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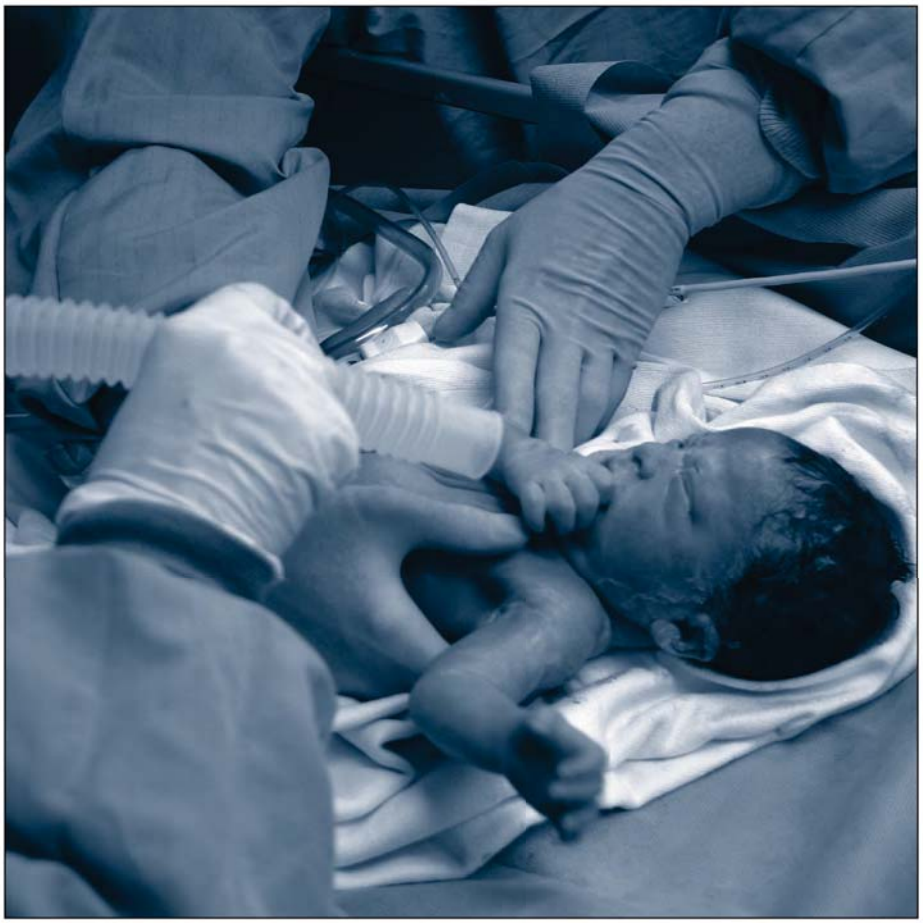

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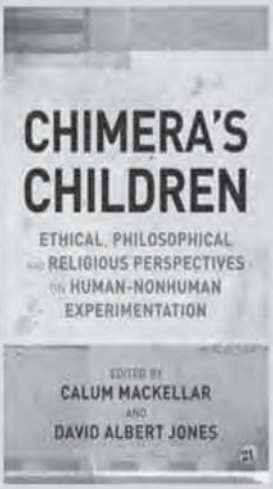

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The idea of human-nonhuman combinations has been a recurrent theme throughout the history of humanity. From the myths of the Minotaur and the centaurs in ancient Greece to the dogheads of the Middle Ages right through to the monsters of modern science fiction, these beings have always been a source of fascination. In recent years, however, biomedical advances have demonstrated the potential to make these entities a reality through the creation of inter-species combinations. As a result, pressing and perplexing ethical questions arise.

Introducing the reader to the historical context of human-nonhuman experimentation and potential future developments, this volume offers clarification, analysis and a thorough overview of the ethical challenges relating to human-nonhuman chimeras, true hybrids, cybrids and other combinations.

This book is the first accessible survey of the different ethical dilemmas facing contemporary society in the creation of human-nonhuman embryonic, foetal and postnatal entities. These include important cultural, legal, philosophical and religious perspectives. As such it will act as a springboard for future debate.

