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SECOND OPINION

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A sculpture of workers on the exterior of the Lakshmana Temple in Khajuraho, India. This temple was built c. 930–950 and dedicated to the deity Vishnu.

EDITOR'S NOTE

BY MARTIN E. MARTY

This issue of *Second Opinion* includes articles designed to help readers discover resources that they or their contemporaries may overlook. We have all experienced occasions when, after we looked to all the predictably promising and obvious places for help, we find it serendipitously or in locations we had written off as irrelevant. The best way to illustrate this theme in the present instance is to frame the first two articles in this issue.

The first resource is the past. Vigen Guroian takes us there in an effort to find lessons for dying well. He not only takes us to the past; he has the remote

past in mind. He chooses the ancient church, Christianity as of many centuries ago. As we pile on additions to our list of “unlikelys,” note that he draws us to the Armenian funeral rite. Expect yawns from the major media. They have it all figured out: the present, the near, and the immediately relevant are all that matter.

I had an early experience with the issue of remote and near pasts, remote and near places. On my first day as a teacher at the University of Chicago, which means my first day as a teacher, I chatted with Langdon Gilkey, a theologian who was also beginning at Chica-

go. He asked me what course I was offering. I told him I was not offering it; the powers that be had assigned it—"History of Christianity 303: the Modern Period."

Gilkey had come from Vanderbilt and knew a good deal about Christian history and about course numbering. Why start with 303? What happened to 301 and 302, on ancient and medieval eras? They are usually met up with first by anyone who has chronology in mind. I told Gilkey that the curriculum planners reasoned differently. The times were, after all, the sixties, when academics had to be relevant above all else. And they assumed that by teaching the modern period first we would grasp students where they are, and could then tantalize them to go backward. Gilkey said he could buy that logic as soon as we could show how American Puritans influenced Tertullian, one of the puritanical Christian ancients.

After that smiling response he and I got serious. We agreed that for historians of Christianity, the study of heresies, orthodoxies, councils, expansions, and persecutions in the first four centuries would reveal more about life today than might many stops along the way in the eighteenth and nineteenth

centuries. We are shaped by many pasts, and these dead pasts, as novelist William Faulkner reminded us, are neither dead nor past. They live in us.

Today more women graduate students are writing theses on medieval women mystics than on modern spiritual leaders. Hildegard of Bingen, Margery Kempe, and company are more relevant to them than women of our time. They study these figures of long ago not to turn medievalist but to find better ways to live in our own time.

I remember a paraphrase of something in conversation uttered by Gershom Scholem, the great scholar of Jewish mysticism. Asked why he spent his life on obscure medieval texts, he justified it only by saying that he thought they knew "back there" something that we do not know "as yet." Guroian hypothesizes the same about the ancient Christian world and informs our own.

Now, not everything in the past is full of potential. Much of its leavings are inert, and nothing we do can make them "ert." It takes discerning scholars and practitioners to help isolate the best prospects, and that is what Guroian does.

The other illustration is contemporary. Joseph J. Kotva Jr. finds resources in a profession and a context. The profession is pastoral ministry, and the con-

text is the congregation, the local community of belief.

To most pastors their relevance to health care, care of the soul, and care for the good, is so obvious that it hardly needs selling. They are constantly positioned at bedsides or family gatherings where people have to make decisions about the good and the true. Most of them are trained not only in theology and ministerial practice but in specialized versions of practice, for example through Clinical Pastoral Education. Many are formed by undergraduate training in philosophy and philosophical ethics.

The professional bioethicists who are not at home with pastoral and congregational life pursue their disciplines and crafts in different fashion than do ministers. Even those trained as ministers before they specialized in medical ethics often slip into another mode of perception and discourse when they put on their bioethics coats. Kotva gives us good reasons to ask whether such a division of disciplines, practices, and labor are best for patients. He offers cases and examples, ones that we will not now anticipate.

Before one even explores the equipment of those trained as pastors, it is useful to probe their congregational contexts. Some years ago Don Browning,

mentioned in Kotva's article, wrote at book length on the moral context of pastoral care. He could as well have spoken of the pastoral context of moral care. What might we mean by that?

Chaplains, perhaps more of whom see these pages than do parish ministers, may love their work. But they know its difficulties and limits. When ethical issues come up as they tend to do in most circumstances, they find it hard to speak of the good and the true when they cannot find a context. This does not mean they are all relativists or mere improvisers. It does mean that when they understand philosophically and religiously where a patient derives resources, where she or he is "coming from," it is easier to help lead them to the place where they can make judgments. Chaplains on their own often cannot discern what might be the roots of good decisions by families, those close to them, and physicians.

The rich resources of pastoral and congregational worlds are by no means automatically available. These worlds can represent routine, unreflective, boring, tired ways of life. But at their best they are attentive, offering communal help in times of loneliness and substantive approaches to ethics on their own. Let Kotva make the case. ■

DIVINE THERAPY

BY VIGEN GUROIAN

Lessons on Dying Well from the Ancient Church

With the advent of a new millennium we on the North American continent are anticipating an increase in the average human life span to four score or more years. In this century, the accomplishments of scientific medicine have been truly astonishing. There are many reasons why we should be grateful for these advances. But with these marvelous achievements, come technologies that give us the capacity to control and manipulate life and death processes beyond the wildest dreams of

our ancestors. It is no exaggeration to say that a society resembling Aldous Huxley's *Brave New World* may soon be within our reach and might even suit our desire. In such a society reproductive technologies and eugenics could insure that every human being is "predestined" to be "useful" to society. And what Doctor Kevorkian has named obitiatric and thanatologic medicine might be carried on in hospitals as human beings are dispatched the way dogs and cats are now put to "sleep."

In addition to the available technologies, ideological currents that challenge traditional religious prohibitions against radically altering human nature or medically ending human life swirl through the culture. Today's medicine is not yet consciously antagonistic toward biblical faith, nor does it deliberately seek to subvert or contravene religiously inspired moral and legal limitations on what humans do with their bodies and biology. But the medical profession is under increasing pressure to use new technologies in ways that challenge these limits.

THE CULTURE OF DEATH

In his hilarious and deeply troubling short story, "The Death of Justina," John Cheever introduces his readers to a character named Moses who rebels against our culture's aversion to death and disrespect of the dead. Moses makes this stunning comment at Justina's funeral: "How can a people who do not mean to understand death hope to understand love, and who will sound the alarm?"¹ Moses's unsettling statement is reminiscent of that chilling scene in Huxley's novel when John, the so-called Savage, is called to the Park Lane Hospital for the Dying to visit his dying mother Linda. In this facility, the

"patients" are put out of their misery in the pleasantest way possible, with plenty of soma, canned music, perfume mists, television, and other amenities. In *Brave New World*, care for the dying has been perfected into a clinical and sanitized form of warehousing bodies until they may be utilized by society one last time—as phosphorous extracted by cremation. Love, attachment, and feelings of loss are discouraged in this brave new world as marriage and parenthood have been abolished. Suffering has been isolated and death is not mourned; both are sequestered to places where, apart from the attendants, the living needn't be.

I think Moses is right. At the heart of our culture's moral sickness is a growing aversion to death and the dying. This may be traced to a commensurate diminishment of abiding love in human relations. There spreads through society a willingness to impose death upon the sick and dying in order to cause the least discomfort and distraction to the healthy and the living. With such attitudes in mind, Pope John Paul II has rightly warned that ours is becoming a culture of death.² There is a compelling need for Christians to be far better educated about what the faith says about the meanings of sickness and death.

From the beginning the Christian church understood death as the counterpoint of life within the broad scope of God's providence. God's unbounded and steadfast love in Jesus Christ was the remedy to mortality. In our day, however, the church has not said enough about death, and it is failing to persuade society to guard life and love adequately in the medical environment.

I will present, first, a religious view on the meaning of death that draws especially from Eastern Christian theology and liturgy. Second, I will examine some of the ancient sources of the church's long-standing interest in the healing arts. And, third, I will illustrate with a true story how this theology of death applies in our own day, urging Christian churches to assume a much greater role in and responsibility for preparing people to die well.

DEATH AND CHRISTIAN BELIEF

Not according to God's will, but by sin, has sickness unto death come to define the human condition, says the ancient tradition. Because of sin the entire race of Adam and Eve has been disconnected from God's immediate life-giving energies. We are like run-down batteries that finally lose their charge. All humanity is under this condition of mortality:

In our day . . . the church
has not said enough
about death.

no one is exempt. Original sin is the intractable habit of making the wrong moral choices and doing damage to the human environment. It is passed from generation to generation, and its effects are deadly. Saint Paul writes in his Epistle to the Romans: "Sin came to life, but I died."³

The fear of death threads through the whole fabric of human life. It drives human beings to desperate and often selfish acts. Sometimes it moves them to end their own lives so that they do not suffer the agony of death's onset. The ancient fathers of the church named the death that we die due to sin "corruptible death." They often cite the Wisdom of Solomon, a Greek intertestamental text included among the so-called Apocrypha of the Old Testament. "God created him for incorruption, and made him in the image of his own eternity, but through the devil's envy death entered the world," says the Wisdom of Solomon.⁴

Drawing upon this, Saint Athanasius recounts the story of the advent of

corruptible death in his tract entitled *On the Incarnation*:

God set them [Adam and Eve] in His own paradise, and laid upon them a single prohibition. If they guarded the grace and retained the loveliness of their original innocence, then the life of paradise should be theirs without sorrow, pain or care and after it the assurance of immortality in heaven. But if they went astray and became vile, throwing away their birthright of beauty, then they would come under the natural law of death and live no longer in paradise, but, dying outside of it, continue in death and corruption.⁵

Thus, because of sin, human existence comes under the strict determinism of nature's law. In other words, sin throws human existence into nature's cycle of life and death, into the entropy of natural existence that draws every living thing toward extinction. Sin activates our creaturely proclivity to fall into the darkness and nothingness from which we were lifted into light and life by God's creative doing. Corruptible death, therefore, is a profound tragedy that has befallen the image of God. A hymn of the Byzantine Burial Rite lends powerful

expression to this: "I weep and I wail when I think upon death, and behold our beauty, fashioned in the image of God, lying in the tomb disfigured, dishonored, bereft of form. O marvel! What is this mystery which doth befall us? Why have we been given over unto corruption, and why have we been wedded to death?"⁶

Only for the human being is death contrary to nature because in man's case mortality is a consequence of sin. At the close of the Armenian Church Service for Burial of the Dead, the priest gives voice to the deceased as the coffin is carried in procession out through the doors of the sanctuary. The deceased laments his fallen and corruptible state and prepares himself to meet "the Righteous Judge," adding the inevitable and strong penitential note found in all Eastern Christian funeral and burial rites.

Let the whole world look upon me
and witness my woes . . .

I have sinned and am condemned
to oblivion.

I have dug my own grave. I have
plotted against myself.

I have betrayed, I cheated . . .

Once I was light and now I am in
darkness and the shadow of death.

How shall I recount my sins, they
are so numerous . . .

Hurry, O my person, flee from evil,
desire goodness.

Collect yourself, before Death's
sleep overcomes you.

Commit yourself to the Righteous
Judge.

Lord, have mercy.⁷

As reflected so poignantly in this Armenian hymn, the ancient tradition is quite clear that the death we know in a fallen world is not what God intended for human beings. Saint Gregory of Nyssa writes: "From the nature of the dumb animals, mortality is transferred to a nature created for immortality."⁸ God created Adam and Eve for eternal life, not to endure personal extinction, insists Gregory. Had the first couple not sinned, the parents of the race would have passed on to eternal life with God after the duration of their temporal lives. This passage into eternal life would not have entailed the radical rupture of body and soul, and the demise of the person that we see in death. However, Jesus Christ, the only begotten Son and express image of the Father, reversed the entropy and corruption that sin activated in humankind. Only the incarnate Son of God, who lived and died in our human flesh, was capable of renewing human nature by restoring the image of God

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within us through his sinless life and freely-willing death on the Cross. By these things Christ healed humankind so that all might be whole and inherit eternal life. Christ, by his good death, transformed death back into a passage to eternal life. This is the conviction of the ancient tradition.

THE MEDICINAL METAPHOR IN THE ANCIENT TRADITION

From this theological perspective, we are invited to think of the redemptive act of God in Jesus Christ as a kind of divine therapy. God's love and compassionate care have cured our diseased and mortally sickened human nature. In Georges Florovsky's words: "Redemption is not just man's reconciliation with God. Redemption is the abolition of sin altogether, the deliverance from sin and death . . . The death of Our Lord was the victory over death and mortality, not just the remission of sins, nor merely

justification of man, nor again a satisfaction of an abstract justice.”⁹ Florovsky’s view is rooted deep within the ancient tradition and is forcefully reflected in the liturgies of the Orthodox Church. Salvation is understood as healing and also growth toward perfection. God’s medicinal prescription of salvation in Christ remedies the carcinogenic effects of sin and cures the mortal sickness that corrupts our whole being. The fourteenth century Byzantine theologian Nicholas Cabasilas evokes this meaning of healing in his great work of sacramental theology, *The Life in Christ*. There he explains:

Many are the remedies which down through the ages have been devised for this sick race; it was Christ’s death alone which was able to bring true life and health. For this reason, to be born by this new birth [of baptism] and live the blessed life and be disposed to health and, as far as lies in man, to confess the faith and take on oneself the passion and die the death of Christ, is nothing less than to drink of this medicine.¹⁰

This is a wonderful image of salvation in Christ through faith and baptism by water and the Spirit. Cabasilas plumbs

the deep etymology of salvation. Its Greek root is *sozo* from *saos*, which literally means healthy. The Hebrew equivalent is *yasha*, which is to rescue from danger. The second century church father Clement of Alexandria leads us in this same direction when he states: “The Word of the Father, who made man, cares for the whole nature of His creature; the all-sufficient Physician of humanity, the savior, heals both body and spirit.”¹¹ Clement maintains that “the whole nature of His creature [man]” needs to be healed. Gregory of Nyssa may exceed all of the Greek fathers in his vivid description of the Christian eucharist as medicine for a mortally sickened human nature, a remedy for corruptible death. In his Great Catechism Saint Gregory states:

Those who have been deceived into taking a poison use another drug to counter its harmful effects. Moreover the antidote, just like the poison must enter a man’s system, so that its healing effect may be thereby spread throughout his whole body. Such was our case. We had eaten something that was disintegrating our nature. It follows, therefore, that we were in need of something to restore what had been disintegrated; we needed

an antidote which would enter into us and so by its counteraction undo the harm already introduced into the body by the poison.

And what is the remedy? It is that body which proved mightier than death and became the source of our life. For, as the apostle says, a little yeast makes the whole lump of dough like itself [see 1 Cor 5:6]. In the same way, when the body which God made immortal enters ours, it transforms it entirely and makes it like itself. It is just like mixing poison with something wholesome, where everything in the mixture is rendered as worthless as the poison. Similarly the entry of the immortal body into the body that receives it transforms it in its entirety into its own immortal nature.¹²

If we venture to say that medicine has gained inspiration from the Christian ethos, it is equally true that Christian theology has taken from medicine metaphors that help to identify the mystery of salvation in Christ. These metaphors imprint a value to medicine deep within the Christian imagination. In contrast to the juridical and forensic metaphors that have so often been dominant in Roman Catholicism and Protestantism, Eastern Christian writers

According to Eastern
Christian writers, true faith
brings about an inner
change or cure.

employ medicinal metaphors to explain salvation; true faith brings about an inner change—or cure—that enables persons to pursue perfection. This perfection is no mere moralism. While it includes good works, it is primarily a process of inner transformation and healing of the sinful self. This process is engendered by faith so the person may increase in divine similitude.

ANCIENT CHRISTIAN ANTHROPOLOGY AND MEDICINE

This medicinal interpretation of redemption is rooted in a Christian anthropology that does not make a sharp distinction between body and soul. Rather, the ancient tradition emphasizes that the unity of the two constitutes the whole person. God breathed the breath of life into the man he made from dust, and the man became a living soul.¹³ The body without a soul is a corpse, and the soul without a body is a ghost. Only when they

are perfectly one is the person alive and present.

This notion of the human person as a psychosomatic unity was alien to the Hellenic mind. And my experience in the college classroom and in church parishes leads me to conclude that it is nearly as strange to many modern people, including Christians. Many in the churches embrace the Hellenic dualism that the soul is immortal but the body perishes. My undergraduate students at Loyola College—the vast majority of whom have attended Catholic parochial schools—are surprised to hear that the soul is by nature no more immortal than the body. They have a hard time believing that Christianity defines personal identity as the unity of body and soul.

