11 Salvation and Health: Why Medicine Needs the Church

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A Text and a Story

While it is not unheard of for a theologian to begin an essay with a text from the Scripture, it is relatively rare for those who are addressing issues of medicine to do so. However I begin with a text, as almost everything I have to say is but a commentary on this passage from Job 2:11-13:

> Now when Job's friends heard of all this evil that had come upon him, then came each from his own place, Eliphaz the Temanite, Bildad the Shuhite, and Zophar the Na'amathite. They made an appointment together to come console with him and comfort him. And when they saw him from afar, they did not recognize him; and they raised their voices and wept; and they rent their robes and sprinkled dust upon their heads toward heaven. And they sat with him on the ground seven days and seven nights, and no one spoke a word to him, for they saw that his suffering was very great.

I do not want to comment immediately on the text. Instead, I think it best to begin by telling you a story. The story is about one of my earliest friendships. When I was in my early teens I had a friend, let's call him Bob, who meant everything to me. We made our first hesitant steps toward growing up through sharing the things young boys do — i.e., double dating, athletic activities, and endless discussions on every topic. For two years we were inseparable. I was extremely appreciative of Bob's friendship, as he was not only brighter and more talented than I, but also came from a family that was economically considerably better off than my own. Through Bob I was introduced to a world that otherwise I would hardly know existed. For example, we spent hours in his home playing pool in a room that was built for no other purpose; and we swam in the lake that his house was specifically built to overlook.

Then very early one Sunday morning I received a phone call from Bob requesting that I come to see him immediately. He was sobbing intensely but through his crying he was able to tell me that they had just found his mother dead. She had committed suicide by placing a shotgun in her mouth. I knew immediately I did not want to go to see him and/or confront a reality like that. I had not yet learned the desperation hidden under our everyday routines and I did not want to learn of it. Moreover I did not want to go because I knew there was nothing I could do or say to make things even appear better than they were. Finally I did not want to go because I did not want to be close to anyone who had been touched by such a tragedy.

But I went. I felt awkward, but I went. And as I came into Bob's room we embraced, a gesture that was almost unheard of between young men raised in the Southwest, and we cried together. After that first period of shared sorrow we somehow calmed down and took a walk. For the rest of the day and that night we stayed together. I do not remember what we said, but I do remember that it was inconsequential. We never talked about his mother or what had happened. We never speculated about why she might do such a thing, even though I could not believe someone who seemed to have such a good life would want to die. We did what we always did. We talked girls, football, cars, movies, and anything else that was inconsequential enough to distract our attention from this horrible event.

As I look on that time I now realize that it was obviously one of the most important events in my life. That it was so is at least partly indicated by

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how often I have thought about it and tried to understand its significance in the years from then to now. As often as I have reflected on what happened in that short space of time I have also remembered how inept I was in helping Bob. I did not know what should or could be said. I did not know how to help him start sorting out such a horrible event so that he could go on. All I could do was be present.

But time has helped me realize that this is all he wanted — namely, my presence. For as inept as I was, my willingness to be present was a sign that this was not an event so horrible that it drew us away from all other human contact. Life could go on, and in the days to follow we would again swim together, double date, and generally waste time. I now think that at the time God granted me the marvelous privilege of being a presence in the face of profound pain and suffering even when I did not appreciate the significance of being present.

Yet the story cannot end here. For while it is true that Bob and I did go on being friends, nothing was the same. For a few months we continued to see one another often, but somehow the innocent joy of loving one another was gone. We slowly found that our lives were going in different directions and we developed new friends. No doubt the difference between our social and cultural opportunities helps explain to some extent our drifting apart. Bob finally went to Princeton and I went to Southwestern University in Georgetown, Texas.

But that kind of explanation for our growing apart is not sufficient. What was standing between us was that day and night we spent together under the burden of a profound sadness that neither of us had known could exist until that time. We had shared a pain so intense that for a short period we had become closer than we knew, but now the very pain that created that sharing stood in the way of the development of our friendship. Neither of us wished to recapture that time, nor did we know how to make that night and day part of our ongoing story together. So we went our separate ways. I have no idea what became of Bob, though every once in a while I remember to ask my mother if she has heard about him.

Does medicine need the church? How could this text and this story possible help us understand that question, much less suggest how it might be answered? Yet I am going to claim in this essay that it does. Put briefly, what I will try to show is that if medicine can be rightly understood as an activity that trains some to know how to be present to those in pain, then something very much like a church is needed to sustain that presence day in and day out. Before I try to develop that thesis, however, I need to do some conceptual groundbreaking to make clear exactly what kind of claim I am trying to make about the relationship of salvation and health, medicine and the church.

Religion and Medicine: Is There or Should There Be a Relation?

