire for control on the part of both patient and caregiver. This desire for control is expressed as desire for the return to one's previous condition of health, the hope for which lies in the power of the physician's knowledge and skill.

For others, illness becomes, paradoxically in the midst of this breakup, an opportunity to achieve an integrated wholeness previously unknown and unimaginable. What, if anything, do people who find such wholeness have in common? It is the quest for an answer to this question that carries Barasch through a seven-year odyssey of self-discovery. His story and the stories of the people he profiles provide examples of the many ways people search not only for wellness but also for the meaning of health and illness.

Knowledge of the underlying concept of health is central to understanding, evaluating, and advancing any system of medicine. It is crucial to specifying the goals of health care practitioners and patients. Most definitions of health under scientific medicine have assumed that it, like disease, is simply located in the body and that a specific person's experience of health is generally isolated from social life and larger forces. Health is usually seen as a subjectively experienced, unshared, individual process, even though it is objectively affected by external events and relationships. Other thinkers claim that there is an intimate connection between the individual's experience of health and the vast complexity of the individual's immediate family, work, community settings, social networks, and physical environment. Some now posit the existence of a connection identified by mystics and religious thinkers centuries ago as the cosmological connection to the inner self (Salmon 1984:265). These concepts surface in current discussions of the definition of health (and the treatment of illness) as more consideration is given to what previous cultures viewed as the spiritual dimensions to health and illness (Sobel 1979).

The scientific medical model assumes a state of health in the individual when its extensive clinical findings appear within normal ranges. The foundations of this model go deep. To mention just one, during the later years of the last century the germ theory of disease and the theory of specific etiology (single causation) became the means for constructing new conceptions of disease and health, which became and remain basic supports of scientific medicine. With the practical success of medicine in treating infectious diseases, germ theory and specific etiology became the principal way of understanding the causes of disease. The result was the tendency to downplay social and environmental factors and focus on more limited concerns that medicine could more easily remedy. When the body came to be viewed more as a machine, with the natural occurrence of disease located in the individual, treatment logically was extended to individualized biomedical intervention to fight disease. From this narrow clinical perspective of biomedicine, the patient's behavior was not always regarded as important (Engel 1977). This is not to say that in practice physicians were not sensitive to patients' well-being but that the orientation of biomedicine has tended toward an engineering or mechanical approach for repair of the human machine. Less-than-precise interactions (including, too often, the human interaction between the patient and the doctor) were considered of lesser importance or excluded from consideration altogether. The non-scientific spiritual realm of health and illness was neglected, even stigmatized, in the subsequent development of biomedicine.

There are, of course, other, broader definitions of health that have persisted alongside the biomedical model. Generally, these posit a multicausal view of disease, where internal biological, along with external human factors (families, social networks), govern the response of the individual to specific agents of disease, whether microbial, chemical, radiation, or whatever. René Dubos saw medicine as constantly changing to confront disease, but never completely producing health: "The concept of perfect and positive health is a utopian creation of the mind. It cannot become reality because man will never be so perfectly adapted to his environment that his life will not involve struggles, failures, and sufferings" (in

Salmon 1984:256). Given the complexities of human biology and social life, there may be many causes of disease that are generally neglected by the biomedical model. Alternative definitions of health, and the practices that spring from them, form the basis of the resurgent complementary health care. For the most part, the major therapeutic interventions of holistic health care principally focus on the internal balancing of the person, with greater participation by the patient in the process of treatment.

In contrast to the materialism of scientific medicine, a common element in alternative systems of medicine is an implied unity between the person and nature, which is said to account for an innate healing potential both within the person and from an external healing source (Salmon 1984:266). While an imbalance in this unity may cause illness, health is tied to the patient's response to illness, not merely to the objective, nonpersonal, physicochemical explanations of disease along with its technical control. In contrast, "many traditional systems of healing are . . . aimed principally at providing meaningful and understandable explanations of illness experience" (Sobel 1979:108). In this sense, alternative medicines focus mainly on the patient's response to illness, not on disease. This approach was advocated by the influential turn-of-the-century physician William Osler, who admonished doctors to treat the patient who had the disease, not just the disease that the patient had. Such an approach, by recognizing that each person is also a social being, allows for a fuller accounting of the complex and interrelated dynamics of disease causation, onset, progression, and alleviation, including an individual's physiological and psychological dimensions, as well as social, cultural, ecological, nutritional, and spiritual factors.