The earliest Christian creeds boldly insist that the final resurrection is a bodily resurrection. And it is precisely because the ancient church understood that salvation pertains to the whole human being, body and soul as one, that it valued scientific medicine as an important human art, aiding the process of our temporal journey to God. In the fourth century Saint Basil the Great commented at length on the importance of medicine among the other arts and sciences that God uses to help us

sustain our earthly existence and to advance toward our heavenly home. In his Long Rules for monastic living, Basil declares:

Each of the arts is God's gift to us, remedying the deficiencies of nature, as, for example, agriculture, since the produce which the earth bears of itself would not suffice to provide for our needs; the art of weaving, since the use of clothing is necessary for decency's sake, and for protection from the wind; and similarly for the art of building. The same is true, also, of the medical art. In as much as our body is susceptible to various hurts, some attacking from without and some from within by reason of the food we eat, and since the body suffers affliction from both excess and deficiency, the medical art has been vouchsafed us by God, who directs our whole life, as a model for the cure of the soul, to guide us in the removal of what is superfluous and in the addition of what is lacking. Just as we would have no need of the farmer's labor and toil if we were living amid the delights of paradise, so also we would not require the medical art for relief if we were immune to disease, as was the case, by God's gift, at the time of Creation before the Fall.¹⁴

According to Saint Basil, medicine functions within the catastrophic effects of the Fall and is a partial remedy for those effects. Rational or scientific medicine cannot save the human being from death, but it can contribute to a healthy and meaningful life, so long as human beings do not put their whole hope in it. Saint Basil's advice is especially pertinent in our day when so many people mistakenly idolize medicine and expect their physicians to be priests and shamans also. He continues:

So then, we should neither repudiate this art [medicine] altogether nor does it behoove us to repose all our confidence in it; but, just as in practicing the art of agriculture we pray God for fruits, and as we entrust the helm to the pilot in the art of navigation, but implore God that we may end our voyage unharmed by the perils of the sea, so also, when reason allows, we call in the doctor, but we do not leave off hoping in God.¹⁵

HOW EVEN DEATH BECOMES A PRESCRIPTION FOR LIFE

The ancient tradition is able to guard against inflated expectations in the curative power of scientific medicine because it allows for hope even in

death. The Cross and Resurrection have transformed death into a medicine of salvation. Nowhere that I know of in Christian liturgy is this more movingly portrayed than in the central portion of the Armenian funeral ritual performed in the home.

We first encounter a compelling series of penitential and intercessory hymns that are dialogical in character. Both the deceased and the congregation are lent voices. The deceased pleads with God for healing because sin—the infective source of all sickness and of mortality itself—requires supernatural cure even after death. By willing submission to the judgment and mercy of Christ the sins of the deceased may be washed away forever.

When my days are consumed, help me, O Lord, lover of mankind.

You, who have assumed the torments and death on the cross, help me, O Lord, lover of mankind.

Through the intercession of the ever-virgin Holy Mother of God, help me, O Lord, Lover of mankind . . .

As a sinful person, I cry to you, O Heavenly father, help me in my distress, I, who am dead in my sins, help me.

I have been wounded by the invisible enemy, O Healer of the sick, cure

my malady. I, who am dead in my sins, help me.¹⁶

These hymns embrace the entire meaning of salvation, understood both as rescue from danger and healing of the whole person. After several more hymns, a litany, and prayers, the deacon chants Psalms 39:5–6 as the mourners are reminded that they share the fate of the deceased under a common condition of mortality. A reading from Saint Paul's Second Epistle to the Corinthians follows and complements the psalmist's meditation on the brevity of our lives. The Apostle invokes God the Father who is merciful and comforts us in our afflictions so that we may comfort others. He reminds his reader of the Son, Jesus Christ, who has shared in human suffering and by his death and resurrection heals humanity of the sickness and mortality of sin.

Blessed be the God and Father of our Lord Jesus Christ, the father of mercies and God of all comfort, who comforts us in all affliction, so that we may be able to comfort those who are in any affliction, with the comfort with which we ourselves are comforted by God.¹⁷

Medicine needs better patients, and the church can and should help provide them.

These three elements of the Armenian funeral rite, penitential and intercessory hymns, psalm, and Pauline blessing, exemplify the three principal steps of the ancient Christian church's pedagogy of dying well in Christ. The first is to recall our mortality in the light of God's enduring love. The second is to seek meaning in our suffering through the crucifixion and resurrection of Christ. And the third is to envision salvation as cure of sin and healing of body and soul, leading to eternal life. If this simple pedagogy were practiced more often and consistently in the Christian churches, medicine might be infused anew with an ethos of healing and life.

A MODERN STORY OF DEATH AND DYING

Medicine needs better patients, and the church can and should help provide them. In contemporary medical ethics the character of the patient is often

ignored. All too frequently medical ethics is fixed in quandary ethics that focus on the decisions, agency, and acts of the physician. Even when issues of character are taken up, the professional care provider is usually the focus of attention, not the patient. Much good could be accomplished if the church were to attend to the rest of us—who may never be professional care providers but will be patients at some point, at the least when we are dying.

In a recent book, *The Measure of Our Days: New Beginnings at Life's End*, physician Jerome Groopman tells a disturbing story that illustrates the importance of character and internal resources when facing the prospect of personal demise.

Kirk Bains was a highly successful businessman who made a small fortune in speculative investment ventures. Before coming to Dr. Groopman, Bains went to the top cancer treatment hospitals and was told repeatedly that nothing could be done for him. But Bains was a fighter. He told Groopman on their first meeting: "You've seen my records from Yale and Sloan-Kettering . . . They think I'm too sick for their research studies. So you cook up some new magic. Make me a guinea pig, I take risks all the time. That's my business. I won't sue you."¹⁸

Groopman decided to run the standard tests. But he also trusted his intuition, believing that it is at least as important to know the story of the patient as to know clinically what he suffers from. The test results were as grim as the records said. He explained to Bains the difficulty of his case. And the conversation turned in this direction:

"I had hoped it would be a replay of *The Exorcist*," Kirk painfully quipped. "Remember how the priest took the demon out of the child, a bloody, ugly creature? I thought the surgeon would do the same. Maybe I'd have been better off with a priest than a doctor. Never thought I'd need the clergy. But that's what everyone is recommending now."

"Are you affiliated with a church?" I always try to learn the scope of religious feeling, the ties of the patient and his family to faith. God, whether positive, negative, or null, is an essential factor in the equation of dying.

"Episcopalian. I celebrate Christmas. The food. The music. Decorating the tree. Giving gifts. That's fun. But the religion—I can't take much stock in a church founded because Henry VIII wanted a younger wife."

My response was a skeptical look.

"Let me put it in my own terms. I'm not a long-term investor. I like quick returns. I don't believe in working for dividends paid in heaven."¹⁹

Dr. Groopman decided to try a radical and unorthodox combination of treatments. The night before the surgery, Groopman visited Bains in his hospital bed and noticed that he was troubled and agitated:

"Are you thinking you could die tonight? . . . You won't, Kirk," I said confidently.

"So you're a prophet, not a wizard. Shall I call you St. Jerome? . . . I didn't expect to be so afraid, Jerry," Kirk paused, reaching for his thoughts . . . "Maybe it's because I know this is my last chance and I'll probably die, and after death . . . it's just nothingness."

I absorbed his words and tightened my grip on his hand. I now understood why he had insisted on treatment, and I realized it would be wrong to readdress that decision tonight.

"So then it would be the same as before we were born?" I softly replied. "Is that terrifying, to be unborn? That's what my father used to say to

comfort me as a child when I asked him about death."

"See if you still find that enough comfort when you're the one in this bed. Nothingness. No time. No place. No form. I don't ask for heaven. I'd take hell. Just to *be*."²⁰

Kirk Bains's imagination is strong and vivid; and it terrorizes him. The church he neglected or which neglected him might have helped form in him a religious imagination better equipped to cope with the futility of his physical condition. Dr. Groopman himself is aware of the importance of imagination and how it is formed. He comments: "I thought about how we all develop our inner pictures of death and an afterlife, from stories and words we hear as children, which form our first image. As we pass through life, we redraw these images, hoping that at the end we will be prepared for what awaits."²¹

My friend Rev. Charles Kratz, an Episcopal priest, first brought Dr. Groopman's story to my attention. Rev. Kratz commented that he has seen many like Kirk Bains in his fifty-plus years as a priest, and he also knows how miserably his church has failed to address matters of mortality and personal demise in the pulpit or at the

bedside. "I couldn't help thinking," he said, "that we clergy are to blame. Look at what kind of a person and patient we left for this doctor to deal with."

The conversation Dr. Groopman cites constitutes a crucial moment in the life and death of Kirk Bains; he is open to counsel, but Dr. Groopman's father's religious views do not allay Bains's fears or satisfy his needs. Of this scene, Rev. Kratz said, "Maybe something might have been accomplished with the right religious counsel at that moment. But we rarely get to be there at those moments. And by this time, it is almost too late for people like Kirk Bains, short of a divine act of grace."

Dr. Groopman is himself shaken by this conversation with Bains. He spends several paragraphs ruminating over it. He recalls his father's death. And he acknowledges that probably the reason he rarely visits that memory is that it is a nearly unbearable reminder of the personal nature of death.

After he died, it was impossible for me to imagine my father as disintegrated into nothingness . . . It was too painful, too stark an image in my mind, that his body, the warm expan-

sive body that had snuggled me in bed when I was fearing the shadows of the night, held me in the water when I learned to swim, embraced me with surprising strength when I succeeded, and embraced me with even greater strength when I had failed. That that body was now inanimate matter . . . And nothing more . . . I hoped I would not lie terrified in bed, like Kirk.²²

The radical treatment prescribed by Dr. Groopman worked for a time. The tumors shrank, and the cancer went into temporary remission. Kirk Bains was given four months of relatively comfortable living. How did he use this gift? Dr. Groopman stayed in touch with Bains and his wife during this period of time. When the cancer came back, he visited Bains in the hospital after an initial radiation treatment:

"I'm sorry the magic didn't work longer," I finally offered to Kirk.

"It did more than anyone expected, Jerry. But you shouldn't feel sorry. There was no reason to live anyway . . . You read newspapers?" Kirk asked abruptly . . . "I don't read newspapers anymore. I don't know how to. Or why I should," Kirk paused and his voice

lowered. “Newspapers used to be a gold mine for me. They’re filled with what to you looks like disconnected bits of information. A blizzard in the midwest, the immigration debate in California . . . For you, Jerry, those articles are about the lives and fortunes of individuals and nations. For me, they mean nothing beyond information for deals and commodity trading. I never really cared about the world’s events or its people. Not deep down inside . . . And when I went into remission I couldn’t read the papers because my deals and trades seemed pointless. Pointless because I was a short-term investor. Like I told you Jerry, I had no patience for the long term. I had no interest in creating something, not a product in business or a partnership with a person. And now I have no equity. No dividends coming in. Nothing to show in my portfolio,” Kirk grimaced with pain.

“How do you like my great epiphany? No voice of God or holy star but a newspaper left unread in its wrapper . . . Jerry, you realize I’m right. The remission meant nothing because it was too late to relive my life. I once asked for hell. Maybe God made this miracle to have me know what it will feel like.”

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Groopman says he felt “the crushing weight of Kirk’s burden.” He continues pensively, “There is no more awful death than to die with regret, feeling that you have lived a wasted life—death delivering this shattering final sentence on your empty soul.”²³

It’s a terrifying tale of modern death. The story is a challenge, not primarily to medicine, but to the Christian faith. There will always be patients like Kirk Bains who believe in nothing or very little and who come to the medical practitioner with the demand: “Save me! Save me in whatever way you can!” But in the future there may well be increasing numbers of others who will come to physicians with the equally ferocious demand: “If you can’t fix me, then put me out of my misery!”

So much of what constitutes dying a good death depends not on the

health care setting or the medical skills of care providers but the religious and moral resources of the dying. Sr. Sharon Burns, R.S.M., taught theology for many years, but for the past fifteen, she has worked as a chaplain at Stella Maris Hospice in Towson, Maryland. She told me how much it helps if her patients have religious formation, equipping them with beliefs that can carry them through. She says these people can be healed deeply during their dying.

At Stella Maris the stories, symbols, and rituals of the Christian faith are brought to a prominence in the daily routine that secular culture does not permit. Much in the way of penance and forgiveness, reunion and reconciliation can be accomplished in the lives of Stella Maris patients in a relatively brief period of time. Love, too often hindered and sometimes discouraged in more typical health care environments, is given and returned by staff and family. Suffering is not isolated, but shared in a manner that reflects the great pastoral counsel of Saint Paul in 2 Corinthians.

Churches need to more conscientiously prepare people for dying. Indeed, the ancient fathers of the church considered the unremitting

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remembrance of death a principal virtue of Christian life. This is a virtue long neglected in Christian teaching and sorely needed today. "The unremitting remembrance of death is a powerful trainer of body and soul," wrote Saint Hesychios of Sinai. "Vaulting over all that lies between ourselves and death, we should always visualize it, and even the very bed on which we shall breathe our last, and everything connected with it."²⁴ While a secular world might view this as a call to morbidity, Christians should receive this advice in the joyful light of their resurrection faith. Death and resurrection are inevitably and necessarily woven together in the Christian imagination. This pedagogy of the remembrance of death is already present in the liturgies of the church. I mean especially the theology and spirituality communicated through baptism, the Eucharist, and the rites of burial. Thus, for example, near the conclusion of the Byzantine

rite of burial, the mourners are asked specifically to exercise this remembrance of death. "As we gaze on the dead who lieth before us, let us all accept the example of our own last hour."²⁵

Care of the dying has been a deep concern of the church from the earliest centuries, but so too has the preparation of Christians to meet their deaths. Much has been written in the annals of medical ethics about virtues that physicians and health care professionals need in order to care properly for the terminally ill and dying. Yet surprisingly little has been said about the character the church must cultivate in persons so that they make good patients.²⁶ If there is a lesson to be learned from the story of Kirk Bains, it is that medicine cannot cure our mortality. We must be prepared, with courage and hope, to accept that this is true in order to be best served by our physicians. The resources that Christianity has to help people live toward their dying cannot be instantaneously transmitted to the sick person waiting for death. The meaning for living and dying supplied by faith must be claimed over a lifetime.

Physicians have always needed good patients to be good healers. The

situation has not changed in our day and may, in fact, be more necessary than ever before. How else will physicians feel free to shift their goals at the appropriate time, from cure to being present for their patients as death approaches. The physician's most important obligation is to be present throughout for the sick or dying person, to never abandon them. This can only be accomplished successfully if doctor and patient collaborate. As Christian ethicist Stanley Hauerwas wisely said in his book *Suffering Presence*: "It is important, then, that the one who is dying exercise the responsibility to die well. That is, the person should die in a manner that is morally commensurate with the kind of trust that has sustained him or her in life . . . A good death is a death that we prepare for through living because we are able to see that death is but the necessary correlative to a good life."²⁷ Good care for the terminally ill and dying begins with care for the healthy and living. Through the church's own best standards, that care is the fundamental responsibility of the church, not of medicine. By the example of Christ and all the martyrs and saints, it is the responsibility of the church to prepare people to die well, while they are still living, through the

sacraments, prayer, and preaching. If the church and those of us who are its living members could look to this pedagogy and preparation more conscientiously, then we might make a great contribution toward strengthening the humane ethos of medicine. ■

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NOTES

1. John Cheever, "The Death of Justina," in *Stories of John Cheever* (New York: Ballantine Books, 1980), 515.
2. John Paul II, "Evangelium Vitae," *Origins* 24, no. 42 (1995): 689, 691-730.
3. Rom. 7:9, New King James Version.
4. Wisd. of Sol. 2:23-24, New Revised Standard Version.
5. Saint Athanasius on the *Incarnation: The Treatise De Incarnatione Verbi Dei*, trans. A. Religious of C.S.M.V. (Crestwood, N.Y.: St. Vladimir's Seminary Press, 1982), 28-29.
6. *Service Book of the Holy Orthodox-Catholic Apostolic Church*, ed. and trans. Isabel Florence Hapgood (Englewood, N.J.: Antiochian Orthodox Christian Archdiocese, 1975), 386.
7. *Canon for the Burial of Laypersons according to the Sacred Rites of the Armenian Orthodox Church*, trans. Very Rev. Ghevont Samourian, unpublished. However, a portion of this recessional hymn may be found in *The Rituals of the Armenian Apostolic Church* (New York: The Armenian Prelacy, 1992), 145.
8. I am using Georges Florovsky's translation here as it appears in *Creation and Redemption*, vol. 3 of *The Collected Works of Georges Florovsky* (Belmont, Mass.: Nordland Publishing, 1976), 106. This may be found in English translation also in *The Great Catechism*, in *Gregory of Nyssa: Selected Works, A Select Library of Nicene and Post-Nicene Fathers of the Christian Church*, 2d ser., vol. 5 (Grand Rapids, Mich.: Eerdmans, 1979), 483.
9. Florovsky, *Creation and Redemption*, 103-104.
10. Nicholas Cabasilas, *The Life in Christ*, trans. Carmino J. deCatanzaro (Crestwood, N.Y.: St. Vladimir's Seminary Press, 1974), 94.

11. Clement of Alexandria, "The Instructor" in *Fathers of the Second Century, Ante-Nicene Fathers*, vol. 2 (Peabody, Mass.: Hendrickson Publishers, Inc. 1994), 210.
12. Gregory of Nyssa, *Catechetical Oration 37*, in *Documents in Early Christian Thought*, ed. Maurice Wiles and Mark Santer (Cambridge: Cambridge University Press, 1975), 194.
13. Gn. 2:7.
14. Basil of Caesarea, *The Long Rules*, (Question 55) in *Saint Basil: Ascetical Works*, trans. Sr. M. Monica Wagner, C.S.A., *The Fathers of the Church*, vol. 9 (New York: Fathers of the Church, Inc., 1950), 330-31.
15. Basil, *Long Rules*, p. 336 (Question 55).
16. *The Rituals of the Armenian Apostolic Church*, 123-24.
17. Whereas I have abbreviated, the rite includes a reading of the entire text of 2 Cor. 1:3-11.
18. Jerome Groopman, *The Measure of Our Days* (New York: Penguin Books, 1998), 7.
19. *ibid.*, 13-14.
20. *ibid.*, 23-24.
21. *ibid.*, 25.
22. *ibid.*, 25-26.
23. *ibid.*, 35-37.
24. Saint Hesychios, "Watchfulness and Holiness," in *The Philokalia*, vol. 1, trans. and ed. G. E. Palmer, Philip Sherrard, and Kallistos Ware (London: Faber & Faber, 1970), 178.
25. Hapgood, *Service Book*, 390.
26. By "good patient" I do not mean a simply cooperative or compliant patient, as the term has come to mean in common medical parlance. I mean a patient who is formed and habituated in patience, fortitude, and faith, among other virtues valued and invoked in the Christian sacraments.
27. Stanley Hauerwas, *Suffering Presence* (Notre Dame, Ind.: University of Notre Dame Press, 1986), 96-98.