It is a well-known fact that for most of human history there has been a close affinity between religion and medicine. Indeed that very way of putting it is misleading, since to claim a relation suggests that they were distinguished, and often that has not been the case. From earliest times, disease and illness were not seen as matters having no religious import but rather as resulting from the disfavor of God. As Darrel Amundsen and Gary Ferngren have recently reminded us, the Hebrew scriptures often depict God promising

> health and prosperity for the covenant people if they are faithful to him, and disease and other suffering if they spurn his love. This promise runs through the Old Testament. "If you will diligently hearken to the voice of the Lord your God, and do that which is right in his eyes, and give heed to his commandments and keep all his statutes, I will put none of the diseases upon you which I put upon the Egyptians; for I am the Lord, your healer" (Exod. 15:26). ([2], p. 92)

This view of illness was not associated only with the community as a whole, but with individuals. Thus in Psalm 38 the lament is

> There is no soundness in my flesh because of thy indignation; there is no health in my bones because of my sin. . . . My wounds grow foul and fester because of foolishness. . . . I am utterly spent and crushed; I groan because of the tumult of my heart. . . . Do not forsake me, O Lord! O my God, be not far from me! Make haste to help me, O Lord, my salvation! (vv. 3, 5, 8, 21-22)

Amundsen and Ferngren point out this view of illness as accompanied by the assumption that acknowledgment of and repentence for our sin was essential for our healing. Thus in Psalm 32:

> When I declared not my sin, my body wasted away through my groaning all day long. For day and night thy hand was heavy upon me; my strength was dried up. . . . I acknowledged my sin to thee, and I did not hide my iniquity; I said, "I will confess my transgressions to the Lord"; then thou didst forgive the guilt of my sin. (vv. 3-5) ([2], p. 93)

Since illness and sin were closely connected it is not surprising that healing was also closely associated with religious practices — or, put more accurately, healing was a religious discipline. Indeed Amundsen and Ferngren make the interesting point that since the most important issue was a person's relationship with God the chief means of healing was naturally prayer. That clearly precluded magic and thus the Mosaic code excluded soothsayers, augurs, sorcerers, charmers, wizards, and other such figures who offered a means to control or avoid the primary issue of their relation to Yahweh ([2], p. 94). They also suggest that this may have been why no sacerdotal medical practice developed in Israel particularly associated with the priesthood. Rather, the pattern of the Exodus tended to prevail, with illness and healing more closely associated with prophetic activity.

The early Christian community seems to have done little to change these basic presuppositions. If anything it simply intensified them by adding what Amundsen and Ferngren call the "central paradox" in the New Testament:

> Strength comes only through weakness. This strength is Christ's strength that comes only through dependence upon him. In the Gospel of John, Christ says: "I have said to you, that in me you may have peace. In the world you have tribulation; but be of good cheer, I have overcome the world" (16:33). "In the world you have tribulation." It is simply to be expected and accepted. But for the New Testament Christian no suffering is meaningless. The ultimate purpose and meaning behind Christian suffering in the New Testament is spiritual maturity. And the ultimate goal in spiritual maturity is a close dependence upon Christ based upon a childlike trust. ([2], p. 96)

Thus illness is seen as an opportunity for growth in faith and trust in God.

Because of this way of viewing both the positive and negative effect of illness, Amundsen and Ferngren note that there has always been a degree of tension in the way Christians understand the relation between theology and secular medicine, between the medicine of the soul and the medicine of the body.

> According to one view, if God sends disease either to punish or to test a person, it is to God that one must turn for care and healing. If God is both the source and healer of a person's ills, the use of human medicine would circumvent the spiritual framework by resorting to worldly wisdom. On another view, if God is the source of disease, or if God permits disease and is the ultimate healer, God's will can be fulfilled through human agents, who with divine help have acquired the ability to aid in the curative process. Most Christians have asserted that the human agent of care, the physician, is an instrument of God, used by God in bringing succor to humankind. But in every age some have maintained that any use of human medicine is a manifestation of a lack of faith. This ambivalence in the Christian attitude, among both theologians and laity, has always been present to some degree. ([2], p. 96)

Nor is it possible to separate or distinguish religion and medicine on the basis of a distinction between soul and body. For as Paul Ramsey has reminded us, Christians affirm that God has created and holds us sacred as embodied souls ([14], p. xiii). Religion does not deal with the soul and medicine with the body. Practitioners of both are too well aware of the inseparability of soul and body — or perhaps better, they know the abstractness of both categories. Moreover when religion too easily legitimates the independence of medical care by limiting medicine to mechanical understanding and care of the body, it has the result of making religious convictions ethereal in character. It may be that just to the extent Christianity is always tempted in Gnostic and Manichean direc-

tions it accepts too willingly a technological understanding of medicine. Christians, if they are to be faithful to their convictions, may not ever be able to avoid at least potential conflict between their own assumptions about illness and health and how the ill should be cared for and the assumptions of medicine. One hopes for cooperation, of course, but structurally the possibility of conflict between church and medicine cannot be excluded, since both entail convictions and practices concerned with that same subject.