The branch of medicine most deeply affected by studies on body-mind communication is immunology. Psychoneuroimmunology (PNI), a relatively new branch of behavioral medicine, examines the relationship between the central nervous system, which can be affected by behavioral factors such as stress, and the immune system. The developing field of PNI, plus attention to the biopsychosocial model of medicine, suggests alternative paths of healing for the critically ill. Basing his discussion of a "soul"

approach to illness on these emerging medical disciplines, Barasch calls for a multidisciplinary approach to the attempt to discern all the factors (physical, psychological, and social) that may exert some influence on the immune response. While thousands of studies offer a mix of findings, nobody disputes the fact that the immune, endocrine, and central nervous systems of the body are interconnected (Droege 1991:10). If stress has a negative influence on the immune system, and if there is therefore a connection between illness and consciousness, Barasch wonders whether positive imagery, for example, can influence the body's immunological system. The imagery he employs in the course of his own illness is that of the journey along a path that challenges him to undergo a physical, emotional, psychological, and spiritual transformation.

Although Barasch describes the healing path as a soul approach to healing, he does not define *soul* as some eternal essence. Rather, he explores a holistic approach to life that embraces the usually partitioned elements of emotion and reason, thought and sensation, social and private selves, and that leads to some integration of heart, mind, body, and spirit. Using his own experience with illness as a starting point, Barasch interviews dozens of others for whom serious illness had become a catalyst for change. He listens closely to their stories of hope and defeat, loss and triumph, and claims to have discovered a universal pattern, which he calls the healing path, with signposts others can use to guide their way.

Barasch uses narrative to help delineate this path. Drawing on Joseph Campbell's "hero's journey," and spicing his exposition with references to stories such as the Book of Job, *The Wizard of Oz*, and *It's a Wonderful Life*, Barasch presents an archetypal map of a perilous transition that honors the individual's need for physical healing while championing the quest for a fully integrated, spiritual life.

The path is perilous because the steps are hard and the way is unknown. Looking to the past for an understanding of one's present situation is necessary, for the roots of one's present condition lie there. Thus, Barasch favors various models of psychotherapeutic intervention. But, as therapists know, a recognition that the past is prologue is difficult for us fully to accept. If illness leaves one feeling disorient-

ed or dis-membered and longing for a recovery of the once-upon-a-time condition of health, we invariably turn to the past for solace or clues to re-member the present. Trusting the intuition and guidance of others as we let go of the past, however, is very hard. The very availability of experts to help us with this sort of interpretation is evidence of a tendency to become fixated with the prologue to the journey, a desire to look to others for rescue. Because we have lost a sense of the soul, we falter at a direct engagement with our inner life. As Barasch puts it, while visionaries, shamans, or therapists are necessary, "someone still has to make the coffee" (p. 385) and that someone is the patient.

The healing path, then, is hard work; it requires discipline. There is no unerring formula for success. It represents a challenge to those of us who have grown conditioned to expect a "quick and easy fix" from modern medicine. The outer world—particularly the institutionalized world of medicine—presents clear distinctions between evil and good, sickness and health, with treatment options. As represented in the story of Job, however, healing contains mixed, ambiguous outcomes (pp. 60–61, 334–35). The transformation that accompanies healing (pp. 287, 290, 343) carries with it changes in the social fabric, as well as in the self (pp. 338, 344, 352), and these changes take as much time as the journey requires. The traveler or pilgrim on the way must cultivate a willingness to confront and accept the reality and pain of changes over which he or she finally has no control. The soul approach to healing involves a surrender to grace (the ego alone cannot do it), a spiritual, neuroimmunologic, biopsychosocial grace (p. 366).