THE CHRISTIAN PASTOR'S ROLE IN MEDICAL ETHICS

BY JOSEPH J. KOTVA JR.

In the Pew and at the Bedside

Since discussions of medical ethics often focus on a case, consider Eve. Eve was a fixture at Christ Church. She married and buried her husband there. She raised her children there. For fifty years she sat in the same pew and joined with fellow members in offering prayers of invocation, thanksgiving, confession, and petition. For fifty years she looked at the stained glass windows of the Good Shepherd, Jesus blessing the children, and the resurrected Christ welcoming all. For fifty years she sang hymns about

God's providential care and listened to countless sermons about God's grace and how we are to respond with faith, hope, trust, and love. For most of those years she read the scriptures with her Sunday School class while facing pictures of Christian martyrs.

At eighty-four years old, Eve elected to have major surgery despite her age and a significant chance that she would not survive the operation. She chose surgery because her heart had become so bad that she could no longer partic-

ipate in the church and family activities that she loved.

Paul, Eve's pastor, visited the night before surgery. They talked about her faithful life and the hope and risks of surgery. Eve responded that God had been good to her and that matters were now in God's hands, as they had always been. They read Psalm 16 together: "Protect me, O God, for in you I take refuge."

Although surgery went well, Eve's recovery did not. She looked and felt good initially. But her heart would not stay in sinus rhythm, her kidneys began to fail, and her lungs filled with fluid. Two weeks after surgery Eve was on a respirator and maximum doses of heart and kidney medications. The doctor told the family that there was some chance that Eve would recover and recommended starting dialysis. The family agreed.

At that point, Pastor Paul, who stayed with Eve and her family throughout the two weeks, intervened. Paul pressed the doctor to explain to the family what "some chance" of recovery meant. The doctor responded that Eve probably had a two or three percent chance of getting significantly better. Although chilled by this news, the family was still inclined to start dialysis.

Paul then gently suggested that continuing treatment seemed inconsistent with Eve's life and with the family's own trust in God.

After prayerful consideration, Eve and her family decided against dialysis and asked for the respirator's removal. Christ Church was filled for Eve's funeral service. The service itself was filled with tears and laughter—the latter celebrating the well-lived life of one who trusted that we are in God's hands.

Unlike typical case studies in medical ethics, Eve's case starts long before and separate from hospitalization and culminates after her death. I begin with this case because it illustrates my contention that for Christians the pastor's relationship to medical ethics extends from the pew to the bedside.

Reflecting the dual focus on pew and bedside, my argument has two distinct sections. The first section does not deal with what first occurs to most of us when we hear someone say "ethics" or "medical ethics"—that is, a forced choice between undesirable alternatives or a violation of moral norms or the principles and procedures we adhere to in making decisions. Instead, the first section directs our attention to concerns that are antecedent to this type of ethics by contending that, for Christians, med-

The pastor's priestly role of representing the faith community's and God's presence to the patient helps limit medicine to its proper authority.

ical ethics is an outgrowth of congregational life. More specifically, I argue that both moral medical decision making and medicine as a morally worthwhile social practice are dependent on preceding theological convictions and qualities of character. I then argue that the pastoral responsibilities of communicating Christian convictions and helping shape Christian character constitute a significant pew-based, that is, congregation-based, relationship to medical ethics.

Many will recognize this first section as an argument for concerns arising from character or virtue ethics. Central to virtue ethics is a shift in the focus of ethical reflection. Since the eighteenth century, moral theory has tended to focus on moral quandaries, rules, principles, and methods for determining the moral status of specific acts. By con-

trast, virtue ethics shifts the focus by concentrating on "background" issues, such as character traits, personal commitments, community traditions, and the conditions for humans to excel and flourish.¹ The first section of this paper argues for this shift in focus. However, instead of an extended technical discussion of virtue theory, I use Eve's case to argue for the importance to medical ethics of background issues, such as convictions and character. And, consequently, I locate much of the pastor's role in medical ethics in the background.

Without losing sight of these background concerns, the second section deals more directly with what most understand when they think of medical ethics. This section discusses the pastor's role at the bedside by sketching interconnected images of ministry: the pastor as priest, theological interpreter, medical translator, prophet, and friend. I use these images to highlight aspects of the pastoral bedside task and to suggest how that task intersects with medical ethics. Thus, for instance, I argue that the pastor's priestly role of representing the faith community's and God's presence to the patient helps limit medicine to its proper authority.

A caveat about the scope of this project is in order. Due largely to my

own social location, this paper addresses how the pastor in the Christian congregation or parish intersects with and informs aspects of medical ethics. How these issues work out for leaders in other faith traditions is not my explicit concern. Further, while some aspects of the second section are applicable to Christian clergy in noncongregation-based ministries—hospital chaplains, for example—I do not directly address these ministries.²

CONGREGATIONAL LIFE

CHRISTIAN CONVICTIONS

In her wonderful book *Stewards of Life*, Sondra Wheeler observes that virtually “every serious decision about the treatment of the sick has theological implications.”³ Wheeler is right. In Eve’s case, for example, the decisions to not start dialysis and to remove the respirator presumed certain theological convictions, including the need to “honor your parents.” Remembering the serenity with which Eve approached this risky surgery, the family realized, with help from the pastor, that continuing to deny death’s approach was to dishonor their mother and her convictions.⁴

The family also shared Eve’s belief that her life was in God’s hands and that death is not the last word. Eve

raised her family in the church. They always attended Good Friday and Easter services. They grew up with that window of the resurrected Jesus and those same pictures of the martyrs. They knew that suffering and death are not the worst evils. With Pastor Paul’s help, they gradually realized that to deny death not only dishonored their mother, it belied their own faith in God.⁵

This contrasts sharply with the physician who recommended dialysis while suggesting that Eve might still recover. It is possible, indeed likely, that the physician made the recommendation in part because he viewed death as the end and final defeat. Although seldom explicit, this view is common in our culture. When death is viewed as the ultimate defeat, fighting death to the bitter end becomes the medical imperative. Thus, when we compare the doctor’s actions to those of Eve and her family, we see that convictions about death that are at heart theological lead to different medical decisions.

Like the decision to forgo dialysis, Eve’s decision to pursue surgery rested on theological convictions, specifically about the purpose of life. As a Christian, Eve viewed life as a good directed to God and others. Life is for relationship to God, worship of God, and serving

God through the church; life is for relating to and caring for others. Yet Eve's health left her unable to participate in church or to join in family activities. Eve cherished life and would never have aimed at her own death.⁶ Her decision for surgery aimed instead at getting well enough to participate more fully in the purposes of life: worship, relationships, service.

End-of-life decisions are not the only ones to rest on theological beliefs. Other examples include abortion and issues of justice. Two years ago, a young woman, still in high school, told me and some of her peers that she was pregnant. Someone soon raised the question of abortion. The young woman responded immediately, "Oh, I couldn't do that." When pressed for a reason, she offered religious convictions; talking about the limits of human freedom and about the unborn being precious to God. Her religious convictions ruled out abortion. So too, when medicine wrestles with questions of justice—such as who gets the transplant or how health care should be distributed—it wrestles with "an area that the prophets and epistle writers persist in viewing as a theological matter."⁷

Medical decisions presume beliefs that are at bottom theological, although

these convictions are often implicit and unconscious. They assume that we are essentially autonomous or interdependent, that life is merely a personal project or necessarily involves vocation and service, that we are embodied selves or merely bodies or trapped in our bodies, that our worth derives from our social contribution or our being-in-relation to God.

To realize this dependence on theological premises is to recognize that, for Christians, medical ethics is an outgrowth of congregational life and pastoral leadership, for it is in our churches that we discuss and learn, or fail to discuss and learn, Christian theology. It was in the church that Eve learned the convictions that led to her surgery and then to forgoing further treatment. Lacking a congregational context like Eve's, or failing to talk explicitly in church about beliefs and their real world implications, Christians slowly adopt assumptions that are often at odds with Christian beliefs.

CHRISTIAN CHARACTER

Although our beliefs are important, moral decision making requires more than mere intellectual assent to certain claims. Determining and doing the right requires our having developed

the appropriate tendencies, dispositions, and capacities; it requires our having developed the requisite virtues. Some examples will clarify what I mean.

Over a lifetime, Eve acquired virtues she drew on in her decision for surgery. We see hope both in her desire for healing and in the serenity with which she approached death. Truthfulness is visible both in Eve's description of her current life, its value and its limits, and in her recognition that surgery might fail.

Contrast Eve with Harold, another member at Christ Church. Harold successfully hid his fifty years of heavy smoking from fellow church members. To those few who knew his secret, Harold insisted that it was a harmless habit. Harold developed serious lung and circulatory problems, but he continued to smoke, claiming that smoking had nothing to do with his "minor" problems. As things progressed, Harold's physician frequently hinted that there was little point in additional treatments or therapies, but Harold could not hear this limit. Indeed, for the last six months of his life, Harold was repeatedly rushed to the hospital, admitted to various treatment and rehabilitation programs, and then sent home again. Harold continued to insist that he was getting better and

Medical decisions presume beliefs that are at bottom theological.

would often note, "I just don't know what is wrong with me."

The difference between Eve and Harold does not rest on their beliefs. They believed the same things. The difference is that those shared beliefs were not rooted in Harold's character in the form of the virtue of truthfulness. Harold never intentionally lied; he simply did not have the ability to look at himself and the world honestly. He lacked the quality of truthfulness. Deficient in this characteristic, Harold never faced his impending death. The result was that instead of getting ready to die, instead of having those important conversations with family, instead of getting his house in order, Harold spent much time and money (private and public) in treatment programs that provided marginal improvement at best.

In the stories of Eve and Harold we see that moral decision making requires well-formed character. It is important to recognize, however, that moral decisions depend on character at multiple levels: our character informs not only how we

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handle the decisions that we confront but also what decisions we confront.

I treat the latter point first. Character significantly influences what we see as choices before us. In Harold's case, character not only informed his decisions, it determined what he encountered as a choice. Harold's inability to be truthful about his impending death meant that he never encountered or viewed treatment as an option that might be declined.

Our virtues and vices enable us to perceive certain choices and incline us to overlook others. A physician or nurse who has internalized a concern for justice will notice when someone is being treated unfairly or when the real underlying question is one of distribution.

Those who lack the virtue of justice are unlikely to recognize when it is at stake.

Similarly, I notice that some nurses quickly sense when a patient does not understand the doctor's explanation of treatment options, while other equally caring nurses never recognize the patient's confusion. The difference, I suspect, is that the former have acquired characteristics and skills—that is, virtues such as patience, sympathy, and the ability of imaginative listening—that enable them to recognize when communication and patient understanding is amiss.

Beyond influencing what decisions we confront, well-formed character is vital to deciding well. Lacking the requisite virtues, we are far less likely to find the right course or to see it through. Consider how vital the virtue of courage is to moral medical decisions. In our litigious age, doctors often need courage to reject unnecessary tests. Lacking courage, the tests will be ordered, perhaps under the guise of thoroughness or patient autonomy. Nurses need courage when deciding whether to approach a doctor who discounts a patient's wishes or when contemplating whether to submit an incident for ethics review. Patients need courage when they consider asking for another opinion or contemplate rejecting their doctor's recommendation.

Moral medical decisions rest on character: character informs both what moral choices we confront and how we decide them. Yet to realize the importance of character is to realize that congregational life and pastoral leadership are related to medical ethics. Church life and pastoral leadership is, or ought to be, eminently concerned with shaping Christian character, for the church is the principle place in which Christians seek to become the kind of people God is calling them to be.

MEDICINE NEEDS THE CHURCH

The argument that medical ethics is, for Christians, an extension of congregational life can be extended to suggest that the practice of medicine needs the church or church-like communities. Stanley Hauerwas claims that what we value about medicine depends on health workers and patients alike belonging to communities like the church.⁸ It is in the church and church-like communities where people acquire the convictions and character necessary to sustain medicine as a morally worthwhile activity.⁹

Consider, for example, the commitment to stay with the sick in the midst of pain, fear, and helplessness, even when we cannot cure or they cannot pay. I take it that most Christians,

perhaps most people in our society, would accept this commitment as one of medicine's central purposes.

Note, however, that this commitment assumes certain convictions and qualities of character: we are essentially social creatures who need each other, and we owe each other care even when it is uncomfortable, financially unprofitable, or risky. This commitment also assumes a host of virtues, including courage, fidelity, and hope. It takes courage not to flee when we are confronted with disease, sickness, and death. And we cannot trust our doctors and nurses to remain with us in crucial moments if they lack fidelity and hope.

The problem is that these convictions and virtues are not supported by the broader culture. Our culture prizes autonomy and freedom above interdependence and obligations. Our culture idolizes effectiveness and the technological control of nature. Ours is an ethos of the marketplace, where skills are commodities to be purchased by autonomous consumers. We Americans share few socially accepted examples of courage—except perhaps the soldier, who may not be the best role model for health workers. Our culture's notion of fidelity is seen in the divorce rate and the preponderance of absentee fathers.

The commitment to remain with the sick assumes convictions and character that are increasingly at odds with this dominant ethos. To the extent that medicine still exhibits this commitment, it exhibits a morality that is out of step with our culture. To the extent that medicine is becoming something less morally worthy, we need look no further than the society shaping the convictions and character of those who practice medicine.

There are, in fact, good reasons to be distressed about medicine's direction. The doctor/patient relationship is starting to look more like a contract than a covenant. Patients increasingly sue physicians for failing to meet their expectations. Hospitals compete over patients, cut staff to improve profit margins, and send people home before they are ready. And, in a great irony, medicine's technologically driven imperative to cure is now being resisted with appeals to autonomy that would force another—the very one we have asked to cure us—to help us die.

Yet, as Stanley Hauerwas and Charles Pinches point out, we should not ascribe

blame to the institution of medicine for our present state of ill health . . . The

simple fact is that we are getting precisely the kind of medicine we deserve. Modern medicine exemplifies a secular social order shaped by mechanistic economic and political arrangements, arrangements that are in turn shaped by the metaphysical presumption that our existence has no purpose other than what we arbitrarily create.¹⁰

The problem with modern medicine is not the institution of medicine itself but the wider society that shapes medicine and its practitioners.

Our society cannot be trusted to form the kind of people necessary to sustain medicine as a morally worthwhile activity. This is why Hauerwas suggests that medicine needs communities, like the church, whose convictions and practices might shape a people capable of morally worthy medicine.¹¹

PASTORAL IMPLICATIONS

This dependence on well-formed people has profound implications for pastoral moral leadership. Pastors help shape the convictions and character of their parishioners and help their congregations become the kind of communities that facilitate the formation of Christian beliefs and virtues.¹² The following discussion illustrates how the pas-

tor facilitates the formation of Christian convictions and character by attending to everyday matters, such as funerals, prayer, and visual images. This discussion also highlights the connection between such formation and medical ethics.

Communicating convictions. To consider the importance of clearly communicating Christian theological convictions and their possible moral implications in medical settings, let us return to Eve's case. Besides the biblical prescription to honor your parents, Eve's case includes the beliefs that (1) God cares about us and can be trusted; (2) death is not the end; and (3) we are created for the purposes of worship, fellowship, and service. These beliefs are not rules or prescriptions for action, nor are they commonly discussed in standard works on medical ethics. Yet Eve's case turned on such obviously theological notions.

Pastors need to be aware that such basic theological convictions do real work in parishioners' lives outside of worship. Knowing this, it behooves pastors to be explicit about what Christians believe and to illustrate how those beliefs function in shaping lives and informing decisions, including medical decisions.

For example, funerals and Ash Wednesday offer opportunities to remind

parishioners that they are made of dust and should be unashamed of their finitude. Christians know that it is fine to be finite, that it is okay to be dust, because God views these earthen vessels as good, and because they commune with a God who breathes life into their clay bodies.

To illustrate how these convictions function in the life of a Christian, the pastor can allude to their implications in end-of-life decisions. Much of modern technological medicine is a denial of our finitude. We pour as much as 80 percent of medical dollars into the last two years of life, because we do not know that the end of life is at hand and because we deny our finitude and the propriety of death. People who know themselves to be divine breath-filled dust do not need to so deny death.

Another example of Christian convictions and their potential medical implications is the apostle Paul's vision of the church as a body.¹³ Pastors can rightly highlight the implications of this image for Christian medical decision making. If Christians are as interdependent as the parts of a body, then they should seek the counsel of other parts of the body when making major medical decisions. So too, in making those decisions, they need to ask whether the contemplated course is

commensurate with building up the body.¹⁴

Shaping character. Pastors must also attend to character formation. Here the issue is broader and subtler than merely explicating Christian beliefs from the pulpit or in Sunday School. Pastors must consider matters as diverse and mundane as prayer, visual images, music, and church potlucks because every choice, experience, and relationship has “some effect—no matter how small—on the person we are in process of becoming.”¹⁵

To illustrate let us again return to Eve’s case. She offered prayers with the same congregation for fifty years. If Eve learned to pray well during those fifty years, if she learned to attend to and wait on God, then in the process she acquired virtues such as humility, patience, and solidarity.