Put differently, given Judaism and Christianity's understanding of humankind's relation with God — that is: how we understand salvation — health can never be thought of as an autonomous sphere. Moreover, insofar as medicine is a specialized activity distinguished from religious convictions, you cannot exclude the possibility that there may well be conflict between religion and medicine. For in many ways the latter is constantly tempted to offer a form of salvation that religiously may come close to idolatry. The ability of modern medicine to cure is at once a benefit and potential pitfall. Too often it is tempted to increase its power by offering more than care, by offering in fact alleviation from the human condition — e.g., the development of artificial hearts. That is not the fault of medical practitioners, though often they encourage such idolatry; rather the fault lies with those of us who pretentiously place undue expectations on medicine in the hope of finding an earthly remedy to our death. But we can never forget that the relation between medicine and health, and especially the health of a population, is as ambiguous as the relation between the church and salvation.

In the hope of securing peace between medicine and religion, two quite different and equally unsatisfactory proposals have been suggested. The first advocates a strong division of labor between medicine and religion by limiting the scope of medicine to the mechanism of our body. While it is certainly true that medicine in a unique way entails the passing on of the wisdom of the body from one generation to another, there is no way that medical care can be limited to the body and be good medicine [10]. As Ramsey has reminded us again and again, the moral commitment of the physician is not to treat diseases, or populations, or the human race, but the immediate patient before him or her ([14], pp. 36, 59). Religiously, therefore, the care offered by physicians cannot be abstracted from the moral commitment to care based on our view that every aspect of our existence is dependent upon God.

By the same token the clergy, no less than physicians, are concerned about the patient's physical well-being. No assumptions about technical skills and knowledge can legitimate the clergy retreating into the realm of the spiritual in order to claim some continued usefulness and status. Such a retreat is as unfaithful as abandoning the natural world to the physicist on the grounds that God is a God of history and not of nature. For the church and its officeholders to abandon claims over the body in the name of a lack of expertise is equivalent to reducing God to the gaps in scientific theory. Such a strategy is not only bad faith but it results in making religious convictions appear at best irrelevant and at worse foolish.

The second alternative to accepting the autonomy of medicine from our religious convictions seeks to maintain a close relationship by resacralizing medical care. Medicine requires a "holistic vision of man" ([7], p. 9), because the care it brings is but one aspect of salvation. Thus the church and its theology serve medical care by promoting a holistic view of man, one that can provide a

> comprehensive understanding of human health [that] includes the greatest possible harmony of all man's forces and energies, the greatest possible spiritualization of man's bodily aspects and the finest embodiment of the spiritual. True health is revealed in the self-actualization of the person who has attained that freedom which marshals all available energies for the fulfillment of his total human vocation. ([7], p. 154)

Such a view of health, however, cannot help but pervert the kind of care that physicians can provide. Physicians rightly maintain that their skill primarily has to do with the body, as medicine promises us health, not happiness. When such a general understanding of health is made the goal of medicine, it only results in making medical care promise more than it can deliver. As a result, we are tyrannized by the agents of medicine because we have voluntarily vested them with too much power. It is already a difficult task in our society

to control the expectations people have about modern medicine; we only compound that problem by providing religious legitimacy to this overblown understanding of health. Certainly we believe that any account of salvation includes questions of our health, but that does not mean that medicine can or ever should become the agency of salvation. It may be a fundamental judgment on the church's failure to help us locate wherein our salvation lies that so many today seek a salvation through medicine.

Can Medical Ethics Be Christian?

The already complex question of the relation between religion and medicine only becomes more confusing when we turn our attention to more recent developments in medical ethics. For even though religious thinkers have been at the forefront of much of the work done in the expanding field of "medical ethics," it is not clear that they have been there as religious thinkers. Joseph Fletcher [5], Paul Ramsey [15], James Gustafson [6], Charles Curran [4], Jim Childress [3], to name just a few, have done extensive work in medical ethics, but often it is hard to tell how their religious convictions have made a difference for the methodology they employ or for their response to specific quandaries. Indeed it is interesting to note how seldom they raise issues of the meaning or relation of salvation and health, as they seem to prefer dealing with questions of death and dying, truth-telling, etc.

By calling attention to this fact by no means do I wish to disparage the kind of reflection that has been done concerning these issues. We have all benefited from their careful analysis and distinctions concerning such problems. Yet one must wonder if, by letting the agenda be set in such a manner, we have already lost the theological ball game. For the very concentration on "issues" and "quandaries" as central for medical ethics tends to underwrite the practice of medicine as we know it, rather than challenging some of the basic presuppositions of medical practice and care. Because of this failure to raise more fundamental questions, concerns that might provide more access for our theological claims are simply never considered.

There are at least two reasons for this that I think are worth mentioning. The first has to do with the character of theological ethics itself. We tend to forget that the development of "Christian ethics" is a relatively new development [8]. It has only been in the last hundred years that some have styled themselves as "ethicists" rather than simply theologians. It is by no means clear that we know how to indicate what difference it makes conceptually and methodologically to claim our ethics as Christian in distinction from other kinds of ethical reflection. In the hopes of securing great clarity about their own work many who have identified their work as Christian have nonetheless assumed that the meaning and method of "ethics" was determined fundamentally by non-Christian sources. In a sense the very concentration on "medical ethics" was a godsend for many "religious ethicists," as it seemed to provide a coherent activity without having to deal with the fundamental issue of what makes Christian ethics Christian.