VOL. 29:2 SUMMER 2013

EDITORIAL

MEDICAL ETHICS AND MORAL *HABITUS*

C. BEN MITCHELL, PHD

Readers of this journal are all too familiar with the specious notion that medical ethics is primarily about moral dilemmas. In fact, ethical conundrums involve little time in the average clinical practice. Yet we would be dangerously naïve to assume, therefore, that ethical concerns are not present in each clinical encounter.

The relationship of a physician with his or her patient is an inherently moral relationship. When a patient, typically with some dis-ease, presents to a doctor, typically with years of clinical training and experience, an ethical context is created in which the physician brings the best of his or her skills—and his or her very humanity—to the serve another person's well-being. The disequilibrium created by the patient's dis-ease and the physician's skills are laden with moral obligation. This is why the Hippocratic physician covenanted to "prescribe regimens *for the good of my patient*s… and never to harm anyone." The mantra, "for the good of my patients," should, and most often does, become, through the course of the physician's training, a doctor's way of inhabiting the world.

I have been helped to think about this recently through the work of the European phenomenologist Pierre Bourdieu, who suggests that we do not inhabit the world as pure thinking-things, as pure rationalists, but as actors in the world. That is to say, we do not "decide" our way through each day, carefully calculating every move as if we were computers made of meat. Rather, we embody a *habitus*—a complex of inclinations and dispositions—that, upon reflection, help us understand that we are primarily "doers" who are acting on the world rather than "thinkers" who perchance do things. Moreover, most of us function within a community of practice. Whether we are educators, clinicians, or researchers, we embody the *habitus* of the community of which we are members.

It seems to me that Bourdieu's theory of the "logic of practice" and the place of *habitus* has applications not only to the skills of medicine, but to the ethics of medicine as well. Medical training includes countless opportunities to "watch one, do one, teach one," where "one" refers to some procedure. Eventually, the training is meant to help a physician develop good clinical skills as a habit. Especially in acute situations (e.g., emergency medicine and surgery), a physician does not have the luxury of consulting a medical textbook before intubating a patient or performing resuscitation. Those practices must become what we describe as "second nature." However, not only do physicians learn to embody the habits of good or bad clinical skills, they also learn to embody professional virtues or vices. That "great bedside manner" patients often discuss need not only imply a pleasing etiquette, it may be, even more importantly, an apt description of a virtuous physician. It may well describe a state of affairs in which the disequilibrium is slowly eroded by the sense of confidence and comfort patients feel in the presence of a physician who takes his or her moral obligations seriously—a person who is habituated "to prescribe regimens for the good of my patients . . . and never to harm."

The moral life of a virtuous physician, nurse, or pharmacist is not characterized primarily by a kind of ethical cleverness that enables him or her to reason through the

next case presented in ethics grand rounds, but by a moral *habitus* that shapes every relationship, especially relationships with patients. **E&M**

GREY MATTERS

DOCTORS' HANDWRITING GONE DIGITAL: AN ETHICAL ASSESSMENT OF VOICE RECOGNITION TECHNOLOGY IN MEDICINE

WILLIAM P. CHESHIRE, JR., MD

If the transcription had been correct, there would have been no death.

- an Alabama medical malpractice attorney in response to a $140 million verdict[1]

Abstract

The pen, once the instrument of clinical documentation, is yielding to the more efficient technology of computer-assisted voice recognition. With this transition, in place of the quirky handwriting that has long characterized medical practice, electronic medical documents supply readable and detailed, yet imperfect, text. Technology has not fully solved the problem of medical error but has, in some ways, magnified it. The ethical dimensions of physician-to-computer communication raise questions regarding moral responsibility at the interface of mind and machine.