When we pray well we cease to be preoccupied with ourselves and cease to be the center of our own attention. We thereby begin to acquire humility. So too, as we rightly learn prayers of confession, we learn to own our limitations, failures, and rebellion. And as we learn to pray prayers of petition, we are reminded of our needs and our dependence on God and others. Humility is therefore a virtue of prayer. In learning

to pray rightly—learning to attend to God, learning to confess and petition properly—we also grow in humility.

Humility is also essential to moral medicine. Humility is part of what enables physicians to recognize their limits and part of what prevents them from taking advantage of vulnerable patients. Humility enables patients to recognize honest, human mistakes by doctors and nurses for what they are: the normal consequences of well-intentioned but limited people endeavoring to offer care. Lacking humility, patients will sue for any perceived mistake or failure, irrespective of genuine incompetence or negligence. Finally, patients require humility to open their bodies to strangers and to grant these caregivers invasive authority. When patients lack humility, medicine loses its authority and starts to look like one commodity among others from which we may pick and choose.

Other prayer-formed, medically relevant virtues include patience and solidarity. As Michael Duffey notes, prayer teaches the prayerful to wait:

Prayer is the suspension of time and the adoption of a patient and quiet heart in order that we might be led into deeper communion with God. Praying requires stepping out of the current

of activities in which we are caught up . . . Prayer is first of all the intention to create an opening, a space where we might wait for the stirrings of God.¹⁶

Learning to pray thus means learning to wait, learning patience.

Prayer also teaches solidarity. This is seen in the Lord's Prayer, where Christians are taught: pray to *our* Father, ask for *our* daily bread, and seek forgiveness for *our* debts. Solidarity is also learned in intercessory prayers, where one presents another's need to God.

Morally worthy medicine also needs these virtues. It is difficult to imagine how one could be a good doctor, patient, or nurse, without patience. How can we remain with each other in our sickness if we have not learned to wait? Similarly, how can medicine expect to stand with those who cannot pay or cannot be cured unless health workers have acquired a deep sense of solidarity with those whom they serve?

Prayer is thus relevant to medical ethics. It is also an issue of pastoral leadership, for Christians learn how to pray from and with others in the church. They learn how to pray as they stand in the liturgy and pray prayers of invocation, confession, petition, and so on; as the Psalms are read aloud and as the

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congregation recites the Our Father; as prayer is modeled by teachers, friends, and those viewed as saints. They learn to pray as others teach them how.¹⁷

Congregational life involves many other character shaping practices besides prayer, for example, viewing the windows of Jesus and pictures of Christian martyrs. Such images have power to shape. They provide pictures of the ends and purposes of life, present role models to be emulated, and "create assumptions about how the world really is."¹⁸ Routinely viewing pictures of martyrs would lead one to expect suffering as part of faithful Christian existence. The image of Jesus the Good Shepherd could affirm one's self-worth, while the image of the resurrected Christ might make one less anxious about death.

This ability to shape is relevant to medical ethics. One who expects suffer-

ing is likely to respond differently to end-of-life decisions than is one who views suffering as an evil to be avoided at all costs.¹⁹ The person who has learned his or her self-worth is less likely to be bullied into or out of medical procedures. And Eve is a perfect example of what happens when death is less feared.²⁰

Prayer and images are only two aspects of congregational life that bear character shaping implications. Nevertheless, it should already be clear that pastoral moral leadership requires attention to mundane, everyday matters. There is nothing earthshaking about prayer and pictures of martyrs. Such matters present no obvious dilemmas or conflicts. Indeed, they are so mundane that they usually escape our attention. Yet, it is in and through them that Christians become, or fail to become, the kind of people they should be. Thus, pastoral moral leadership includes such seemingly insignificant matters as helping parishioners learn to pray well, evaluating the images to which they are exposed, testing whether music cultivates emotions and desires befitting Christians, asking whether potlucks encourage Christian friendships, exploring how the Lord's Supper might train the believer in community and forgiveness, and so on.

These everyday pastoral concerns are indirectly relevant to medical ethics. Patients, nurses, and doctors will confront the right questions, choose the right answers, and engage in the right actions only if they are rightly formed. Moreover, medicine's moral value as an expression of solidarity with the sick depends on character-shaping communities whose ethos is at odds with our culture's.

Pastor's role. In short, the pastor's role in medical ethics is neither cursory nor centered at the bedside, and it has surprisingly little to do with medical moral dilemmas or the four standard principles of medical ethics. The focal point of the pastor's relationship to medical ethics is the pew: pastors help or fail to help parishioners acquire the requisite convictions and character.

This conclusion does not mean that pastors should spend an enormous amount of time thinking about medicine's requirements. The foremost reason for teaching Christian convictions is not that medicine needs them, but that we believe them to be true and relevant to our whole lives. Likewise, serving medicine is not the primary reason for cultivating Christian character; the primary reason is that God calls and enables us to become a certain kind of people.

Nevertheless, pastors must remain cognizant of medicine. As any active pastor or priest can attest, medicine suffuses the lives of parishioners. Indeed, institutionalized medicine seems to have become more culturally powerful and “pervasive in our lives than the church ever was and surely far more powerful than it is today.”²¹ Since Christians cannot and should not avoid medicine, they need to help each other acquire the convictions and character required to meet medicine as Christians.

Medicine pervades the lives of parishioners—whether as patients, families of patients, or health workers. Pastors do not teach and seek to cultivate character because of medicine, but since virtually all North American Christians confront Western medicine and medical decisions, pastors must ask whether church teaching and practices equip parishioners to morally navigate contemporary medicine well.

Pastors can, for instance, ask whether they sufficiently teach Christian convictions about the purposes and nature of life, and they can use medical examples to illustrate the repercussions of such convictions. Pastors can similarly ask whether the congregation provides sufficient opportunities to grow in patience, humility, solidarity, and so on.

So too, when privileged to stand with a patient like Eve, the pastor can ask what convictions and practices enabled her to make the choices she did. When standing with a patient like Harold, the pastor can ask how the congregation may have failed to help Harold become more truthful.

AT THE BEDSIDE

Although the pastor’s greatest contribution to medical ethics is in the pew, Eve’s case reminds us that pastors also play an important role at the bedside. Pastor Paul read scripture with Eve the night before surgery, visited her and her family throughout the ordeal, and intervened in the family’s discernment process. This extensive involvement is common when parishioners know and trust their pastors. I unpack this involvement at the bedside by using a series of partial, interconnected images of ministry: priest, theological interpreter, medical translator, prophet, and friend.²²

PRIEST

Perhaps the central dimension of the pastor’s role at the bedside is that of priest.²³ This dimension is not limited to churches with formal liturgies or an officially sanctioned priesthood. Even in less formal traditions, such as Baptist or Mennonite, the pastor’s presence has a sym-

bolic and ritual function. Specifically, the pastor represents the church community and often represents God's own loving and faithful presence.²⁴ As many pastors can attest, parishioners often view the church as virtually absent—irrespective of how many congregational members visit—until the pastor appears. Yet when the pastor makes himself or herself readily available, those same parishioners see the church as overwhelmingly present. Moreover, the extraordinary comfort that many find in unhurried pastoral visits is understandable once we grant that those visits symbolize God's own presence.

This priestly function includes the rituals of prayer, scripture reading, confession, and Communion. Pastors offer prayers of invocation, gratitude, and intercession; they sometimes also offer prayers that voice the feelings, thoughts, and fears that patients themselves dare not express. Such prayers console and often strengthen the patient's resolve to cling to God. Sometimes they even bridge the chasm that patients sense between themselves and a seemingly distant God. Similarly, the pastor's reading of Scripture allows patients to affirm the faith that they share with the biblical writers and to listen to God's Word for comfort and encouragement.²⁵ Although many would not call it "confession," patients often

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acknowledge their sins in the pastor's presence. In these moments, the "priest" is especially evident: the pastor both verbally expresses God's promise of forgiveness and physically demonstrates the patient's reconciliation to God and the church by remaining present.²⁶ In many traditions, the patient's participation in Communion is a comparably powerful reminder of God's love and presence in the midst of suffering.

Pastors fulfill this priestly function to serve God, not to serve medicine. But this dimension of the pastor's role does affect medical ethics. Minimally, Christian patients will make more consistently Christian decisions when they experience their faith community's support and know themselves reconciled to God. It is easier to calmly and honestly face uncertain or even life-threatening decisions when we know that we are not alone.

This priestly function serves another task vital to medical ethics; it helps to counteract medicine's excessive authority. In our day, medicine and psychology provide the major metaphors for healing, and laity often heed medical advice "with the kind of deference given religious disciplines in earlier centuries."²⁷ My personal experience is that many parishioners, especially older ones, obediently accept "doctor's orders" without questioning or understanding those orders. This excessive authority is visible in Eve's case: Eve's family initially accepted without question the physician's recommendation to start dialysis and still inclined to dialysis even after hearing that Eve's chance of recovery was slim. This reaction reflects their unquestioning acceptance of the physician's authority. If they were looking for a medical miracle, then it also reflects medicine's hegemonic control of healing metaphors. The pastor's priestly function helps curb this immense authority. By symbolically representing God's presence, calling in prayer on the one true redeeming God, and reading passages wherein God through Christ is healer, the pastor helps the patient take medicine and his or her doctor a little less seriously.

H. Phil Gross, a retired orthopedic surgeon and professed Christian, writes that he only prayed silently for himself and his patients. The major reason for not praying aloud, he says, is that such prayer can be construed as a lack of authority and confidence.²⁸ I believe that Dr. Gross was wrong never to pray aloud, but he was right about prayer's ability to rein in a physician's authority. As Allen Verhey points out,

One cannot invoke the one true God and take a presumptuous medicine too seriously . . . When we invoke God as redeemer, we are freed from the vanity and illusion of wielding human power to defeat mortality or to eliminate the human vulnerability to suffering. An honest prayer could . . . restore a modest medicine to its rightful place alongside other measures that protect and promote life and health.²⁹

I concur with Verhey. Prayer's ability to restrain medicine's authority is enhanced when combined with the pastor's priestly representative function.

THEOLOGICAL INTERPRETER

The pastor's task as theological interpreter includes two related elements: helping patients search for theo-

logical meaning and helping patients properly understand their traditions. Regarding the former point, hospitalization often occasions a search for meaning. Whether faced with a life-threatening procedure or merely with the strangeness and inconvenience of hospitalization, many ask questions of meaning. Am I being punished? Do I somehow deserve this suffering? Where is God in this? What am I to learn from this experience?

The pastor can gently guide the parishioner in this search for meaning.³⁰ This guidance takes various forms. Pastors can point out appropriate scriptures or discuss the role of suffering in the life of a disciple or ask what it means to believe in a God who suffers. Pastors can also suggest worthy lessons that can be learned from the experience. For example, I suggested to a parishioner that her frequent but not serious hospital stays were an occasion for her to grow in patience—a virtue she recognized was not well developed in her life. So too, pastors can sometimes legitimately suggest that a parishioner view his or her illness as an opportunity for growth in humility, trust, or hope.

In guiding the search for meaning, pastors must sometimes challenge a patient's theological assumptions. If a

parishioner assumes too simple a connection between sin and suffering, for instance, then the pastor may need to challenge this linkage—perhaps by pointing to Job or to Jesus' explicit rejection of a simple correlation between sin and suffering or to Jesus' own innocent death. Of course, the pastoral goal in pointing to Job and Jesus is not merely to challenge assumptions but to offer a more profound engagement with suffering—that is, an invitation to wrestle with the meaning of suffering and to cling to God's presence, even when such meaning eludes us.

In addition to guiding the search for meaning, the pastor also helps the patient or family properly understand their tradition. Faithful adherents of a tradition often misconstrue its beliefs or implications. Consider as examples the cases offered by Don Browning and William O'Brien.

Browning's case is that of "Margaret and the Will of God." Browning notes that Margaret and her family held "to a rigid version of Reformed Christianity . . . in which all life's fortunes, good or bad, were regarded as the direct will of God." Browning says that these beliefs were not "just idle chatter. Margaret did not comply well with even the simple routines of her everyday care."³¹

After all, why should she? If God decides that she will be sick, then she will be sick. And if God decides that she should get better, then she will get better.

For our purposes, it is the chaplain's response that makes this case noteworthy. The chaplain acknowledged God's providential governance, but challenged Margaret's understanding of that rule by using scriptural arguments to show that God's providence does not mean that God wills particular sicknesses. Instead, argued the chaplain, God's providence is such that we can strive with it toward health. The chaplain must have been caring in his conversation and skillful in his use of scripture, for the effect on Margaret was profound. Her attitude and behavior changed; she started to cooperate with her treatment.

O'Brien's case concerns sixty-five-year-old Thelma.³² Thelma was ventilator dependent. Thelma had a large, growing, inoperable tumor in her face and sinus cavity. She had a history of pulmonary embolism, heart disease, asthma, lupus, and diabetes. Thelma was lucid, but she grew understandably frustrated and asked for the ventilator's removal.

Thelma's request sounds unremarkable, given the circumstances. But

Pastors can . . . legitimately suggest that a parishioner view his or her illness as an opportunity for growth in humility, trust, or hope.

Thelma and her loving family were devoted Catholics who worried that withdrawal, and the resulting death, amounted to suicide or euthanasia. They feared that Thelma's death would leave her rejected by God and by her church. Thelma's family had cared for her the past eight years and was willing to continue that care. They strongly resisted Thelma's request.

As a Catholic priest, Father O'Brien helped Thelma and her family move toward a more accurate understanding of their shared tradition. By clarifying the distinction between "killing" and "letting die," O'Brien helped them to see that, from a Catholic perspective, Thelma was neither committing suicide nor asking for euthanasia. Thelma was instead asking to be allowed to die. Once relieved of their fears about suicide, the family, guided by Father O'Brien, directed their energy toward caring for and assuring each other.

We see the theological interpreter at work in both Browning's and O'Brien's cases. The chaplain helped Margaret and her family come to a more classic expression of their Calvinist faith. O'Brien helped Thelma and her family move toward a fuller and more accurate understanding of Church teaching. In both cases, the person responsible for pastoral care did more than help an individual in her private search for meaning. Accepting the authority of their respective traditions, the pastors directed patients and their families toward more complete understandings of those traditions.

As with the priestly image, pastors do not fulfill their function as theological interpreters to serve medical ethics. If they fulfill this function well, they serve God and their parishioners, and they do so in the belief that the theological claims are true. Nevertheless, this aspect of the pastor's role is relevant for medical ethics. The pastor as theological interpreter is primarily concerned with beliefs and convictions, although the search for meaning sometimes also includes character growth. But as we saw earlier, convictions and character matter to medical ethics.

The moral implications of the interpretive function are obvious in the

cases discussed by Browning and O'Brien. Margaret's care and Thelma's death hinged on their gaining better understanding of their respective theological heritages. Without this understanding, Margaret had no reason to comply with her treatments and Thelma's family had every reason to resist her decision.

Note too that the standard principles of medical ethics—such as the principles of autonomy and beneficence—could not substitute for this interpretive function. Granting Margaret's autonomy or talking about beneficence does nothing to address her lack of self-care.³³ Indeed, the lack of self-care could be claimed as an autonomous right. Even worse, to emphasize Thelma's autonomy would disregard the moral claims that her family rightly makes on her. As a good Catholic, Thelma may not make her decision in isolation. Her faith and her family have a voice that she is morally obligated to hear. Unlike a generic appeal to autonomy, Father O'Brien recognized these moral connections. He also recognized that Thelma and her family were misunderstanding their faith. Attending to either the principle of autonomy or the pastor's interpretive function might have arrived in Thelma's case at the same physical action—

removing the respirator. The latter, however, honored Thelma's existing moral commitments in a way that the former could not.

TRANSLATOR

The pastor's role at the bedside also includes translation, where he or she works toward mutual understanding between all parties, including the patient, family, and hospital staff.³⁴ As translator, the pastor helps patients and their families "hear" each other, asks questions of medical personnel that patients and families find difficult to voice, and ensures that patients and their families understand what they are being told about tests or treatment options.³⁵

Pastor Paul acted as a translator, as an agent of communication, when he pressed the doctor to explain Eve's chance of recovery. Suspecting that relevant information was being left out, Paul asked the doctor a question that the family could not bring themselves to ask.

The chaplain in Browning's case also acted as translator. Margaret was hospitalized with severe kidney problems when dialysis was still scarce and kidney transplantation was new. Seeing Margaret's lack of self-care, the hos-

pital committee charged with determining her course of treatment concluded that she lacked the intelligence and background to follow the routines and procedures that would make such treatments effective. The chaplain objected to this conclusion. He realized that Margaret's behavior, which was perfectly consistent with her world view, was being interpreted by the committee as a lack of intelligence. The chaplain argued that what the committee saw as signs of mental deficiency were actually signs that Margaret looked at the world differently. Thus, besides helping Margaret reinterpret her tradition, the chaplain acted as translator by helping the committee to understand Margaret's view of God's providence.³⁶

Facilitating open communication is a task shared with others in the health care setting, including nurses, social workers, and ethics consultants.³⁷ People in these roles are often positioned to recognize breaks in communication and understanding. Nevertheless, there are several reasons that pastors are especially well situated to this task.

First, there is a good chance that the pastor and the patient already know and trust each other. In contrast, the patient experiences the hospital as a virtual "universe of strangers."³⁸ Amid

those strangers, the pastor offers an established relationship of trust in which the patient may explicitly or implicitly confess questions and concerns that he or she would not otherwise admit. Moreover, because the pastor knows the patient as a real person outside the hospital, the pastor may notice when the patient's care, mannerisms, or decisions seem unbecoming his or her identity.