This path of transformation is not easy, but according to Barasch the journey is not in vain. By turning illness into an exploration of the furthest reaches of the self, the people interviewed by Barasch had perhaps extended their lives and inestimably deepened their understanding of its mysteries (p. 286). For him, this deepening is what healing is all about, but it requires a process of facing and accepting the certainty that the one who returns from the journey is not the same one who embarked.

Finally, the pilgrim arrives at a renewed or revitalized understanding of health. "Cured" is one of

the most welcomed words in our language, but in another sense "cured" means "alive to die of something else" (Lamm 1994:87). Thus, along with no quick fix, there is no final destination of health that is common to all. If there is a sense of health in today's culture as the absence of illness, badness, or darkness in some final or absolute sense, Barasch is persuasive in reminding the reader that health must be a mixture of life and death, shattering and reforming (pp. 381–82), never a state that is finally reached. While many of the people whose stories he relates experience a dramatic turnaround in their pathologies, some have recurrences, some are healed, some live with a chronic condition, and some die. For those who seem cured, there is the realization that their health is a new condition, not something guaranteed.

Barasch touches on a variety of therapeutic options, both conventional and complementary, available to or undertaken by patients. He is not offering a comparative evaluation of these approaches. For example, he does not offer a review of the risks and benefits of conventional and complementary therapies. He is concerned about what happens when a person's story becomes a patient's case. For Barasch, healing occurs when the healer creates a space for the patient that is outside the ordinary, where their habitual boundaries can be redrawn in a more holistic fashion. For him, complementary therapies and therapists can do more to foster this space and this redesign than the standard approach to illness and healing of biomedicine.

There is something of a double standard in his discussion: he tends to cite scientific studies that give evidence of the healing potential of complementary therapies, but he does not discuss studies that might undermine his argument. Biomedicine consistently is presented as a mechanistic and reductive undertaking, but many physicians would tell a different story of medicine. Concepts like alienation from one's body, the quest for meaning in the midst of illness, and the interconnection between one person's need, the sense of community, and another person's response (and responsibility) are only secondarily intellectual phenomena: they are, after all, widely shared human experiences that medical practitioners struggle to describe and under-

stand. Many doctors are sensitive to the limits of medical examinations and therapies, and quite a few of them appreciate the value of attention to spiritual realities.

At the same time, too often the well-being movement and more generally mind-body studies as a whole pay too much attention to matters of personality and self and do not adequately acknowledge the social context of health and illness. In an important corrective to this tendency, Barasch recognizes the limitations both of modern medicine's understanding of the patient who "presents" with an illness and of the wellness movement's tendency to focus on the work of trying to change the inner elements that may contribute to illness. Rather than concentrating on treating heart disease caused by smoking or demonstrating the benefits of a wellness program directed against smoking, Barasch sees that the healing path he is traveling requires an appreciation of the social environment that encourages or reinforces smoking. While combining an awareness of personal or individual responsibility with a recognition of the value of scientific medicine, he does not neglect the social conditions that promote illness rather than health.

If the spiritual-physical conception of human consciousness is valid, many of scientific medicine's key notions about health need to be reevaluated—and some discarded. Yet alternative therapies are new, and more theoretical development is needed. Albeit in disarray, the Office of Alternative Medicine at the National Institutes of Health and a journal such as *Advances: The Journal of Mind-Body Health* represent efforts to establish correlations. Books like Barasch's may contribute to the dominant scientific community's acceptance of complementary systems of medicine and understanding that alternative beliefs and practices can be an ally of biomedicine. In order for an alliance between biomedicine and complementary therapies to occur, more biomedical practitioners must come to appreciate the value of the inner struggle for meaning and the potential of cultural symbols and practices to aid in that quest.