This can be illustrated by attending to the debate among Christian ethicists concerning whether Christian moral reasoning is primarily deontological or consequential. This debate has been particularly important for medical ethics, as obviously how you think about non-therapeutic experimentation, truth-telling, transplants, and a host of other issues seems to turn on this issue. For instance, Joseph Fletcher, who wrote one of the first books by a Protestant in medical ethics, has always argued in favor of a consequential stance, thus qualifying the physician's commitment to an individual patient in the name of a greater good [5]. In contrast, Paul Ramsey has emphasized that the "covenant" of the physician with the patient is such that no amount of good to be done should override that commitment [14].

It is interesting to note how each makes theological appeals to support his own position. Fletcher appeals to love as his basic norm, interpreting it in terms of the greatest good for the greatest number, but it remains unclear how his sense of love is theologically warranted or controlled. Ramsey provides a stronger theological case for his emphasis on "covenant" as a central theological motif, but it is not clear how the many "covenants of life with life into which we are born" require the covenant of God with a particular people we find in Scripture. Ramsey's use of

covenant language thus underwrites a natural law ethic whose status is unclear both from a theological and/or philosophical perspective.[1]

What is interesting about the debate between Fletcher and Ramsey is that it could have been carried on completely separate from the theological premises that each side claimed were involved. For the terms of the debate — *consequential* and *deontological* — are basically borrowed from philosophical contexts and are dependent on the presuppositions of certain philosophical traditions. Of course that in itself does not mean that such issues and concepts are irrelevant to our work as theologians, but what is missing is any sense of how the issue as presented grows, is dependent on, or informed by our distinctive commitments as theologians.

The question of the nature of theological ethics and its relation to the development of ethical reflection in and about medicine is further complicated by our current cultural situation. As Ramsey has pointed out, we are currently trying to do the impossible — namely, "build a civilization without an agreed civil tradition and [in] the absence of a moral consensus" ([13], p. 15). This makes the practice of medicine even more morally challenging, since it is by no means clear how one can sustain a non-arbitrary medicine in a genuinely morally pluralistic society. For example, much of the debate about when someone is "really" dead is not simply the result of our increased technological power to keep blood flowing through our bodies, but witnesses to our culture's lack of consensus as to what constitutes a well-lived life and the correlative sense of a good death. In the absence of such a consensus our only recourse is to resort to claims and counterclaims about "right to life" and "right to die," with the result of the further impoverishment of our moral language and vision. Moreover, the only way to create a "safe" medicine under such conditions is to expect physicians to treat us as if death is the ultimate enemy to be put off by every means. Then we blame physicians for keeping us alive beyond all reason, but fail to note that if they did not we would not know how to distinguish them from murderers.

Alasdair MacIntyre has raised this sort of issue directly in his "Can Medicine Dispense with a Theological Perspective on Human Nature?" Rather than calling attention to what has become problematic for physicians and surgeons — issues such as when it is appropriate to let someone die — he says he wants to direct our attention to what is still taken for granted, "namely, the unconditional and absolute character of certain of the doctor's obligations to his patients" ([12], p. 120). The difficulty is that modern philosophy, according to MacIntyre, has been unable to offer a persuasive account of such an obligation.

> *Either* they distort and misrepresent it *or* they render it unintelligible. Teleological moralists characteristically end up by distorting and misrepresenting. For they begin with a notion of moral rules as specifying how we are to behave if we are to achieve certain ends, perhaps *the* end for man, the *summum bonum.* If I break such rules I shall fail to achieve some human good and will thereby be frustrated and impoverished. ([12], p. 122)

But MacIntyre notes that this treats moral failure as if it is an educational failure and lacks the profound guilt that should accompany moral failure. More importantly, such an account fails entirely to account for the positive evil we know certain people clearly pursue.

Moral philosophers who tend to preserve the unconditional and absolute character of the central requirements of morality, however, inevitably make those "oughts" appear as if they are arbitrary. What they cannot do is show how those oughts are rationally entailed by an account of man's true end. Kant was only able to do so because he continued the presupposition (which he failed to justify within his own philosophical position) that "the life of the individual and also of that of the human race is a journey toward a goal" ([12], p. 127). Once that presupposition is lost, however, and MacIntyre believes that it has been lost in our culture, then we lack the resources to maintain exactly those moral presuppositions that seem essential to securing the moral integrity of medicine.

Such a situation seems ripe for a theological response, since it might at least be suggested that it thus becomes our task as theologians to serve our culture in general and medicine in particular by supplying the needed rationale. Yet, MacIntyre argues, such a strategy is doomed, since the very intelligibility of theological claims has been ren-

dered problematic by the ethos of modernity. Therefore, just to the extent theologians try to make their claims in terms offered by modernity, they only underwrite the assumption that theological language cannot be meaningful.