Second, it is socially acceptable to acknowledge need and express vulnerability to a minister. There is a social stigma attached to admitting need; yet, many who would never admit need or questions to a doctor, nurse, social worker, or ethics consultant are free to talk to their pastor.

Third, the pastor and parishioner operate out of the same world view. They share beliefs and convictions that health workers may not share. As Browning's case suggests, understanding each other's convictions is no small matter. Behavior or wishes that seem odd to hospital staff may be perfectly comprehensible to one who shares the patient's world view.³⁹

To fulfill this function of translator well, the pastor must cultivate a climate of trust, security, and openness to human vulnerability. The pastor also must exhibit a basic familiarity with the

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clinical and moral language used in the hospital setting. For example, it helps to know the difference between a nasogastric and a PEG tube. It helps to know what a respirator does or how violent—and often futile—resuscitation is. It helps to know what is meant by DNR (do not resuscitate) or PVS (persistent vegetative state) or EEG (electroencephalogram). Pastors do not need a technical understanding about such matters, but a modest level of understanding is essential if they are to help bridge communication gaps.⁴⁰

Similarly, pastors need a basic working knowledge of matters such as living wills, health care proxies, informed consent, and the four principles of bioethics: autonomy, nonmaleficence, beneficence, and justice. As translators, pastors take these notions and relate them to language and convictions that are more natural for their Christian parishioners. Conversely, pastors sometimes need (as best as possible)

to translate patient and family concerns into the moral language of modern medicine.

PROPHET

In invoking the image of prophet, I suggest two aspects of the pastor's role at the bedside: (1) challenging parishioners to live and die in a way consistent with what they profess, and (2) explicitly advocating for patients whose voices are ignored or drowned out.

Pastor Paul acted as prophet when he gently suggested to Eve's family that continuing treatment was not in keeping with their trust in God. Paul's gentle suggestion reminds us that being a prophet at the bedside does not require harsh, caustic, or demanding speech. The words may be gentle, the tone quiet. What is required is hard honesty about making decisions that are faithful to what one believes. Pastor Paul exhibited this honesty in Eve's case.

Such hard honesty is conspicuously absent, however, from Harold's case. Harold lived and died his last few months in a way that belied his faith in God. Harold never admitted the harmful effects of his addiction or that he was dying. Perhaps the pastor should have been more prophetic in Harold's case. Perhaps he should have reminded

Harold that Christians need not deny their sinfulness or their mortality. Perhaps what Harold needed was a soft but clear word from his pastor: "Harold, you are dying. Spend your time with your family. Spend your time getting things in order."

Being a bedside prophet also means advocating for the patient whose voice is unheard. The chaplain in Browning's case not only translated Margaret's world view, he championed her cause. The chaplain challenged the committee's conclusion that Margaret lacked the mental resources for treatment. He also challenged their assumption that perceived intellectual capacity should determine treatment: "He argued that Margaret was a human being and for that reason alone was deserving of treatment."⁴¹

Pastors should not underestimate the need for prophetic patient advocates. Institutional medicine is still basically benevolent, but the cultural and economic forces shaping a different, less caring kind of medicine are strong. Pastors need to watch out for patients who are poor and for patients who lack family as advocates.

I pastor a small urban church, and my parishioners go to any of four local hospitals. I see much good care at these

hospitals. But in the last few years I have also seen: the grossly inadequate pain management of an elderly person afraid to complain; the discharge to an unsupervised apartment of a scared, elderly, confused woman who was both incontinent and unable to walk; the failure to determine proper medication levels before discharge, resulting in multiple readmissions; nursing assistants who repeatedly failed to close the door, pull the curtain, or cover an unconscious, naked patient; technicians and support personnel who allow patients to believe that they are trained nurses; physicians who do not present patients with all their treatment options; and doctors and families who ignore a patient's advance directives.

The patients in these instances were unable to advocate for themselves and lacked family to advocate for them. With the current cultural and economic pressures on medicine, pastors will need to fulfill their prophetic function in part by becoming patient advocates.

This prophetic function at the bedside may, of course, inform the pastor's prophetic role beyond the hospital walls. Many difficulties confronted within the hospital are systemic. The second-rate or shortened care a patient receives often has more to do with limited or

absent health insurance or a health maintenance organization's focus on the bottom line than it does with the particular doctors and nurses involved. Nurse or physician error is often ultimately rooted in hospital organization, not health worker incompetence. So too, patient care is directly influenced by the exorbitant cost of medications and indirectly influenced by the way drugs are marketed to physicians and public alike. I believe that when such systemic issues emerge in the pastor's advocacy at the bedside, they should inform aspects of the pastor's prophetic task outside the patient's room, outside the hospital walls. These experiences within the hospital could prompt us, for instance, to ask how the church should voice its concerns within public debates about universal health coverage, error reporting, Medicare, drug costs, and so on.

The reach of the pastor's prophetic task beyond the bedside is a reminder that the direction of influence is not unidirectional. What happens at the bedside also informs our activity within the congregation and in "the world."

FRIEND

Sometimes pastors are fortunate enough to have their parishioners also

become their friends. I do not mean that they pal around together or that it is a peer relationship. Rather, I refer to that deep connection between people who share common values and goals, who have come to know, respect, and trust each other, and who desire each other's well-being.

This image of friendship hints at moral aspects of care at the bedside that do not easily fit within the other images. Consider, for instance, what it means for a friend to visit, or hold your hand, or cry with you. Friends do not visit out of duty or obligation or because they fill a specific social role. Friends visit because they care about you—with all your particular needs, wants, commitments, experiences, and idiosyncrasies. Friends visit because they prize what you bring to the relationship.

There is something deeply affirming and solidifying about a visit from a friend that is not encompassed by the images of priest, interpreter, translator and prophet. When the pastor is lucky enough to be a friend, the visit involves mutual care, even though it is more focused on the patient. When the pastor is a friend, the patient is affirmed as an utterly unique individual who knows that he or she has received and given more than a priestly visit.

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Relatedly, friends listen. Careful, empathetic, and imaginative listening skills are also vital to the pastoral dimensions of interpreter and translator, but good friends listen in a way that is not entirely captured by those images. Good friends often understand what we mean even though our words are not carefully chosen. Friends are frequently the best at understanding what we mean, not what we say. Conversely, friends are sometimes called upon to listen even when they do not understand what we mean or what we are talking about. At such times, what is important is not the understanding but the personal affirmation implied by the act of listening. Indeed, sometimes we need our friends to listen even when we are not speaking at all.

Friends are also those whom we are most likely to invite into our moral

discernment. Pastors are often involved in a patient's moral deliberation, but that involvement is most profound when the pastor is a friend. In deliberating with true friends, we do not need to ask about what some abstract rational person would do. When deliberating with friends, we are not even limited to asking what a believing Christian should do. When friends discern together they ask a different question: "What should you—my friend, an individual whom I value, a person with a unique story—do?"

CONCLUSION

The Christian pastor's relationship to medical ethics extends from the pew to the bedside. It starts in the pew, for it is in the church that we acquire the convictions and character vital both to deciding well and to sustaining medicine as a praiseworthy practice. It extends to the bedside since pastors are, or sometimes become, priests, interpreters, translators, prophets, and friends. ■

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NOTES

1. See also Joseph J. Kotva Jr., *The Christian Case for Virtue Ethics* (Washington, D.C.: Georgetown University Press, 1996), 5.
2. For my reflections on hospital chaplaincy, see: "Hospital Chaplaincy as Agapeic Intervention," *Christian Bioethics* (December 1999): 257–275.
3. Sondra Ely Wheeler, *Stewards of Life: Bioethics and Pastoral Care* (Nashville: Abingdon Press, 1996), 14.
4. Honoring a parent is very different from acknowledging another's autonomy. Honoring parents is an intrinsically relational notion that presumes interdependence and responsibility. By contrast, autonomy is an individualistic notion that leaves us responsible only to accept another's autonomous wishes.
5. See also Allen D. Verhey, *The Practices of Piety and the Practice of Medicine: Prayer, Scripture, and Medical Ethics* (Grand Rapids: Calvin College and Seminary, 1992), 59–60.
6. For the importance of this distinction, see Joseph Kotva, "A View from Two Sides: The Principle and its Cases," *Christian Bioethics* 3/2 (1997):158–172, especially 167–171.
7. Wheeler, *Stewards of Life*, 14.
8. Stanley Hauerwas, *Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped, and the Church* (Notre Dame, Ind.: University of Notre Dame Press, 1986), 14, 75–82; see also, Allen Verhey and Stephen E. Lammers, *Theological Voices in Medical Ethics* (Grand Rapids: Wm. B. Eerdmans, 1993), 67.
9. To be fair to Hauerwas, his claim focuses more on character than convictions. Indeed, Hauerwas says that he does not believe that "medicine necessarily requires theological presuppositions in order to subsist" (*Suffering Presence*, 14,

- also 75). What Hauerwas means by this, however, is unclear. His central claim is that “medicine needs the church not to supply a foundation for its moral commitments, but rather as a resource of the habits and practices necessary to sustain care of those in pain over the long haul.” Nevertheless, in the same paragraph, Hauerwas admits that believing that we can and should be present with the sick “entails a belief in a presence in and beyond this world” (*Suffering Presence*, 81). Similarly, Hauerwas’s final comment is that we cannot count on the values necessary to medicine “being transmitted without a group of people who believe in and live trusting in God’s unfailing presence” (*Suffering Presence*, 82). Medicine therefore appears to need the church as a character forming community whose convictions have taken root in the community’s common life and practices.
10. Stanley Hauerwas and Charles Pinches, *Christians Among the Virtues: Theological Conversations with Ancient and Modern Ethics* (Notre Dame: University of Notre Dame Press, 1997), 170.
 11. That institutionalized medicine is shaped by the larger ethos is also why authors such as Hauerwas and Allen Verhey question whether the vision of medicine as a caring presence is still sustainable in our culture, e.g., Verhey, *Practices of Piety*, 62; Hauerwas and Pinches, *Christians Among the Virtues*, 217 no. 31.
 12. Joseph Kotva, “The Formation of Pastors, Parishioners, and Problems: A Virtue Reframing of Clergy Ethics,” *The Annual of the Society of Christian Ethics* 17 (1997): 271–90, especially, 283–386.
 13. 1 Cor. 10:17; 12:12–31; Rom. 12:4–5, New Revised Standard Version.
 14. E.g., 1 Cor. 8:1ff; 10:23ff; 12:7; 14:12, 26, NRSV.
 15. David L. Norton, “Moral Minimalism,” in *Midwest Studies in Philosophy XIII Ethics Theory: Character and Virtue*, ed. Peter A. French, Theodore E. Uehling, and Howard K. Wettstein (Notre Dame, Ind.: University of Notre Dame Press, 1988), 186.
 16. Michael K. Duffey, *Be Blessed in What You Do: The Unity of Christian Ethics and Spirituality* (New York: Paulist Press, 1988), 38.
 17. I am not suggesting that we learn to pray in order to become better people. Prayer is about attending to God, and if we engage in prayer for some other purpose than waiting on God, it quickly ceases to be prayer. Nevertheless, learning to pray well shapes character. And if character is left unchanged by prayer, we should ask about the quality of our prayers.
 18. Michael Warren, “The Material Conditions of Our Seeing and Perceiving: Religious Implications of the Power of Images,” *New Theology Review* 7, no. 2 (May 1994): 45; see also Gregor Goethals, “TV’s Iconic Imagery in a Secular Society,” *New Theology Review* 6, no. 1 (February 1993): 40–53.
 19. See also Wheeler, *Stewards of Life*, 32–35.
 20. The power of images to shape us is not lost on corporate America. Their willingness to spend millions of dollars on beer, toothpaste, and truck commercials only makes sense if images shape behavior. Corporations spend this money because they know that images inform our desires and that people copy what they see. They spend this money because they know that we will buy their products if we envision the purpose of life in the back of a pickup, with our teeth white and a beer in one hand. Wall Street does not underestimate the power of images; neither should we.
 21. Hauerwas and Pinches, *Christians Among the Virtues*, 168; see also Bonnie J. Miller-McLemore, “Thinking Theologically About Modern Medicine,” *Journal of Religion and Health* 30, no. 4 (Winter 1991): 289.

22. I chose these particular images to organize the following discussion and call our attention to specific aspects of the pastor's bedside task. The images are helpful on both counts, but I make no theological or biblical claim for these particular images beyond these simple objectives. Moreover, I doubt that the images chosen here provide a comprehensive picture of ministry at the bedside, let alone a full picture of pastoral ministry in its entirety. Others may choose different images with equal effectiveness.
23. See also Richard Bondi, *Leading God's People: Ethics for the Practice of Ministry* (Nashville: Abingdon Press, 1989), 38-40.
24. Richard M. Gula, *Ethics in Pastoral Ministry* (New York: Paulist Press, 1996), 12, 57, 60, 71-73; Kent D. Richmond and David L. Middleton, *The Pastor and the Patient: A Practical Guidebook for Hospital Visitation* (Nashville: Abingdon Press, 1992), 16, 21, 26; Wheeler, *Stewards of Life*, 111-112.
25. See also Richmond and Middleton, *The Pastor and the Patient*, 101.
26. Richmond and Middleton, *The Pastor and the Patient*, 98.
27. Miller-McLemore, "Thinking Theologically About Modern Medicine," 289.
28. H. Phil Gross, "Is It Appropriate to Pray in the Operating Room?" *The Journal of Clinical Ethics* 6, no. 3 (Fall 1995): 273-74.
29. Verhey, *The Practices of Piety*, 22.
30. Richmond and Middleton, *The Pastor and the Patient*, 27, 41, 48.
31. Don S. Browning, "Hospital Chaplaincy as Public Ministry," *Second Opinion* 1 (March 1986): 69.
32. William J. O'Brien III, "Dialogue Between Faith and Science: The Role of the Hospital Chaplain," *The Journal of Clinical Ethics* 6, no. 3 (Fall 1995): 280-84.
33. Aspects of the theological interpreter role undoubtedly fall within the broad principle of beneficence as a role-specific obligation for clergy. However, discussion of the principle does not automatically alert us to the need for a theological interpreter nor does the principle by itself provide the skills of communication, imagination, theological knowledge, and situation-specific perception necessary to the interpretive role.
34. For this section, see Wheeler, *Stewards of Life*, 97-101.
35. Richmond and Middleton, *The Pastor and the Patient*, 67.
36. Browning, "Hospital Chaplaincy as Public Ministry," 69, 71-72.
37. E.g., Joseph J. Fins, "A Secular Chaplaincy," *Journal of Religion and Health* 33, no. 4 (Winter 1994): 373-75; Wheeler, *Stewards of Life*, 100.
38. Wheeler, *Stewards of Life*, 100.
39. See also Deborah Whisnand, "An Enhanced Methodology for Conflicts in Ethics Consultation," *Clinical Ethics Report* 9, no. 4 (Winter 1995): 7.
40. Nurses in the congregation are an excellent resource for such pastoral self-education.
41. Browning, "Hospital Chaplaincy as Public Ministry," 73.

INTEGRATING SPIRITUALITY INTO HEALTH CARE

BY JOHN SHEA

Adaptive Challenges and Spiritual Paths

The current discussions of how spirituality fits within health care can be grouped into different yet related conversations. There are conversations about the spiritual needs of people when they become patients, about how medical caregivers are becoming professionally interested in patient spirituality, and about medical caregivers' interest in their own spirituality. There is a conversation among chaplains about how an emphasis on spirituality influences who they are and what they

do, one within organizations about the spirituality of leaders and employees in faith-based health care, and finally a conversation on how spirituality and ethics interact on medical and organizational levels.¹

The medical and organizational conversations are the most heated and the most visible. The give-and-take of these conversations is not limited only to professionals in health care, but on occasion includes contributions from the larger population. There are strong

opinions on these issues, and these conversations are by no means over.

The medical conversation begins with questions of how to evaluate the recent research into the relationship between religiousness/spirituality and mental and physical health. Many studies show that spirituality/religiousness has positive effects on mental and physical health and is influential in both preventing and coping with illness.² However, questions abound. Is this research methodologically sophisticated? Does it warrant some of the conclusions reached? What effect should this research have on medical practice? Should physicians inquire into patients' spirituality and encourage religious practices as part of a treatment plan? If this is going to happen, what guidelines are available to structure this physician-patient conversation? Do holistic visions of health care warrant a deeper involvement of medical caregivers in the lives of patients? In terms of religion and spirituality, what do patients want from nurses and doctors and, in turn, what level of interaction are doctors and nurses comfortable with? If religion and spirituality enter into the medical conversation in a more systematic way, does this entail a new relationship with chaplains? How do medical caregivers, chap-

lains, and community clergy work together to provide holistic care?

This focus on the nature and extent of the interaction between the medical caregiver and the patient naturally unfolds into questions about the spirituality of the medical caregivers themselves. Does their faith and spirituality influence how they practice medicine? If spiritual beliefs were influential in their choice to become doctors and nurses, how are those beliefs maintained and how have they changed? If they are to ask questions about faith and spirituality, what type of training is necessary? Is this whole question of the religiousness/spirituality of the medical caregivers an intrusion into their personal lives?