Barasch is onto something. First, medicine is more than merely an empirical activity, and physicians are more than just scientists. For example, studies that show no evidence that stressors lead to

cancer may not capture the whole point: if a person thinks there is a connection, then this in itself is an important clinical fact, which needs to be addressed. The physician who ignores such belief is belittling the patient, for whom these are real issues. Similarly, it may be unwise to dismiss dreams as unimportant in the course of treatment. The patient's psychological search for meaning is part of his or her existential struggle, and the sharing of dreams should be respected as opportunities to treat the patient if not the disease.

Second, the effort to find some meaning (in part the work of caregivers and patients) in the midst of the uncertainty of illness often goes underappreciated. There is a medicine that we can provide for ourselves, without a physician, through the work of prevention or complementary therapies, a change in behavior, and a rebalancing of the inner elements that may contribute to our healing (Dienstfrey 1994:5). Attention to the values inherent in the kind of "healthy" world in which we want to live is of paramount importance to these efforts. Such a reimagining of the healing path requires a leap of faith, away from cynicism and fearfulness that inhibits change in medicine, in ourselves, and in our society. Thus health, Barasch argues, comes only after a spiritual quest and a recommitment to a well-integrated biopsychosocial and spiritual life.

In a radical reinterpretation of the all too common view of the division between body and mind, scientific and so-called alternative medicine must be seen as partners, not competitors. In this new vision, the physician and nurse become allied with the dream therapist, the chaplain, the shaman, and other caregivers in the role of the person's guide on the path of illness. This partnership and guiding role requires physicians' letting go of claims to scientific authority, a willingness to experience their own suffering and to share it with patients. Physicians and patients must therefore develop the habit of listening to each other's stories of illness and care and work to make those shared stories an ingredient of caregiving, thereby honoring their journey together.

In summary, Barasch is interested in questions of professional power, self-determination, and practices for healing. In this book he analyzes the tension between conventional medicine and alternative heal-

ing techniques, especially conflicts about the locus of authority and responsibility in the healing process as reflected in a variety of stories. The author argues that such cases reveal the weakness of bioscience's mechanistic view of healing, and he urges the ill to undertake the arduous journey into self-revelation that healing entails.

Such a description of Barasch's book, however, does not do it justice. His close examination of the lived experience of those involved in both conventional medicine and alternative therapies makes the book more than a text on complementary therapies. Barasch enables his readers to enter narrative worlds alien to their own experience. The sympathetic accounts of those who seek conventional medicine and those who seek alternative therapies allow the reader to appreciate the suspicion and resentment each group sometimes has for the other. They enable the reader to enter quite different and alien ways of construing the world, of valuing and seeking heal-

ing. Sometimes the boundaries between these different worlds blur, and sometimes the worlds merge. Through his sympathetic attention to the stories of doctors and holistic healers, as well as to those of the patients (including himself) who entrust themselves to them, the book is significant for the work of all practitioners and similarly useful for clinicians, chaplains, medical ethicists, and sufferers.

The value of *A Healing Path* lies in its engrossing discussion of the importance of communication and acceptance of the patient's journey and the healing opportunities present therein. It is important for caregivers to listen to the hopes and fears of patients on more than a superficial level. The imagery and story developed by the partners as they go along together reveals the need of people facing life-threatening experiences to hope and to understand more deeply the integrated nature of health and illness.

NOTE

1. For a discussion of the extent to which the public turns to "unconventional" therapies in the United States, see Eisenberg et al. 1993.

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BOOK NOTES

Diane M. Komp, *A Window to Heaven: When Children See Life in Death* (Grand Rapids, Mich.: Zondervan, 1992), 125 pp.

Diane M. Komp, *A Child Shall Lead Them: Lessons in Hope from Children with Cancer* (Grand Rapids, Mich.: Zondervan, 1993), 173 pp.

IN 1920 RAINER MARIA RILKE DESCRIBED his goal in writing a series of stories about God told by children for adults as "transferring God from the sphere of rumor into the realm of direct and daily experiencing; the recommending by every means a naive and lively taking-into-use of God with which I seemed to have been charged since childhood" (1932:9).