This kind of dilemma is particularly acute when it comes to medicine. For if the theologian attempts to underwrite the medical ethos drawing on the particular convictions of Christians, just to the extent those convictions are particular they will serve only to emphasize society's lack of a common morality. Thus theologians, in the interest of cultural consensus, often try to downplay the distinctiveness of their theological convictions in the interest of societal harmony. But in the process we only reinforce the assumption on the part of many that theological claims make little difference for how medicine itself is understood or how various issues are approached. At best theology or religion is left with justifying a concern with the "whole patient," but it is not even clear how that concern depends on or derives from any substantive theological conviction that is distinguishable from humanism.

Almost as if we have sense that there is no way to resolve this dilemma, theologians and religious professionals involved in medicine have tended to associate with the patients' rights movement. At least one of the ways of resolving our cultural dilemma is to protect the patient from medicine by restoring the patient's autonomy over against the physician. While I certainly do not want to underestimate the importance of patients recovering a sense of medicine as an activity in which we play as important a role as the physician, the emphasis on the patient's rights over against the physician cannot resolve our difficulty. It is but an attempt to substitute procedural safeguards for what only substantive convictions can supply. As a result our attention is distracted from the genuine challenge we confront for the forming of an ethos sufficient to sustain a practice of medicine that is morally worthy.

Pain, Loneliness, and Being Present: The Church and the Care of the Ill

I can offer no "solution" to the issues raised in the previous section, as I think they admit of no solution, given our social and political situation. Moreover, I think we will make little headway on such matters as long as we try to address the questions in terms of the dichotomies of religion and medicine or the relation between medical ethics and theology. Rather, what is needed is a restatement of the issue. In this section I will try to do that by returning to my original text and story to suggest how they may help remind us that more fundamental than questions of religion and morality is the question of the kind of community necessary to sustain the long-term care of the ill.

Indeed, part of the problem with discussing the question of "relation" in such general terms as "medicine" and "religion" is that each of those terms in its own way distorts the character of what it is meant to describe. For example, when we talk in general about "religion" rather than a specific set of beliefs, behaviors, and habits embodied by a distinct group of people, our account always tends to be reductionistic. It makes it appear that underlying what people actually believe and do is a deeper reality called "religion." It is as if we can talk about God abstracted from how a people have learned to pray to that God. In like manner we often tend to oversimplify the nature of medicine by trying to capture the many activities covered by that term in a definition or ideological system. What doctors do is often quite different from what they say they do.

Moreover, the question of the relation of theology to medical ethics is far too abstract. For when the issue is posed in that manner it makes it appear that religion is primarily a set of beliefs, a world view, that may or may not have implications for how we understand and respond to certain kinds of ethical dilemmas. While it is certainly true that Christianity involves beliefs, the character of those beliefs cannot be understood apart from its place in the formation of a community with cultic practices. By focusing on this fact I hope to throw a different perspective on how those who are called to care for the sick can draw upon and count on the particular kind of community we call the church.

I do not intend, for example, to argue that medicine must be reclaimed as in some decisive way dependent on theology. Nor do I want to argue that the development of "medical ethics" will ulti-

mately require the acknowledgment of, or recourse to, theological presuppositions. Rather all I want to try to show is why, given the particular demands put on those who care for the ill, something very much like a church is necessary to sustain that care.

To develop this point I want to call attention to an obvious but often overlooked aspect of illness — namely, that when we are sick we hurt and are in pain. I realize that often we are sick and yet not in pain — e.g., hardening of the arteries — but that does not ultimately defeat my general point, since we know that such an illness will lead to physical and mental pain. Nor am I particularly bothered by the observation that many pains are "psychological," having no real physiological basis. Physicians are right to insist that people who say they have pain, even if no organic basis can be found for such pain, are in fact, in pain, though they may be mistaken about what kind of pain it is.

Moreover I am well aware that there are many different kinds of pain, as well as intensity of pains. What is only a minor hurt for me may be a major trauma for someone else. Pain comes in many shapes and sizes and it is never possible to separate the psychological aspects of pain from the organic. For example, suffering, which is not the same as pain since we can suffer without being in pain, is nonetheless akin to pain inasmuch as it is a felt deficiency that can make us as miserable as pain itself.[2]

Yet given these qualifications it remains true that there is a strong connection between pain and illness, an area of our lives in which it is appropriate to call upon the skills of a physician. When we are in pain we want to be helped. But it is exactly at this point that one of the strangest aspects of our being in pain occurs — namely, it is impossible for us to experience one another's pain. That does not mean we cannot communicate to one another our pain. That we can do, but what cannot be done is for you to understand and/or experience my pain as mine.

This puts us under a double burden because we have enough of a problem learning to know one another in the normal aspects of our lives, but when we are in pain our alienation from one another only increases. For no matter how sympathetic we may be to the other in pain, that very pain creates a history and experience that makes the other just that much more foreign to me. Our pains isolate us from one another as they create worlds that cut us off from one another. Consider, for example, the immense gulf between the world of the sick and the healthy. No matter how much we may experience the former, when we are healthy or not in pain we have trouble imagining and understanding the world of the ill.