The organizational conversation encompasses the medical conversation, but also goes beyond it. It flourishes in faith-based health care and asks how spirituality is or can be a visible feature on every level of the enterprise, from boardroom to lunchroom. How do leaders in faith-based health care systems articulate the theological values that inform the organization? Should they also have a spiritual life that is in sync with the faith-based nature of the organization? If so, how would that spiritual life manifest itself in their leadership

style and how could it be measured? Also, should a health care organization that welcomes the religiousness/spirituality of patients extend the same welcome to its employees? If so, how should this be done, especially in an interfaith world? What does it mean to be an organization that welcomes the whole person—physically, psychologically, socially, and spiritually?

Into these conversations on how to integrate spirituality into health care, I would like to introduce a distinction and a perspective. The distinction, borrowed and adapted from organizational development, differentiates adaptive challenges from technical fixes. The perspective, taken from contemporary spirituality, focuses on people's experiences and work as a spiritual path. I think this distinction and perspective can illumine these efforts to integrate spirituality into medical practice and organizational life and also point to a possible next step in this process.

FROM PROBLEM SOLVING TO ADAPTIVE CHANGE

In their article "The Work of Leadership," Ronald A. Heifetz and Donald L. Laurie distinguish problem-solving approaches from adaptive change.³ When using the problem-solving approach,

leaders define problems and provide solutions. In doing this, they shield people from the distress the problem is causing, clarify roles and responsibilities, and restore order. In adaptive work the leader identifies the challenges, recruits people into the work of responding, encourages the rethinking of roles and responsibilities, and does not prematurely close down conflict and change in the name of order. Leading adaptive work means facilitating a process of deep change that can involve basic identities, role definitions, and specific responsibilities. Of course, the key is to discern what situations call for problem solving and what situations call for adaptive work.

Heifetz and Laurie think organizational leaders are most comfortable in a problem-solving modality. Leaders have reached their present position of authority by providing leadership in the form of solutions, and there is no reason to call into question what has been successful in the past. Therefore, they are prone "to make the classic error of treating adaptive challenges like technical problems that can be solved by tough-minded senior executives."⁴

The tendency to approach every situation as a problem to be solved

goes beyond organizational leadership. It can be extended to include medical professionals. The dominant method of the medical professional is diagnosis and treatment, which is a variation on defining the problem and providing the solution. The problem-solving mind-set, once it is firmly in place, moves to meet each new situation, sizing it up on the terms with which it is most familiar. It becomes the acceptable and predictable way of doing things.

As spiritual interests emerge in health care settings, they encounter the organizational and medical problem-solving mind-set. Spirituality is automatically appreciated in terms of the medical and organizational structures already in place and evaluated in terms of whether it fits or not. The question becomes: how can this new kid on the block be included in an appropriate way, a way that does not disturb established roles and ways of working? Leaders in consultation with experts address the situation and determine an organizationally acceptable response. In other words, under this modality the inclusion of spirituality is a problem in need of a solution.

In the efforts to integrate spirituality into health care a number of pre-

**Could it be that the
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care will spur deeper
adaptive work?**

dictable problems emerge and solutions are not far behind. If a patient raises a religious or spiritual issue, here is what should be done and what should not be done. If a physician wishes to incorporate a spiritual history into the medical history, here are some guidelines and some sensitive questions to ask. If leadership wants to know whether employees and patients view the organization as spirituality friendly, here is an assessment tool to use. Depending on the outcome of the assessment, here are some procedures and programs to put in place. If, in interviewing prospective chief executive officers for a faith-based health care system, there is a need to assess their theological abilities and spiritual sensitivities, here is a way to go about it. In organizational and professional cultures that value solutions, solutions are supplied, often in the form of guidelines and best practices.

However, once solutions are in place and are regularly evaluated, another process may be triggered. The necessary stage of problem solving may be the forerunner of deeper adaptive work. Although Heifetz and Laurie draw a sharp distinction between problem solving and adaptive work, the health care example that begins their article holds the two approaches together.

To stay alive, Jack Pritchard had to change his life. Triple bypass surgery and medication could help, the heart surgeon told him, but no technical fix could release Pritchard from his own responsibility for changing the habits of a lifetime. He had to stop smoking, improve his diet, get some exercise, and take time to relax, remembering to breathe more deeply each day. Pritchard's doctor could provide sustaining technical expertise and take supportive action, but only Pritchard could adapt his ingrained habits to improve his long-term health. The doctor faced the leadership task of mobilizing the patient to make critical behavioral changes; Jack Pritchard faced the adaptive work of figuring out which specific changes to make and how to incorporate them into his daily life.⁵

Jack Pritchard's situation begins with a technical fix—triple bypass surgery and medication—and unfolds into an adaptive challenge. The adaptive challenge is a call to take personal responsibility and change ingrained habits. Therefore, the problem solving is not an end but a beginning, and not the beginning of more technical fixes, but an invitation to a deeper level of involvement. The authors spell out this deeper involvement in terms of needed behavioral changes. But the call to adaptive work often entails an inner assessment of identity and attitudes as the basis of behavioral change. In other words, adaptive work is often a journey of self-knowledge that looks inside in order to find the energy and perseverance to change the outside.

Could it be that the efforts to integrate spirituality into health care will spur deeper adaptive work? Could it be that as people—patients, physicians, nurses, leadership, and all levels of organizational health care—engage the prescribed solutions of how to integrate spirituality into health care, they will hear and accept the invitation hidden in the solution? Could it be that a patient hearing a physician say, “Is faith or spirituality important to you in this illness?” will begin a process of reflec-

tion leading down a path Rachel Remen marks out?

Through illness, people may come to know themselves for the first time and recognize not only who they genuinely are but also what really matters to them. As a physician, I have accompanied many people as they have discovered in themselves an unexpected strength, a courage beyond what they would have thought possible, an unsuspected sense of compassion or a capacity for love deeper than they had ever dreamed. I have watched people abandon values that they have never questioned before and find the courage to live in new ways. Often these ways are more soul-infused.⁶

Could it be that physicians who ask patients whether faith or spirituality is important to them also pose this question to themselves? Could it be that as leaders struggle to connect theological values to concrete business decisions they will realize no mechanical connection is persuasive, and seek in themselves a deeper, more integrated space to speak from? Solutions are the seeds of deeper work. As people engage them, they are called to more. The invi-

tation may be ignored or accepted. If it is ignored, things go on as usual. If it is accepted, they begin to walk a spiritual path.

SPIRITUAL PATHS

There are many ways to appreciate the complex and mysterious reality that is referred to by words like “religion,” “faith,” and “spirituality.” From the perspective of medical research this reality has been approached by distinguishing and relating religion and spirituality, by focusing on spiritual needs that are companions to physical, psychological, and social needs, and by spelling out the various domains of religiousness/spirituality, from church attendance to religious experience, in order to study them more effectively. However, from the perspective of trying to integrate faith, religion, and spirituality into medical practice and organizational life, a different approach may be helpful. Perhaps the way to proceed is to appreciate how people’s experiences and activities become a spiritual path and how spiritualities—beliefs, stories, and practices—are used on this path to develop spiritual consciousness and service. It is this perspective that will illumine the individual and organizational adaptive work that might go

on as a result of engaging the solutions of integrating spirituality into health care.

Activities become spiritual paths when in and through them people develop spiritually. Traditional spiritual paths would include the various activities of organized religions, e.g., liturgies, religious education, prayer sessions, etc. Many people today include activities that previously would not be considered spiritual. People say parenting is their spiritual path, or volunteering at the hospital is their spiritual path, or they name being a patient or nursing or working in human resources. All these activities have responsibilities and objectives of their own. Yet the people engaging in them are adding a dimension to what is happening. They are using these activities to awaken and develop spiritually.

How does this go on?

A story Rachel Remen tells provides some significant clues. She is working with a cancer surgeon who is suffering from depression. "I see the same diseases over and over again. I just don't care anymore. I need a new life." Remen suggests that each night he review his day by asking three questions: "What surprised me today? What moved or touched me today? What

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to bodies and their
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inspired me today?" He was to write his answers in a journal.

At first he came up empty. He just wrote "nothing" in the journal. Then he began recalling clinical oddities. He was surprised that a cancer had grown or shrunk or that a new experimental drug was effective. But eventually "he saw people who had found their way through great pain and darkness by following a thread of love, people who had sacrificed parts of their bodies to affirm the value of being alive, people who had triumphed over pain, suffering, even death." He was still attending to bodies and their disease processes, but now he was seeing people.

This new sight developed in stages. At first, he became aware only of what he was seeing at night, as he was reviewing the day. But gradually the time lags shortened. "I was building up a capacity I had never used. But I got better at

it. Once I began to see things at the time they actually happened, a lot changed for me.” What changed was how he practiced medicine. He began to share with his patients what he saw, and they responded in kind. One of his patients gave him a stethoscope engraved with his name. When Remen asked him what he would do with it, he responded, “I listen to hearts, Rachel. I listen to hearts.”⁷

A spiritual path has two interlocking elements. The first is the use of spiritualities—beliefs, stories, and practices—to facilitate spiritual awareness, to give new eyes.⁸ In the physician’s story Remen gives him a practice, three questions he must ask himself at the end of each day. This practice puts him on a path, and the path becomes a counterforce to his depression. As John Welwood says, “The nature of path is to lead us on a journey, and it is life’s deepest urge to move forward in this way. Whenever our lives have this sense of forward momentum, we feel an unmistakable stream of vitality flowing through us, which tells us we are on to something real.”⁹ In the extravagant language of mystical traditions, the practice brought him back from death to life.

The surgeon persevered in this practice and gradually came to see more

deeply. This seeing more deeply happened in stages. At first, he saw nothing. Then he saw the surprising on the physical level. Finally, the personal and spiritual came into focus. On a spiritual path there is a need for both perseverance and growth. It is not just the beliefs, stories, and practices people espouse. It is the steadfastness of their attention to these beliefs, stories, and practices. The beliefs have to be consistently entertained and integrated into the mental processes, the stories have to be told and retold to the listening heart, and the practices have to have a greater priority than sleep. Path and perseverance go together.

However, if there is only perseverance and no deepened spiritual awareness, a spirituality is not functioning well. As the story suggests, spiritualities are stethoscopes to hear the pulse of the spiritual in each experience and in every situation. Therefore, they are known by their fruits, the effects they produce in the minds, hearts, and actions of those who espouse them. Spiritualities must facilitate growth in spiritual consciousness. If they do not do this, it is time to find new beliefs, stories, and practices that will. As people walk the path, the spiritualities that illumine the path and inspire the journey often change.

The second interlocking element of a spiritual path is the dynamic interaction of realization and integration. Realization is seeing the deeper dimension of the spiritual as it suffuses physical, psychological, and social life. Integration is the struggle to act on what is seen. The physician reflects on this process.

At the beginning I couldn't talk about it and I just wrote everything down. But I think when I began to see things differently, my attitude started to change. Maybe that showed in my tone of voice or in some other way. People seemed to pick up on it because their attitude seemed to change, too. And after a while, I just began talking to people about more than their cancer and its treatment. I began talking about what I could see.¹⁰

Once again, growth continued—from not being able to talk, to suspecting that his new attitude was showing even though he was not talking about it, to finally saying what he saw. This is the movement from realization to integration. However, it is not always this smooth. In fact, it usually entails extensive trial and error with new ways of talking and new ways of acting.

In general, spiritual growth moves from the inside to the outside and back to the inside. People see or realize the presence of the spiritual as it arises in the ordinary interactions of life and, after a sufficient amount of inner work, venture out of hiding with their new realization. This movement into the outer world has to go through the conditioned mind and deal with recalcitrant and uncomprehending elements in their situations. Also, it is often unclear how this spiritual realization should be embodied. This struggle of integration necessitates a return to the realization to draw from its wisdom and strength, and then another attempt to embody the inner spiritual in the outer world. This inner-outer dynamic is the realization-integration two-step that is used by people who walk a spiritual path.

CONCLUSION

Integrating spirituality into health care is a formidable problem-solving enterprise that must take into account medical, moral, organizational, theological, financial, and legal considerations. Leaders and experts conspire to find solutions and develop time-tables for implementation. What will happen to people as they engage these solutions? Will some hear in the solution an invitation to

deeper adaptive work and begin to walk a spiritual path? Will they experiment with spiritualities to guide them and live in the oscillation between realization and integration? If they do, the integration of spirituality into health care will go beyond structural adaptation into personal transformation. Also, there will be a need for different individual and organizational responses. Envisioning those responses may be the next step in integrating spirituality in health care. ■

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1. For a developed understanding of these spiritual interests, see John Shea, *Spirituality and Health Care: Reaching Toward a Holistic Future* (Chicago: The Park Ridge Center for the Study of Health, Faith, and Ethics, 2000), 21–68.
2. See for example, Harold G. Koenig, “Religion, Spirituality, and Medicine: Application to Clinical Practice,” *Journal of the American Medical Association* 284, no. 13 (October 4, 2000): 1708; Randolph C. Byrd, “Positive Therapeutic Effects of Intercessory Prayer in a Coronary Care Unit Population,” *Southern Medical Journal* 81, no. 7 (July 1988): 826–829; Stephen G. Post, Christina M. Puchalski, and David B. Larson, “Physicians and Patient Spirituality: Professional Boundaries, Competency, and Ethics,” *Annals of Internal Medicine* 132, no. 7 (April 4, 2000): 578–583.
3. Ronald A. Heifetz and Donald L. Laurie, “The Work of Leadership,” *Harvard Business Review* 75, no. 1 (January–February 1997): 124–134.
4. *ibid.*, 133.
5. *ibid.*, 124.
6. Rachel Remen, *My Grandfather’s Blessings* (New York: Riverhead Books, 2000), 29.
7. *ibid.*, 116–119.
8. For a fuller explanation of how this happens, see Shea, *Spirituality and Health Care*, 113–160.
9. John Welwood, *Journey of the Heart* (New York: Harper, 1991), 12.
10. Remen, *My Grandfather’s Blessings*, 118.

JUST GENETICS?

BY MARY B. MAHOWALD

Biological and Philosophical Perspectives

Books Reviewed

The Triple Helix: Gene, Organism, and Environment.

Richard Lewontin.

Cambridge, Mass.: Harvard University Press, 2000. 136 pp. \$22.95 (Hardcover).

From Chance to Choice: Genetics and Justice.

Allen Buchanan, Dan W. Brock, Norman Daniels, and Daniel Wikler.

Cambridge, U.K.: Cambridge University Press, 2000. 412 pp. \$29.95 (Hardcover).

Although these two books address issues raised by advances in genetics, they are hardly similar in other ways. *The Triple Helix* (TH) targets a fairly widespread assumption that genetics alone determines how living things work, amply illustrating that life, in all of its forms, is much more complex. Maverick biologist Richard Lewontin refutes the thesis of genetic determinism—or what might be called “just genetics,” meaning *only* genetics. Lewontin is highly regarded not only for

his research in population biology but also for his empirically grounded and challenging critiques of the field.

In contrast, *From Chance to Choice* (CC) develops a sustained critique of discriminatory practices that arise in applications of genetic information, arguing for policies intended to reduce or avoid injustice. Four mainstream philosophers advocate moral or social ideals of fairness or justice, calling for what could be dubbed as “*just genetics*,” meaning *fair genetics*. Authors Allen Buchanan, Dan W. Brock, Norman Daniels, and Daniel Wikler have often collaborated in their applications of Rawlsian theory to biomedical problems.

The emphases of the two books, empirical in TH and theoretical in CC, befit their authors’ expertise and complement each other: CC may be seen as building on the descriptive material provided by TH, or TH may be viewed as lending empirical support to positions articulated in CC. Lewontin himself apparently construes the work of Buchanan et al. as complementing his own; in the blurb on the jacket he praises the authors for demonstrating “how professional moral philosophers can help us work through a major social issue of immediate concern.”

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I doubt, however, that Buchanan et al.’s exposition of justice in genetics within the context of liberal individualism is compatible with the more radical critique to which Lewontin alludes when he identifies the cause of “degradation of the conditions of human life.” That cause, he says, is not the alterations of the natural world that environmentalists castigate but “the narrow rationality of an anarchic scheme of production that was developed by industrial capitalism and adopted by industrial socialism.” “The environment,” he claims, “does not exist to be saved.” We cannot prevent environmental change or species extinction, nor should we, because there is no evidence that this is either possible or desirable. Eventually, no matter what we do, all life on earth will be extinct; in fact, having originated over two billion years ago, life on

earth is already half over. Rather than engage in futile efforts to “keep things as they are,” Lewontin counsels us “to try to affect the rate of extinction and direction of environmental change in such a way as to make a decent life for human beings possible.” Although death cannot be prevented, we can eliminate or at least reduce the overwork and undernourishment that still lead to premature deaths in countries less “advanced” than ours. Obviously, Lewontin’s concerns are global rather than parochial. In contrast, Buchanan et al. tend to limit their discussion to conditions in the United States.

Lewontin’s slim tome, readable within a few hours, is replete with provocative prose and graphs, sketches, and tables. Lewontin describes behavior in various species of plants and animals, ranging from simple to complex organisms, including those that have been extinct for millennia. Fruit flies (*Drosophila*), with which the author has long been familiar through his own research, figure more prominently than other organisms as examples of the ongoing interactions of genes, organism, and environment that form the triple helix.