Like Rilke, physician Diane Komp believes that as children we adults had intuitive knowledge of God and possessed a wisdom about our lives and ourselves. Children's stories can lift the veil that descends as we move into adult awareness and pre-occupations, and help us glimpse again the springs of hope, trust, and courage that can fill some times of our lives—including times of illness and dying—with meaning.

Komp's stories, unlike Rilke's, are about children with cancer, some of whom recover and some of whom do not. All the children, though, have taught her about God and about what matters in her life. Reading Komp's stories, the reader can listen and learn too, and remember. A three-year-old asked his parents for permission to spend some time alone with his newborn sister. His parents opened the door as he leaned over her bed, "You've got to tell me about God. I'm beginning to forget already" (*Child*, p. 50).

What does Komp, a pediatric oncologist who practices and teaches at Yale University Medical School, learn from her patients? Her stories alone, of course, convey those learnings in depth. I would like to mention a few points in expository prose, under the headings "health," "faith," and "ethics."

Health. Komp has learned from the children that health is compatible with having cancer, even

with dying. She has learned that "the tendency to avoid pain and suffering is 'the primary basis of all human mental illness'" (*Window*, p. 108). Thanks to the children, and contrary to the lore she received through formal channels as a medical student, she now knows that it is healthier for her as a physician to open her heart to her patients and their parents: to care, to cry, to hold and hug, to remain a supportive presence, even when the disease is winning and the pain doesn't go away. "Instead of sapping my energy," she writes of her discovery when she ventured from the lab into clinical care and opened her heart, she found that "these kids were life-giving" (*Child*, p. 40). If more physicians opened their hearts and allowed themselves to be more human in their relationships with their patients, she speculates, it "might just help resuscitate our mortally ill health-care system" (*Child*, p. 93).

She has learned, too, about remarkable medical discoveries and mysteries of recovery from childhood cancer. During her career, she has seen childhood cancer, once an almost universally lethal force, become a curable or chronic illness for growing numbers of young people. She sings in her book of the wonders that chemotherapy and bone marrow transplants have wrought. Simultaneously, she recounts the tales of long-term survivors whose recovery is not scientifically explainable. She has learned from her patients of the truly and measurably medicinal powers of hope, of faith, and of intimacy in the face of pain and supposedly incurable cancers.

Faith. Dr. Komp's children patients have awakened her own faith, not only in the sense of drawing her back into fellowship and worship, but also by lifting that veil referred to earlier and giving her glimpses of "eternal yet invisible" spiritual reality. In that sense, faith is not a "belief in the supernatural" to her. Rather, faith is the ability to see, feel, and touch a dimension of life that has been there all along but hadn't seemed real until the children taught her to pay attention to it. It is like going from being color blind to seeing color, or hearing tunes that have been playing the whole time. The children, she says, "retuned my ear" to the melodies of the spiritual (*Window*, p. 34).

An example is the story of the seven-year-old boy dying of cancer. As the end approached, he spoke

with eyes aglow: "The angels—they're so beautiful. Mommy, can you see them? Do you hear their singing? I've never heard such beautiful singing!" Then he laid his head back on the pillow and died (*Window*, p. 28).

Ethics. Dr. Komp's medical ethics, like her spirituality, is not so much articulated in concepts and principles as blended into her accounts and reflections as a kind of leaven or subtext in her stories. She cites moral theologian Paul Ramsey and ethicist William May occasionally, yet in the main lets her actions bespeak her ethics more than her words.

She does not "argue" that palliative care is important. Rather, she puzzles over a chaplain's remark: "The way I see it, doctors should let the clergy know when someone is dying. That is where your job ends and ours begins" (*Child*, p. 105). Strange, she muses, that a chaplain would see his job and hers as serial rather than parallel. No, she states (and demonstrates, repeatedly), a physician's duty is to accompany her or his patients to the end and to prevent or alleviate their suffering all the way along.