Indeed the terms we are using are still far too crude. For we do not suffer illness in and of itself, but we suffer this particular kind of illness and have this particular kind of pain. Thus even within the world of illness there are subworlds that are not easily crossed. Think, for example, of how important it is for those suffering from the same illness to share their stories with one another. They do not believe others can understand their particular kind of pain. People with heart disease may find little basis of communion with those suffering from cancer. Pain itself does not create a shared experience; only pain from a particular kind and sort. Moreover the very commonality thus created separates the ill from the healthy in a decisive way.

Pain not only isolates us from one another, but even from ourselves. Think how quickly people with a terribly diseased limb or organ are anxious for surgery in the hope that if it is just cut off or cut out they will not be burdened by the pain that makes them not know themselves. This gangrenous leg is not mine. I would prefer to lose the leg rather than face the reality of its connection to me.

The difficulties pain creates in terms of our relation with ourselves is compounded by the peculiar difficulties it creates for those close to us who do not share our pain. For no matter how sympathetic they may be, no matter how much they may try to be with and comfort us, we know they do not want to experience our pain. I not only cannot, but I do not want to, know the pain you are feeling. No matter how good willed we may be, we cannot take anther's pain as our pain. Our pains divide us and there is little we can do to restore our unity.

I suspect this is one of the reasons that chronic illness is such a burden. For often we are willing to be present and sympathetic with someone with an intense but temporary pain — that is, we are

willing to be present as long as they work at being "good" sick people who try to get well quickly and do not make too much of their discomfort. We may initially be quite sympathetic with someone with a chronic disease, but it seems to be asking too much of us to be compassionate year in and year out. Thus the universal testimony of people with chronic illness is that their illness often results in the alienation of their former friends. This is a problem not only for the person who is ill but also for those closely connected with that person. The family of a person who is chronically ill often discover that the very skills and habits they must learn to be present to the one in pain creates a gulf between themselves and their friends. Perhaps no case illustrates this more poignantly than a family that has a retarded child. Often they discover it is not long before they have a whole new set of friends who also happen to have retarded children [9].

Exactly because pain is so alienating, we are hesitant to admit that we are in pain. To be in pain means we need help, that we are vulnerable to the interests of others, that we are not in control of our destiny. Thus we seek to deny our pain in the hope that we will be able to handle it within ourselves. But the attempt to deal with our pain by ourselves or to deny its existence has the odd effect of only increasing our loneliness. For exactly to the extent I am successful, I create a story about myself that I cannot easily share.

No doubt more can be and needs to be said that would nuance this account of pain and the way it tends to isolate us from one another. Yet I think I have said enough that our attention has been called to this quite common but all the more extraordinary aspect of our existence. Moreover, in the light of this analysis I hope we can now appreciate the remarkable behavior of Job's friends. For in spite of the bad press Job's comforters usually receive (and in many ways it is deserved!), they at least sat on the ground with him for seven days. Moreover they did not speak to him, "for they saw that his suffering was very great." That they did so is truly an act of magnanimity, for most of us are willing to be with sufferers, especially those in such pain that we can hardly recognize them, only if we can "do something" to relieve their suffering or at least distract their attention. Not so with Job's comforters. They sat on the ground with Job doing nothing more than being willing to be present in the face of his suffering.

Now if any of this is close to being right, it puts the task of physicians and others who are pledged to be with the ill in an interesting perspective. For I take it that their activity as physicians is characterized by the fundamental commitment to be, like Job's comforters, in the presence of those in pain.[3] At this moment I am not concerned to explore the moral reason for that commitment, but only to note that in fact physicians, nurses, chaplains, and many others are present to the ill as none of the rest of us are. They are the bridge between the world of the ill and the healthy.

Certainly physicians are there because they have been trained with skills that enable them to alleviate the pain of the ill. They have learned from sick people how to help other sick people. Yet every physician soon learns of the terrible limit of his/her craft, for the sheer particularity of the patient's illness often defies the best knowledge and skill. Even more dramatically, physicians learn that using the best knowledge and skill they have on some patients sometimes has terrible results.

Yet the fact that medicine through the agency of physicians does not and cannot always "cure" in no way qualifies the commitment of the physician. At least it does not do so if we remember that the physician's basic pledge is not to cure, but to care through being present to the one in pain. Yet it is not easy to carry out that commitment on a day-to-day, year-to-year basis. For none of us have the resources to see too much pain without the pain hardening us. Without such a hardening, something we sometimes call by the name of professional distance, we fear we will lose the ability to feel at all.

Yet the physician cannot help but be touched and, thus, tainted by the world of the sick. Through their willingness to be present to us in our most vulnerable moments they are forever scarred with our pain — a pain that we the healthy want to deny or at least keep at arm's length. They have seen a world we do not want to see until it is forced on us, and we will accept them into polite community only to the extent they keep that world hidden from us. But when we are driven into that world we want to be able to count on their skill

and their presence, even though we have been unwilling to face that reality while we were healthy.