Although many scholars have explored the interaction between envi-

ronment and genes, few have accorded influence to the organism itself. But different phenotypes can and do develop from identical sets of genes and with identical environments; in both cases, this signals the impact of the particular organism on either of the other strands of the triple helix. Just as phenotype is an indicator of genotype, “if one wants to know what the environment of an organism is, one must ask the organism.” For Lewontin, then, “all organisms construct their own environments,” and “there are no environments without organisms.” His view coincides with the literal meaning of “environment” as “surrounding”: there must be an organism for an environment to surround. Consequently, to consider features of the environment, such as rain forests and river systems, as if they exist apart from native organisms misrepresents environment, exemplifying what philosophers call the fallacy of abstraction.¹

Some might argue that Lewontin’s critique is directed at a straw person. Any respected or respectable scientist, they would claim, is well aware that genes and organisms and environment interact, affecting each other in myriad ways. Lewontin is surely right, however, that genetics has become “the reigning mode of explanation” not only among

biologists but also among the public at large. In general, it has replaced the environmental model that prevailed years ago, when B. F. Skinner published his famous defense of social behaviorism.² Neither environmental nor genetic determinism makes room for human freedom. As Lewontin makes abundantly clear, however, neither model is adequate. Moreover, his triple helix account allows us to impute the capacity to exercise free choice to human organisms. While the author does not examine this possibility, humans may then be properly construed not only as interactive with but directive of genetic and environmental influences on their development.

Although Lewontin employs the triple helix as a new metaphor, his critique challenges the adequacy of metaphors in general. Even the metaphor of “development” comes under fire because it suggests that each individual is entirely defined by “the unfolding of a genetic program immanent in the fertilized egg.” The metaphor of “adaptation,” once useful in explaining evolution, currently serves to support the wrong-headed notion that environment is causally independent of the organism. To correct the flaws of these metaphors, Lewontin proposes one of “construction.” “The construc-

tionist view,” he says, “is that the world is changing *because* the organisms are changing.”

TH provides clarification of scientific concepts that underlie the discussion of policy issues undertaken by CC. Philosophically demanding but fluidly and accessibly written, CC is an impressive example of collaboration and careful scholarship. Although Buchanan is the first author, the principal philosophical source for all four authors is John Rawls,³ whose theory of justice was applied to health care in Norman Daniels’s earlier work.⁴ To his credit, Daniels has acknowledged that the theory of justice he then presented did not allow for social factors that impede access to health care, such as gender, race, and class bias. In its account of the history of eugenics and its examination of current issues involving people with disabilities, CC substantially reduces this limitation of Daniels’s earlier work.

Interestingly, another body of work that has clearly left its mark on the authors of CC is not explicitly acknowledged for its influence: the work of Tom Beauchamp and James Childress in various editions of *Principles of Biomedical Ethics*.⁵ Like Beauchamp and Childress, Buchanan et al. invoke “common sense

morality” and Rawlsian “wide reflective equilibrium” while identifying principles that are applicable to a variety of ethical issues. The “method” of wide reflective equilibrium is defined as follows:

we test various parts of our system of moral beliefs against other parts of our general system of beliefs, seeking coherence among the widest set of moral and nonmoral beliefs by revising or refining them at all levels.

This methodology resembles Beauchamp and Childress’s defense of coherence as a method of justification.⁶ In addition, the principles through which they defend their positions are substantively the same as those developed in *Principles of Biomedical Ethics*, albeit with a different vocabulary than the Georgetown mantra of respect for autonomy, beneficence, nonmaleficence, and justice.⁷ The term “justice” is retained in both accounts, but “beneficence” and “nonmaleficence” are mainly discussed as “harms” and “benefits” in CC, and “respect for autonomy” is mainly considered in the context of “liberty rights” or as “freedom,” especially “reproductive freedom.” Although the same principles are used by both sets of

authors, Buchanan et al. focus on justice, discussing the other principles mainly or only to the extent that they relate to justice.

The authors of CC describe themselves as performing an “ethical autopsy” not only on the history of eugenics but also on current and anticipated issues raised by advances in genetics. While their book explores philosophically rich issues such as genetic determinism, concepts such as “wrongful life” and “normal species function,” and the treatment/enhancement distinction, they mainly ignore the philosophical question that is unavoidable if a thorough ethical autopsy of access to genetic services is conducted: the moral status of the fetus. Their book, they say, is about “problems raised by advances in genetics, not about abortion, and so we limit ourselves to showing the connections between the issues of the prevention of genetic disease, wrongful life and abortion, but cannot pursue the moral and policy complexities of abortion itself.” Yet consideration of the connection between “wrongful life and abortion” is inseparable from examination of “the moral and policy complexities of abortion,” and the core issue to be addressed in examining those complexities is the moral status of the fetus. The genetic services to which

Buchanan et al. believe everyone should have routine access include abortion following a positive prenatal diagnosis. By advocating permissive policies in this regard, they inevitably support a position they decline to defend on the spurious grounds that it is separable from their concluding recommendations.

In a pluralistic culture such as ours, it is not surprising that the authors demur from engaging in philosophical or ethical conflicts that seem irresolvable. The probability that their input will in fact influence the development of public policy may well depend on their not taking sides in such emotionally charged debates. My point here, however, is that they do take a side. Like it or not, their positions assume the permissibility of abortion, and that assumption demands defense or refutation. Acceptance or rejection of at least some of their recommendations rests on the adequacy of the arguments on either side.

Nor is it surprising that Buchanan et al. subscribe to a Rawlsian view of justice, i.e., one that alternates between the emphases on individual liberty and on social equality that mark libertarian and socialist theories, respectively. Most Americans want both liberty and equality, despite the incompatibility between the two if either is construed as an abso-

lute value. Buchanan et al. also want to affirm both values. But this particular rendition of Rawls is more egalitarian than some accounts, and clearly more egalitarian than his more recent work.⁸ The authors' recurrent, well-reasoned concerns about genetic enhancement show their willingness to limit autonomy so as to promote equality: they support a parental right to avoid the birth of children with disabilities while rejecting policies through which enhancement of some people disadvantages others. In addition, they argue strenuously for social accommodations that would reduce the disadvantages endured by people with disabilities solely because currently able individuals have ignored their interests.

Buchanan et al. interpret the normal function model of Daniels, based on the concept of fair equality of opportunity in Rawls, as superior to models based on equal capabilities or equal opportunity for welfare or advantage. The latter models, they argue, betray the diversity and complexity of egalitarian concerns. To better capture this complexity, the authors purport to move beyond Rawls's "veil of ignorance," that is, an effort to overcome potential bias, through a "morality of inclusion." This approach would in fact reduce the inevitable near-

sightedness of policymakers such as themselves.⁹ Of course, all of us are near-sighted in that we cannot adequately see what others see from where they are in the world; from a policy standpoint, this myopia is most troublesome if the policymakers consist only of those who are already dominant in society, i.e., affluent, white, well-educated, currently able, heterosexual men.

Over a decade ago, feminist standpoint theorists elaborated and defended a “morality of inclusion” as a means of promoting justice (including but not limited to gender justice).¹⁰ Their proposal, however, goes farther than that of Buchanan et al. because, on epistemological and ethical grounds, they attribute “privileged status” to the input of those who are nondominant. The privileged status of the nondominant individuals who are typically excluded from policymaking is based on the expectation that they bring to the table relevant content that would otherwise be missing. Ironically, the morality of inclusion of those who have been least represented (if at all) in the development of policies about genetics might exclude some of the authors of CC from their own involvement in that development.

Whether the normal function model defended by Buchanan et al. is

Like it or not, their
positions assume the per-
missibility of abortion, and
that assumption demands
defense or refutation.

morally superior to other models is of course debatable. Because they straddle opposing views on many issues, some of which may be more coherent than those the authors defend, the policies that Buchanan et al. ultimately support seem to this reviewer rather obvious or wishy-washy. On pragmatic grounds, their recommendations may be the best that policymakers who serve a diverse constituency can hope for. On idealistic grounds, however, I would have preferred a more radical critique, one such as Lewontin’s book invites. Nobel laureate Amartya Sen’s model of equal capabilities is much more likely, I believe, to remedy the central flaw of Daniels’s earlier theory, its neglect of social and cultural impediments to human development. While Buchanan et al. have admirably addressed this flaw with regard to race and disabilities, they largely ignore sex, cultural, and class

differences as obstacles to the full and free fulfillment of human capabilities.

CC does fulfill another ideal quite successfully: the principle that intellectual inquiry is most fruitfully conducted collaboratively. Although multi-authoring typically poses risks of disjointedness, incoherence, inconsistency and repetition in the resultant text, Buchanan et al. have not only overcome these risks but produced a work that is probably of higher caliber than any one of them would have produced on his own. In a limited way, then, the authors exemplify the benefits of the morality of inclusion in their own scholarly pursuits. Moreover, even as Lewontin demurs from addressing substantive ethical or policy issues, Buchanan et al. acknowledge their lack of expertise in relevant areas of the biological sciences. To facilitate the reader's understanding of these areas, they append an excellent contribution on the meaning of genetic causation by Elliott Sober. Lest their speculative considerations become inaccessible to readers who are less philosophically minded, the authors intersperse descriptions of cases and issues throughout the text, enhancing its readability while clarifying their exposition. The final fruit of their collaborative labor is not an easy read, but certainly a worthwhile one. ■

NOTES

1. Cf. Mary B. Mahowald, "As If There Were Fetuses without Women: A Remedial Essay," in Joan Callahan, ed., *Reproduction, Ethics, and the Law: Feminist Perspectives* (Bloomington: Indiana University Press, 1995), 199–218.
2. B. F. Skinner, *Beyond Freedom and Dignity* (New York: Alfred A. Knopf, 1971).
3. John Rawls, *A Theory of Justice* (Cambridge: Harvard University Press, 1971).
4. Norman Daniels, *Just Health Care* (Cambridge: Cambridge University Press, 1985).
5. Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* (New York: Oxford University Press, 1979, 1983, 1989, 1994).
6. Beauchamp and Childress, *Principles*, p. 24.
7. As Buchanan et al. observe, these principles have been dubbed the Georgetown mantra because Georgetown is the home institution of one of the authors, Tom Beauchamp.
8. John Rawls, *Political Liberalism* (New York: Columbia University Press, 1993).
9. Mary B. Mahowald, "On Treatment of Myopia: Feminism, Standpoint Theory, and Bioethics," in Susan Wolf, ed., *Feminism and Bioethics: Beyond Reproduction* (New York: Oxford University Press, 1995), 95–115.
10. E.g., Nancy C.M. Hartsock, *Money, Sex, and Power* (Boston: Northeastern University Press, 1985); and Donna Haraway, "Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective," *Feminist Studies* 14 (1988): 575–579.

BOOKS IN BRIEF

Ambiguous Prognosis: Disease and Narrative

*One Hundred Days: My Unexpected
Journey from Doctor to Patient.*

David Biro.

New York: Pantheon, 2000. 291 pp.
\$23.00 (Hardcover).

My favorite line in David Biro's illness narrative occurs after he has been diagnosed with the rare disease that will ultimately lead to a bone-marrow transplant at Sloan-Kettering Memorial Cancer Center. Biro enjoys what many would imagine to be a perfect life. He has just completed a dermatology residency and joined his

father's thriving Manhattan practice; he is happily married to a lovely and successful woman; and he is completing a novel that has good prospects for publication. But as a student of mythology, Biro knows the presence of Nemesis, the redistributor of good fortune. Thus he writes: "There is too much evil and tragedy in this world to pass through unscathed. It wouldn't be fair for only some to bear the brunt of suffering. Otherwise how would we communicate?"

Even when Biro is not offering such insights—and they occur too infrequently for me—he is an excellent guide through the horrors of transplantation.

After considerable medical dispute he is diagnosed with a rare disease called paroxysmal nocturnal hemoglobinuria, a name deriving from the symptomatic presence of blood in the urine (Biro's urine remains clear, confounding diagnosis). PNH has an ambiguous prognosis. Some patients, he is told, do quite well, yet he reads that many others "succumb," a conventional medical description he suddenly finds ominous. Confronting diverse specialist opinions, Biro opts for a transplant with its hope of complete recovery. "I'm a risk-taker," he writes. "I'd rather drive aggressively and dent a fender than sit in traffic for hours on end." Here are the poles of Biro's personality: his insight that without suffering humans could not communicate, and his willingness to dent not only his own fender but also someone else's. His story takes both its fascination and its limitations from the distance between these poles—a distance Biro does not spend much time contemplating.

Most of the book is a well-written medical adventure story of ambiguous diagnosis, troubled decision over treatment, the horrendous treatment itself, and a recovery almost as ambiguous as the diagnosis. Biro's experiences lead him to reflect on how medicine is organ-

ized and practiced but, on my reading, less than he might have. Biro studied classics and took a doctorate in literature at Oxford before becoming a physician; his chapter epigraphs show his considerable intellectual sophistication. But he does not substantially develop the ideas from the epigraphs when describing the phases of his illness. He introduces but does not develop interesting thoughts—for example, the nature and limits of empathy. Likewise, various plot lines never develop. At first the family's medical insurance, carried through his wife's employer, refuses to pay for the transplant; then someone says they will make a call, and the issue disappears. Similarly, Biro's participation in a Yom Kippur service early in the book suggests continuing spiritual reflections that never occur or were cut in editing.

Biro's experiences might be most usefully read by young physicians caught in the myth of their own physical invulnerability, or by those undergoing transplants similar to his. Fellow patients should be warned, however, that Biro's status as a physician leads to various acts of preferred treatment; for example, the chief resident at Sloan-Kettering is a medical school friend who promises him "the presidential suite" as

his room. Such treatment can only spare Biro so much of what everyone goes through, but more than a few rough edges are smoothed by his and his family's resources.

Perhaps the most singular aspect of the book for me was the simmering conflict between Biro's family, with its effusively emotional, protective, ceaseless helping style, and his wife, who finds the family's incessant intervention suffocating. If this conflict also remains unresolved, perhaps this lack of resolution—like the final ambiguity of Biro's physical prognosis—is simply the nature of things.

Looking back on his experience with a physician's appreciation for physiology and a writer's sense of metaphor, Biro asks, "How is it possible for all the broken pieces of the puzzle to be reassembled . . . ?" He has learned that the parts can reassemble, but the puzzle remains. I hope he will continue to return to his illness in future writing and deepen the puzzle into more of a mystery.

—Arthur W. Frank

■ ■

Divorce: The Children's Burden

The Unexpected Legacy of Divorce: A 25 Year Landmark Study.

Judith S. Wallerstein, Julia M. Lewis, and Sandra Blakeslee.

New York: Hyperion, 2000. 352 pp.

\$24.95 (Hardcover).

Most Americans are aware that almost one in two marriages now end in divorce, yet the long-term effects of this revolutionary development in family life are less well known. Social scientists have demonstrated that children of divorce do more poorly than children from intact families on a host of social indicators. Only Judith Wallerstein, however, followed the same group of children of divorce over a span of decades, examining their inner lives as they became adults. At the twenty-five year mark, Wallerstein and coauthors Julia Lewis and Sandra Blakeslee now report that divorce affects children well into adulthood. Since at least one-quarter of adults under the age of forty-four in this country are children of divorce, this is a very significant finding indeed.

Wallerstein argues that a number of "cherished myths" about divorce persist in our culture. One myth is that if

divorce makes parents happier, then children will be happier too. Yet, Wallerstein found, the very changes that can make life better for adults after a divorce—a new lover or spouse, a more demanding but fulfilling career—often make children feel worse because parents become less available to children.

Again contrary to myth, divorce is not a temporary crisis where everything will be normal after six months or a year. Wallerstein found that divorce is just the beginning of a series of upheavals that can last throughout childhood.

Still another myth is that divorce ends conflict between the parents, that after divorce the children may miss their intact family but at least the parents will no longer be fighting. But Wallerstein and her colleagues demonstrate that divorce opens up whole new realms of conflict between parents.

Wallerstein's book does not just dispel myths; it also brings new and important findings to light, and it poses significant questions for our future. After a divorce children often take up new roles in the family. Some children become caretakers, some act out, and still others become loners, essentially abandoned as parents are swept up into postdivorce lives and responsibilities.

Wallerstein found that children of divorce now in their twenties or thirties often reinstalled these childhood roles in their own romantic relationships, and many struggled for years to find loving, stable marriages. Even those who were successful in love reported recurring fears that the relationship could end unexpectedly.

Wallerstein also includes an important—and rare—discussion of how vulnerable children fare. Bright, physically healthy children can be devastated by divorce, but they also have internal resources to help them adapt quickly to the many changes divorce brings. But vulnerable children, especially those with physical or mental disabilities, adapt to change very slowly, if at all. As a consequence, they suffer more and, in the case of one young man Wallerstein discusses at length, they can end up clearly heartbroken.

As the children of divorce in her study aged, Wallerstein found they were more likely to have strained relationships with their divorced parents—especially their fathers—than did adults in a comparison group who grew up in intact families. When adults feel their parents did not fulfill basic obligations to them as children, they are often less willing to help when those parents become older

and dependent. Therefore, Wallerstein raises a critical question for the future. If the baby boomers who first ushered in the divorce revolution are aging—and living longer than previous generations—and if many of them have strained or nonexistent relationships with their adult children, who will care for this new cohort of dependent, disconnected older Americans?

While Wallerstein cannot answer that question, she does offer other suggestions to parents, politicians, and society. In particular, Wallerstein has much to say to family courts. She charges they have treated children in divorce cases as passive, voiceless agents. She urges the courts to seek out and listen to the child's perspective, to allow custody decisions to change as a child's needs change, and to evaluate all custody decisions one year later to see how a child is doing (something, astonishingly, the courts do not do at the present time). She also urges more data gathering. For instance, there is no tracking of how many children of divorce fly alone each year, and no one knows how these solo journeys affect children.

For years, the courts and many parents have been making decisions about divorce with strikingly little information about how divorce affects chil-

dren. Thanks to Judith Wallerstein and a handful of other social scientists the question is no longer whether divorce affects children, but what we should do about it.