She thinks, like Ramsey, that "covenant" best expresses the character of her relationship as a physician to her patients and their families. Physicians should hang in there with their hearts and hands—even with patients who fudge on the terms of their contracts and elicit separation fantasies (or worse) in their physicians. Fidelity is one of Komp's favorite virtues: fidelity to her art and science, fidelity to her God, who is present in her patients, one at a time. For "Dr. Di," doctoring is health, faith, and ethics all together.

These little books, while filled with food for thought, deserve a reading or two with the critical faculties temporarily suspended. My advice is to let these stories and reflections flow in. Notice the lights that they switch on in your memories and attend to the gentle chills along your spinal column. Afterward, pay attention to the next child who crosses your path—and watch, and listen.

—Daniel O. Dugan

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Diana Friel McGowin, *Living in the Labyrinth: A Personal Journey through the Maze of Alzheimer's* (New York: Delacorte Press, 1993), 147 pp.

NOT YET 50 WHEN THE SYMPTOMS of early-onset Alzheimer's first intruded into her life, Diana Friel McGowin from the beginning of her illness kept a journal that eventually became a book. She documented her growing realization that something was wrong, the problems she encountered in securing an accurate diagnosis, her own and her family's difficulty in accepting her diagnosis, the gradual shrinking of her world. This is a book that is painful to read.

She unflinchingly writes about such difficult issues as the increased sex drive of many Alzheimer's patients and her abandonment by some longtime friends. She matter of factly describes acts of competence and kindness—and their reverse—from family members and professionals as well. There is the doctor she saw when she first suspected something was wrong. After reading her MRI results, he sent her home with the words "it probably means nothing. . . . Just keep your nose clean" (p. 16). But when she is lost in the hallways of a large hospital, a doctor who doesn't know her takes the time to escort her to the lab and explain her predicament to a technician. When she receives a letter confirming the diagnosis of Alzheimer's, she hides it from her husband: "I never knew how Jack would react to bad news. Usually he was as much of a morale boost as a rubber crutch to a broken leg" (p. 47). Yet, years later, when Diana helps found a support group for early-onset victims, her husband publicly affirms her courage (p. 118).

Leafing through old family albums and mementos, she comes across a small box she had packed away following her mother's death. Along with childhood drawings by her brother and herself, Diana found "hand drawn maps and bits of directions scribbled on note papers." She smooths out the folded and crumpled papers and finds "maps to every place my mother went about town, even to my home and my brother's home" (p. 52). Suspecting a hereditary link for the first time, she thinks again about her unwillingness to hold a family conference and advise her own children of her condition.

She tells of being unable to cook a meal, of being

afraid to have her young grandchildren visit because she can no longer supervise them adequately. From managing a law office she goes to being a "temp," but before long even those duties are beyond her capacity. She clings to her attempts to cook, to drive, and to perform simple daily tasks. "I feared the possibility of someday losing control over my own home, my own meals, my own family, and my own automobile. . . . I feared losing my last shred of dignity and control over myself" (p. 82).

A concern she touches on repeatedly is one not unique to victims of Alzheimer's or even to the ill. As she acknowledges her increasing dependence, she wonders whom she can count on. "What I wanted, no, needed, was someone to assure me that no matter what my future held, they would stand beside me, or if need be, for me. I wanted assurance from someone that I would not be abandoned to shrivel away. They would give me encouragement, love, moral support, and if necessary, take care of me" (p. 53).

Some illnesses by their very nature will have few (or no) spokespersons. That is one reason this is such a valuable book: patients, families, and caregivers can glimpse the inner world of the dementia patient. McGowin brings home powerfully the patient's frustration, sense of loss of her self, fear of the future, awareness of her fluctuating ability—as well as some grounds for hope in abilities that remain, having good days, reaching and maintaining a plateau, and finding what joy one can. "Life was meant to be lived, not endured. And live it I shall. . . . I am reminded that even with Alzheimer's, life can be fun . . . if you know how to play it" (p. 125).

—Sandy Pittman

Daniel Donovan, *A Time of Grace: One Family's Experience with Chronic Care* (Mahwah, N.J.: Paulist Press, 1990), 98 pp.