But what do these somewhat random and controversial observations have to do with helping us better understand the relation between medicine and the church and/or the story of my boyhood friendship with Bob? To begin with the latter, I think in some ways the mechanism that was working during that trying time with Bob is quite similar to the mechanism that works on a day-to-day basis in medicine. For the physician, and others concerned with our illness, are called to be present during times of great pain and tragedy. Indeed physicians, because of their moral commitments, have the privilege and the burden to be with us when we are most vulnerable. The physician learns our deepest fears and our profoundest hopes. As patients, that is also why so often we fear the physician, because she/he may know us better than we know ourselves. Surely that is one of the reasons that confidentiality is so crucial to the patient-physician relation, since it is a situation of such intimacy.

But just to the extent that the physician has been granted the privilege of being with us while we are in pain, that very experience creates the seeds of distrust and fear. We are afraid of one another's use of the knowledge gained, but even more deeply we fear remembering the pain as part of our history. Thus every crisis that joins us in a common fight for health also has the potential for separating us more profoundly after the crisis. Yet the physician is pledged to come to our aid again and again, no matter how we may try to protect ourselves from his/her presence.

The physician, on the other hand, has yet another problem, for how can anyone be present to the ill day in and day out without learning to dislike, if not positively detest, our smallness in the face of pain. People in pain are omnivorous in their appetite for help, and they will use us up if we let them. Fortunately the physician has other patients who can give him distance from any patient who requires too much. But the problem still remains how morally those who are pledged to be with the ill never lose their ability to see the humanity that our very suffering often comes close to obliterating. For the physician cannot, as Bob and I did, drift apart and away from those whom he or she is pledged to serve. At least they cannot if I am right that medicine is first of all pledged to be nothing more than a human presence in the face of suffering.

But how can we account for such a commitment — the commitment to be present to those in pain? No doubt basic human sympathy is not to be discounted, but it does not seem to be sufficient to account for a group of people dedicated to being present to the ill as their vocation in life. Nor does it seem sufficient to account for the acquiring of the skills necessary to sustain that presence in a manner that is not alienating and the source of distrust in a community.

To learn how to be present in that way we need examples — that is, a people who have so learned to embody such a presence in their lives that it has become the marrow of their habits. The church at least claims to be such a community, as it is a group of people called out by a God who, we believe, is always present to us, both in our sin and our faithfulness. Because of God's faithfulness we are supposed to be a people who have learned how to be faithful to one another by our willingness to be present, with all our vulnerabilities, to one another. For what does our God require of us other than our unfailing presence in the midst of the world's sin and pain? Thus our willingness to be ill and to ask for help, as well as our willingness to be present with the ill is no special or extraordinary activity, but a form of the Christian obligation to be present to one another in and out of pain.

Moreover, it is such a people who should have learned how to be present with those in pain without that pain driving them further apart. For the very bond that pain forms between us becomes the basis for alienation, as we have no means to know how to make it part of our common history. Just as it is painful to remember our sins, so we seek not to remember our pain, since we desire to live as if our world and existence were a pain-free one. Only a people trained in remembering, and remembering as a communal act, their sins and pains can offer a paradigm for sustaining across time a painful memory so that it acts to heal rather than to divide.

Thus 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 the care of those in pain over

the long haul. For it is no easy matter to be with the ill, especially when we cannot do much for them other than simply be present. Our very helplessness too often turns to hate, both toward the one in pain and ourselves, as we despise them for reminding us of our helplessness. Only when we remember that our presence is our doing, when sitting on the ground seven days saying nothing is what we can do, can we be saved from our fevered and hopeless attempt to control others' and our own existence. Of course to believe that such presence is what we can and should do entails a belief in a presence in and beyond this world. And it is certainly true many today no longer believe in or experience such a presence. If that is the case, then I do wonder if medicine as an activity of presence is possible in a world without God.

Another way of raising this issue is to ask the relation between prayer and medical care. Nothing I have said about the basic pledge of physicians to be present to the ill entails that they should not try to develop the skills necessary to help those in pain and illness. Certainly they should, as theirs is an art that is one of our most valuable resources for the care of one another. But no matter how powerful that craft becomes, it cannot in principle rule out the necessity of prayer. For prayer is not a supplement to the insufficiency of our medical knowledge and practice; nor is it some divine insurance policy that our medical skill will work; rather, our prayer is the means that we have to make God present whether our medical skill is successful or not. So understood, the issue is not whether medical care and prayer are antithetical, but how medical care can ever be sustained without the necessity of continued prayer.

Finally, those involved in medicine need the church as otherwise they cannot help but be alienated from the rest of us. For unless there is a body of people who have learned the skills of presence, the world of the ill cannot help but become a separate world both for the ill and/or those who care for them. Only a community that is pledged not to fear the stranger — and illness always makes us a stranger to ourselves and others — can welcome the continued presence of the ill in our midst. The hospital is, after all, first and foremost a house of hospitality along the way of our journey with finitude. It is our sign that we will not abandon those who have become ill simply because they currently are suffering the sign of that finitude. If the hospital, as too often is the case today, becomes but a means of isolating the ill from the rest of us, then we have betrayed its central purpose and distorted our community and ourselves.