—Elizabeth Marquardt

■ ■

The Goods of Marriage

The Case for Marriage: Why Married People Are Happier, Healthier, and Better Off Financially.

Linda J. Waite and Maggie Gallagher.
New York: Doubleday, 2000. 260 pp.
\$24.95 (Hardcover).

Marriage is good for you. This is the message of Linda Waite and Maggie Gallagher's recent book, which has been eagerly anticipated by many in the nascent "marriage movement." Waite is a professor of sociology at the University of Chicago, where she has focused on the family, aging, and women in the work force. Gallagher is a syndicated columnist, social commentator, and director of the Marriage Program at the Institute for American Values. The marriage movement is an emerging coalition of scholars, religious leaders, and civic leaders who view strengthening marriage, reducing divorce, and curtailing unmarried pregnancy as key to building a good society, particularly for children. The health benefits of marriage are part of the arsenal that these folks, and Waite and Gallagher in their book, use to make the "case for marriage."

The thrust of Waite's statistics and Gallagher's rhetoric is that a case can be

made. They debunk what they call the five myths of the postmarriage culture: (1) divorce is the best outcome for children when a marriage is unhappy; (2) the decision of adults to cohabit or remain single does not (and should not) matter to the wider society, so long as they do not have children who could be harmed by these alternative lifestyles; (3) marriage is good for men, but bad for women; (4) marriage puts women at risk for violence; and (5) marriage is a purely private matter.

Waite and Gallagher deconstruct the last of these myths first with a description of a "marriage bargain" that seems to have become unenforceable, if altogether extinct, in recent decades. Significantly, this marriage bargain—the very modern-sounding term by which the authors seem to invoke the classical marital goods of procreation, fidelity, and permanence articulated in many religious traditions—is a public as well as a private good. Society has a role in strengthening marriage, and it benefits from the social stability that these happy unions provide. Indeed, at one point the authors remark that recent attempts of gay and lesbian couples to marry demonstrate the importance of marriage as a social institution.

Marriage and family are not, however, uncontroversial topics—and this will likely not be an uncontroversial book. One area of possible controversy is the use of the language of health. Indeed, the authors strike the notes of the traditional marriage blessings of health, wealth, and happiness throughout. Nonmarried people have higher rates of mortality than the married—50 percent higher among women and 250 percent higher among men. Married surgical patients are less likely to die in the hospital than singles. Happy marriages are thought to foster higher levels of immune function. Married people have better and more frequent sex than single people. Married people are more affluent, and married men make significantly more money than bachelors. Indeed, getting married is reported to increase a man's salary by about as much as a college education. Women, too, benefit from the economies of scale in marriage (two together can live more cheaply than two apart) and from the social capital and support provided by their husbands' families, particularly in childrearing and inheritance. The authors also take care to point out the benefits of marriage to children, which are presumably a boon to parents, as well.

The somewhat dry, utilitarian tone of the argument may sound a discordant note for romantics wont to focus more on marriage's intrinsic goods than its instrumental uses. Somehow the authors never conclude that their strikingly utilitarian argument, unjoined to any language of commitment and reciprocity, also risks making marriage a selfish enterprise, if the consideration of one's own good elides consideration of marital mutuality and the good of the family. Moreover, just as the plea to "eat your vegetables because they're good for you" often falls on a child's deaf ears, the call to get or stay married for one's own good may not persuade an adult to partake of marriage as a means of achieving happiness, health, and wealth.

But then again it just might. One can quibble endlessly with rhetoric, but quibbling becomes more difficult when the rhetoric is backed up with the ample statistics that Waite and Gallagher provide. While children in high-conflict marriages may be better off after their parents' divorce, the evidence suggests that children in low-conflict marriages may do just fine. It turns out that the decision of some adults to cohabit or to give birth to children out of wedlock may have lasting negative effects, not

just for the adults involved, but for the wider society; the ideals of commitment and shared sacrifice in the “marriage bargain” may devolve to the “cohabitation deal” reality of hypertrophied individualism and easy exit. The old view was that single men live a life that is “nasty, brutish, and short” while spinsters flourish; the new knowledge is that, while single men still go to an earlier grave than their married counterparts, married women apparently outrank their single sisters in both length and quality of life.

Perhaps a more contentious issue than the book’s utilitarian twist is the way in which it straddles the line between describing and prescribing. For many growing up in the same Baby Bust/Generation X cohort as this reviewer, the problem is not an inability to appreciate the benefits of those marriages that make it, but the paralyzing perception that far too many marriages do not. Recent studies have shown us to be a generation with ideals of married life that may be so overly romantic and unrealistic that troubles arise when reality does not meet expectations. Growing up in the aftermath of the sexual revolution and the divorce revolution, many of us view the “marriage bargain” as a risky venture. As a

result, we settle for relationships that are less than they could, and should, be. *The Case for Marriage* may not persuade all with its foray into a more normative realm, but its wealth of statistics accompanied by cogent argument should contribute greatly to broader social discussion of the goods—and even the health benefits—of marriage and family.

—M. Christian Green

■ ■

Man With a Balance on a Table

Sovereign Virtue: The Theory and Practice of Equality.

Ronald Dworkin.

Cambridge, Mass.: Harvard University Press, 2000. 511 pp. \$35 (Hardcover).

Whatever else you might want to say about recent philosophical work on justice emerging from the New York area, you can hardly fault the aesthetic taste of its producers: Vermeer's extraordinary *Woman Holding a Balance* decorates the covers of Frances M. Kamm's *Morality, Mortality* (vol. 1, Oxford, 1993), the cover of the May 2000 *Hastings Center Report* (with lead articles on health care justice), and now Ronald Dworkin's new book too.

Using Vermeer's image as the emblem for explorations of justice is, of course, enormously inviting: a woman, possibly pregnant, certainly serene, delicately poises an empty balance over a table strewn with rare and precious things—pearls and gold jewelry. She stands under a painting of Christ judging all souls at the world's end, obscuring just that place where Saint Michael traditionally stands wielding a balance of his own. The

iconographic resonances are almost too available.

Still, in some way, the art is less appropriate for Dworkin's book than it might be—less so than for Kamm's book, certainly. Kamm weighs minute moral distinctions in the finely calibrated balance of her intuitions; Dworkin's procedure is bolder, his ambition to build theory stronger, and the range of application of his views much wider. It almost seems that the background painting, the ultimately authoritative separation of all sheep from all goats at the Last Trump, coheres more closely with *Sovereign Virtue*.

The broad sweep of Dworkin's position is most clearly on view in his statement of the book's fundamental theme. He defends the now unpopular idea that equality is a *sine qua non* for political legitimacy—any state that does not treat its citizens with equal concern is unworthy of their allegiance, and in a state with striking levels of material inequality, the equal concern of the government for its citizens is gravely suspect, since those inequalities reflect decisions and actions of the government. Although he never quite comes right out with it, the implications of his view for the fundamental legitimacy of the American government seem inescapably grim.

The book's first seven chapters are devoted to the idea of equality as the sovereign virtue, first (and most superficially—a curiosity in this densely-argued book) providing basic motivation, then specifying the understanding of equality that is appropriate to the assessment of governmental institutions and practices. Dworkin argues that the pertinent kind of equality is equality of resources, not of welfare, and then turns to the problem of gauging equality of resources. This is tricky, in part because Dworkin's political philosophy is constrained by the two principles of a moral philosophy he calls "ethical individualism": it is equally important that each human life be successful rather than wasted; it is also important that each individual is specially responsible for the choices that shape the kind of life lived. The first of these principles requires social arrangements that strive to render our political and material standing insensitive to our gender, race, class, or particular skills or handicaps; the second principle requires that our social arrangements allow our lives to reflect our choices. Nothing so simple as making sure that everyone always commands an equal share of the gross domestic product will accommodate this view.

To assess whether a given political order accords with these principles, Dworkin has us imagine a situation of initial equality of resources as determined by an auction that divides lots among bidders who were originally equipped with equal amounts of currency. The auction continues to run until all the lots are distributed in such a way that no one envies anyone else's holdings. People will then start to do things with their resources that will likely result in the initial situation being disturbed—some will be more risk prone than others, some luckier, some unluckier—and the initial equality of resources will give way to some individuals controlling more resources than others. Some of the resulting inequality will reflect choice, and thus be acceptable. But some of it will reflect contingencies of fate—ill health, for example—and a legitimate political system must have mechanisms to correct for inequalities not traceable to choice. The amount of social resources appropriately made over to such mechanisms is to be determined by a hypothetical insurance market. Dworkin claims that we can roughly determine what the appropriate rate of redistributive taxation would be, as well as how much of our wealth we should set aside to fund

such things as universal health care, by imagining at what levels reasonable individuals, operating from a position of initial resource equality, would insure themselves against, for example, the possibility that their constellation of talents and interests would command unacceptably low rates of income in a developed economy.

This is only the barest sketch of the book's fundamental argument. But it is not only in the scope of its theorizing that Dworkin's views seem not altogether well symbolized by the painting. Vermeer's woman holds the balance in her hand; it is not set upon the steady table before her. This image seems to better symbolize an understanding of the moral life that is in some important way pluralist—values that are the most deeply important to us can pull against one another in fundamental ways, and moral decisionmaking will require discerning judgment, rather than the skillful application of theory. But what is perhaps most philosophically striking about Dworkin is how insistently systematic his vision is. It is not merely that he builds interesting, and sometimes compelling, connections between the book's first seven chapters on theory and the later seven, which explore health care insurance, welfare reform, campaign

finance reform, affirmative action, genetic engineering, and physician-assisted suicide. It is, rather, in his almost platonic argument for a kind of unity of the virtues that the deepest aspirations of his thought can be seen. Dworkin insists that, far from conflicting with each other, equality and liberty are mutually compatible and that our own hopes to live lives morally admirable on a personal level can be fulfilled only if we live in just communities (yet another grim implication of his view).

Fundamentally, however, *Sovereign Virtue* does manifest, in its own medium, much of what is most generally impressive about *Woman Holding a Balance*. Despite its dense complexity, something like Vermeer's light can be seen washing over its image of a way of life that answers to the strong desire to lead lives richly shared, yet distinctively significant.

—James Lindemann Nelson



NEWS & NOTES

BY KIRSTON FORTUNE

They Want to Believe

The Illuminati are at it again, according to a U. S. conspiracy theorist and the government of South Africa. Manto Tshabalala-Msimang, South Africa's health minister, distributed a chapter from a book written by William Cooper to the country's provincial legislators. In his book Cooper claims that a secret group bent on global domination—the Illuminati, whose purported objective is to enslave the human race by creating a satanic one-world government—desires a reduction in the African population. To

accomplish this, they introduced AIDS via the smallpox vaccine, Cooper wrote. Linked to the conspiracy are extraterrestrial aliens, also tools of the Illuminati. *Harper's Magazine* recently published a transcript of the conversation between Tshabalala-Msimang and South Africa's Radio 702 commentator John Robbie, in which the health minister refused to answer direct questions about the epidemic and her distribution of the Cooper excerpt, one of which was: "Do you accept that HIV causes AIDS?"

Tshabalala-Msimang's evasion is in keeping with official policy. President

Thabo Mbeki, who drew a firestorm of criticism last year with his refusal to provide the drug AZT to infected pregnant women, apparently does not believe that HIV causes AIDS. In the summer of 2000, he assembled an advisory panel to examine the true nature of AIDS, reports the Africa Policy Information Center. The panel included mainstream scientists and “dissidents,” scientists who believe that immune deficiency is caused by a variety of factors including poverty, malnutrition, poor hygiene, and local diseases. Critics charge that by giving HIV deniers a platform, Mbeki is contributing to genocide.

The results of the panel’s deliberations were hardly unexpected: the two sides remained at odds, and no agreement on the cause of AIDS was reached. This lack of consensus will likely serve to justify the government’s continued inaction.

While there is little evidence supporting the existence of the Illuminati, there is a conspiracy afoot—one best described by Nelson Mandela as “a conspiracy of silence.” The current face of this conspiracy is the intentioned blindness that allows the epidemic to rage virtually unchecked. It’s true what they say about denial, it’s not just a river in

Egypt; it is a flood that will devastate an entire nation. ■

“God Loves Ephedra”

The 1994 Dietary Supplement Health and Education Act essentially freed “natural” remedies from federal regulation. Since then vitamins, minerals, herbs, and sports nutrients have become a \$15.7 billion industry, reports the *Washington Post*. The industry uses the usual combination of methods to protect and enhance its interests—lobbyists, political contributions, advertising, and letter-writing campaigns to pressure government agencies—plus a few new techniques that are proving to be quite successful.

The main beneficiary of these efforts is the industry’s biggest money-maker, ephedra. A powerful herbal stimulant, it is primarily taken as a weight loss aid. It is also linked to insomnia, arrhythmia, hypertension, heart attacks, seizures, and strokes. Federal health officials have labeled the substance “legal speed.”

Prompted by reports of more than 1,200 cases of illness and eight deaths linked to the herb, the Texas Department of Health tried and failed three

times since 1994 to impose restrictions on the sale of ephedra. The supplements industry induced a stream of mail to lawmakers, and arranged testimonials at every public hearing on the department's proposals. At one such hearing during the state's 1996 attempt, a woman led a revival-style call and response with the audience: "God loves ephedra because it is a wonderful herb."

While not quite a divine intervention, this is nevertheless an interesting and obviously successful tactic. Take note, those of you who would like to see the legalization of other "wonderful herbs." ■

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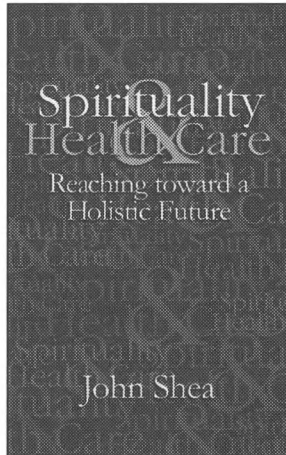
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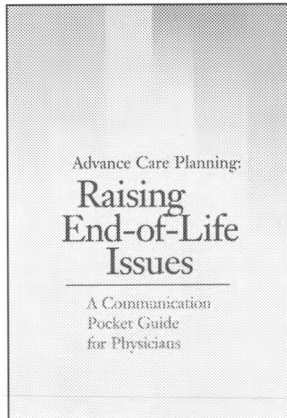
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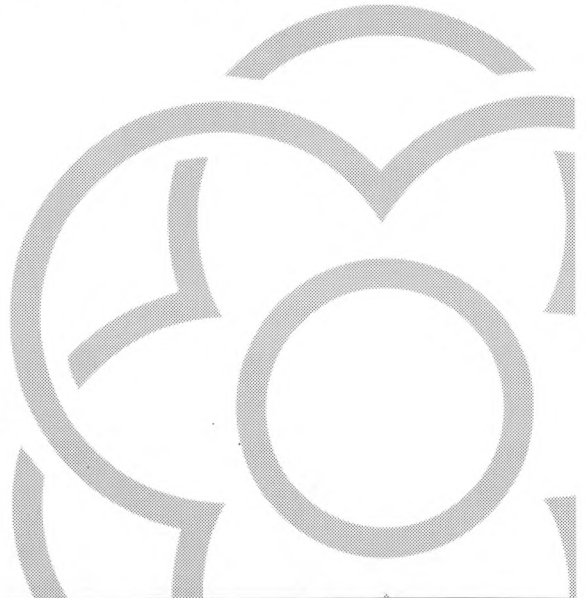
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Second Opinion welcomes manuscripts that address a diverse but educated readership including clinicians, ethicists, policymakers, theologians, chaplains, medical humanities and religious scholars, journalists, and general readers. Given this range, the Park Ridge Center encourages potential *SO* authors to target manuscripts to a reader who thirsts for an understanding of the issues but does not want to delve into academic jargon. Do not write for the specialists in your field, but rather for the general educated reader.

TOPICS

Issues of special interest include but are not limited to spirituality and health; the role of religion and faith-based organizations in health care; perspectives of specific religious traditions on health issues; ethical and religious challenges of science and technology in general and of the post-genomic era in particular; aging; care and coping at the end of life; inequality in health care; public and global health; and social justice.

TYPES OF MANUSCRIPTS

Essays—Original scholarly essays are generally 2,000 to 5,000 words.

Features—First-person narratives, fiction, poetry, art, personal perspectives, debate and commentary, and preliminary works in progress are generally up to 5,000 words where applicable. While *SO* editors intend to publish commissioned poetry, submitted poetry will be considered.

Perspective Book Reviews—Editors will commission these reviews of multiple books on a similar topic. Authors are asked to review the books and provide an overarching perspective within 2,000 to 3,000 words.

Books in Brief—Editors will commission reviews of individual books at 600 to 700 words each.

TO SUBMIT A MANUSCRIPT

Direct inquiries about potential *SO* articles to senior editor David B. McCurdy (phone: 312/266-2222 ext. 225, fax: 312/266-6086, e-mail: dbm@prchfe.org). Submit manuscripts to managing editor Therese Samodral (phone: 312/266-2222 ext. 228; fax: 312/266-6086; e-mail: tsamodral@prchfe.org), or contact her for the document “Guidelines for Authors.”

SECOND O P I N I O N

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Essays

Divine Therapy:

Lessons on Dying Well from the Ancient Church

Vigen Guroian

The Christian Pastor's Role in Medical Ethics:

In the Pew and at the Bedside

Joseph J. Kotva Jr.

Perspective

Integrating Spirituality into Health Care:

Adaptive Challenges and Spiritual Paths

John Shea



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