EXPERTS CONFIRM WHAT OUR EXPERIENCE is already telling us. Increased life expectancy due to medical advances and a greater awareness of health issues is making old age and chronic care part of the normal experience of more and more families. *A Time*

of Grace: One Family's Experience with Chronic Care offers practical and religious insights, as well as encouragement and hope, to those who face the challenge of chronic care.

Through narrative and reflection, this book tells the story of one elderly but still active and independent woman who was suddenly incapacitated by a stroke and of how she and her family attempted to cope with her reduced state. The author—her son—in order to help her, had to learn to deal not only with his own feelings and with his relationship to her but also with a variety of institutions. Positive as well as negative experiences convinced him of the importance of family involvement in the care of the chronically ill and the crucial role that health care professionals are called upon to play in fostering it.

Families find it difficult to see parents or friends suddenly stricken by a chronic condition. People are afraid of hospitals and especially of chronic-care facilities. They are reminded of their own vulnerability and mortality when they realize that, in spite of efforts to plan or control the nature and duration of their last days, they suddenly may find themselves incapacitated, in need of long-term care, and facing their own deaths. Such emotions can be crippling if family members feel inadequate or frustrated when they visit. They make it more difficult for people to come the next time, and before long they may not come at all. If there are no programs that introduce families to the institution and its services and no real encouragement to families to become an integral part of caregiving, this last opportunity for families and patients to be together can become very tense and frustrating.

The challenge for an institution is to translate the ideals and values of its mission statement into attitudes and behavior of the staff. Because families are upset and have so little experience with chronic-care facilities, Donovan feels that the responsibility for establishing lines of communication and for making them known resides with the institution. Once that has been done, the family has its own responsibility to enter into the process and, while respecting the nature of the institution and the workload of its staff, courteously but clearly to make known its concerns. When the technical and medical knowledge of the institution is brought into creative

relationship with the personal sensitivity and awareness of family and friends, a genuinely helpful program of care can be developed.

The critical illness and death of our parents puts us in the front rank of our family's continuing journey through the generations. Inevitably we become more conscious of our own death. Yet, by entering as deeply as we can into what is most authentic about our life through caring for an ailing parent—enter-

ing his or her world with all its weakness, frustrations, depression, confusion, and all its triumphs and joys—Donovan believes that we can find grace. In giving, even in the most trying times, we find how much we receive. In telling the story of one family's experience with chronic care, Donovan offers valuable insight to patients, families, and caregivers.

—Edwin R. DuBose



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.
2. Style and spelling are governed by *The Chicago Manual of Style* (14th edition) and *Webster's New International Dictionary*. If you have any questions on style, please consult these sources.
3. Authors are urged to use nonsexist language.
4. Figures, diagrams, tables, and charts, if appropriate, should be submitted on separate pages and keyed to their position in the text. In addition, a list of legends or captions should be typed separately.
5. We welcome suggestions for illustrations. Our criteria for selecting illustrations are relevance to the article and visual interest.
6. Articles should be aimed at a diverse but educated public. Do not write for the six specialists in your field but rather for the general reader.
7. Notes, citations. Notes are to be reserved for substantive observations, and their use is discouraged. They should be numbered consecutively and placed in a separate section following the text. All notes that consist merely of supporting citations should be placed in parentheses in the text, listing (in order): last name of author, year of publication, and page numbers where appropriate, e.g., (Tillich 1967:353). Subsequent citations of the same source should also follow this model.
8. In a separate section titled "References" list alphabetically by author (and, for works by the same author, in order of publication with the most recent last) all items that are cited in the text. Give complete bibliographical information, including the author's first name, publisher, and place of publication. If there is more than one reference to the same author and year, distinguish them by the use of letters (a, b) attached to year of publication, e.g., Smith 1978a.

Examples

Tillich, Paul. 1946. "The Relation of Religion and Health: Historical Considerations and Theoretical Questions." *Review of Religion* 10 (May): 348–84.

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