If the church can be the kind of people who show clearly that they have learned to be with the sick and the dying, it may just be that through that process we will better understand the relation of salvation to health, religion to medicine. Or perhaps even more, we will better understand what kind of medicine we ought to practice, since too often we try to substitute doing for presence. It is surely the case, as Paul Ramsey reminds us, "that not since Socrates posed the question have we learned how to teach virtue. The quandaries of medical ethics are not unlike that question. Still, we can no longer rely upon the ethical assumptions in our culture to be powerful enough or clear enough to instruct the profession in virtue; therefore the medical profession should no longer believe that the personal integrity of physicians alone is enough; neither can anyone count on values being transmitted without thought" ([14], p. xviii). All I have tried to do is remind us that neither can we count on such values being transmitted without a group of people who believe in and live trusting in God's unfailing presence.

Notes

1. Ramsey's position is complex and I certainly cannot do it justice here. His emphasis on "love transforming natural law" would tend to qualify the point made above. Yet it is also true that Ramsey's increasing use of covenant language has gone hand in hand with his readiness to identify certain "covenants" that need no "transformation." Of course he could object that the covenant between doctor and patient is the result of Christian love operating in history.

2. For a fuller account of the complex relation between pain and suffering see [11].

3. I am indebted to a conversation with Dr. Earl Shelp for helping me understand better the significance of this point.

References

[1] Amundsen, D., and Ferngren, G. 1982. "Medicine and Religion: Pre-Christian Antiquity." In M. Marty and K. Vaux, eds., *Health/Medicine and the Faith Traditions,* pp. 53-92. Philadelphia: Fortress Press.

[2] Amundsen, D., and Ferngren, G. 1982. "Medicine and Religion: Early Christianity Through the Middle Ages." In M. Marty and K. Vaux, eds., *Health/Medicine and the Faith Traditions,* pp. 93-132.

[3] Childress, J. 1981. *Priorities in Biomedical Ethics.* Philadelphia: Westminster Press.

[4] Curran, C. 1978. *Issues in Sexual and Medical Ethics.* Notre Dame, Ind.: University of Notre Dame Press.

[5] Fletcher, J. 1954. *Morals and Medicine.* Boston: Beacon Press.

[6] Gustafson, J. 1975. *The Contributions of Theology to Medical Ethics.* Milwaukee: Marquette University Press.

[7] Haring, B. 1973. *Medical Ethics.* South Bend, Ind.: Fides Publishers.

[8] Hauerwas, S. 1983. "On Keeping Theological Ethics Theological." In A. MacIntyre and S. Hauerwas, eds., *Revisions: Changing Perspectives in Moral Philosophy,* pp. 16-42. Notre Dame, Ind.: University of Notre Dame Press.

[9] Hauerwas, S. 1982. "The Retarded, Society and the Family: The Dilemma of Care." In S. Hauerwas, ed., *Responsibility for Devalued Persons.* Springfield, Ill.: Charles C. Thomas.

[10] Hauerwas, S. 1982. "Authority and the Profession of Medicine," In G. Agich, *Responsibility in Health Care,* pp. 83-104. Dordrecht, Holland: Reidel.

[11] Hauerwas, S. 1979. "Reflections on Suffering, Death, and Medicine," *Ethics in Science and Medicine* 6:229-37.

[12] MacIntyre, A. 1981. "Can Medicine Dispense with a Theological Perspective on Human Nature?" In D. Callahan and H. Englehardt, eds., *The Roots of Ethics,* pp. 119-38. New York: Plenum Press.

[13] Ramsey, P. 1973. "The Nature of Medical Ethics." In R. Neatch, M. Gaylin, and C. Morgan, eds., *The Teaching of Medical Ethics,* pp. 14-28. Hastings-on-Hudson, N.Y.: Hastings Center.

[14] Ramsey, P. 1970. *The Patient as Person.* New Haven: Yale University Press.

12 Bio-ethics: Some Challenges from a Liberation Perspective

Karen Lebacqz

The Task

In Lewis Carroll's delightful story *Alice in Wonderland,* Alice has a tendency to change size, not always at will. On once such occasion, the following dialogue ensues:

"Don't squeeze so," said the Dormouse to Alice.

"I can't help it. I'm growing," she replied.

"You've no right to grow *here.*"

"Don't talk nonsense; you know you're growing, too."

"Yes, but *I* grow at a reasonable pace, and not in that ridiculous fashion."

These words describe all too accurately what many of us feel today in the face of the so-called "biological revolution": sitting next to something that appears to be growing at a ridiculous rate, we feel "squeezed" and are tempted to cry out: "You've no right to grow *here.*" Wonderland, or bad dream? Current arguments posit one or the other: proponents hold out visions of miraculous cures for human ailments and new freedoms in human living, while opponents raise the spectre of Huxley's *Brave New World.* Perhaps the only thing on which both would agree is that developments in biomedical technology threaten to change the nature of our existence.

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