Introduction

Traditional lore has long regarded physicians' handwriting as an untidy scrawl, decipherable only by other physicians and, with luck, by pharmacists. Although one study found physicians' handwriting to be comparable in clarity to that of other people,[2] other studies have found it to be comparatively less readable.[3,4] Even occasionally illegible handwriting can lead to miscommunication and carry serious implications for the quality and safety of healthcare.[5-7] Poor handwriting is one of the causes of preventable medical error.

The Institute of Medicine, in its 1999 report entitled *To Err is Human: Building a Safer Health System*, estimated that as many as 98,000 people die in U.S. hospitals each year as a result of medical errors that could have been prevented.[8] They found that a majority were caused by systems failures that could have been improved by better information systems capable of making accurate drug and patient information readily accessible at the time it is needed. Its 2006 follow-up study found that medication errors are among the most common sources of medical error, harming at least 1.5 million people each year.[9] Another study found that 6% of preventable adverse drug events are due to transcription errors.[10]

In response, the Institute of Medicine recommended the development of new technologies at the human-machine interface for the purpose of preventing error.[8] Other strategists also look to improvements in information technology for more effective methods, if not the final solution, of eliminating errors in healthcare.[11,12]

The path of progress in the technology of healthcare communication has advanced from the quill to the ballpoint pen and, most recently, from secretarial transcription to dictated voice recognition technology. A number of technological developments have made possible the recognition of continuous speech and large vocabularies, including accelerated computer processing speed, capacious memory for data storage, dedicated digital signal processing chips, and affordable portable hardware systems.[13] Voice recognition software matches patterns of audio input to the digital profiles of previously recorded sounds and calculates the probability that certain sounds will follow other sounds in sentence construction. Current systems can be trained to improve recognition of the accent and style of the speaker, and the user can, to some degree, modify the digital library of words and phrases. Templates, macros, and voice-activated commands further enhance their utility.

Like the medical transcriptionist, the computer listens to either the physician's voice or a recording thereof and renders it into a string of digital text. Unlike the transcriptionist, the computer cannot comprehend the content, whether of technical terminology or even ordinary speech. Substituting for the mind of the transcriptionist is the microcircuitry of the silicon chip. The human mental filter of the intermediary having been removed, the advantages of voice recognition technology for improving the efficiency of communication and decreasing the expense of transcription may come at the cost of mistakes that are unexpected and, at times, quite surprising.

Voice recognition dictation systems raise interesting questions regarding what degree of textual accuracy is ethically acceptable in medical documentation. Acceptable levels of error may differ depending on their type and consequence. Whether current voice recognition technology succeeds in reducing medical error to a tolerable level is a complicated question that has yet to be tested empirically. The following experiment may be a first step.

Methods

The author, who is an experienced user of voice recognition technology in medical practice, undertook a prospective study to assess the accuracy of the current level of this technology. Using Dragon® Medical Practice Edition by Nuance, which claims in its advertisements "99% accuracy out of the box,"[14] the author, seated in a quiet office and speaking clearly and distinctly into a noise-canceling microphone, dictated a 565 word document without making corrections. The chosen text was the 2011 ethics statement of the Christian Medical and Dental Associations (CMDA) on "A Christian Response to Adverse Outcomes Arising from Medical Error."[15] The content of the dictated document was then compared to that of the original text. No human subjects were involved.

Results

In comparison to the original document, the dictated document contained 65 errors, which represents an 88% accuracy rate. The types of errors consisted of one omission; 8 errors of punctuation, tense or plurality; and 46 word or phrase substitutions. Of the errors, 4 did not alter the meaning, 14 altered the meaning but did not affect understanding, and 47 altered the meaning incomprehensibly.

Some of the substitutions that altered the meaning incomprehensibly included "couple ability" for culpability, "more Raleigh" for morally, "permission" for omission, "repayments" for repentance, "contraction" for contrition, "impression" for confession, and "approximately response" for a prompt sympathetic response.

In other instances the substitutions were contextual. Because the software had been programmed for medical usage, it did not allow or recognize religious language within the context of what the software expected to be a clinical note. One dictated sentence read, "Whether or not we are morally coupled well, we need consult to respond rightly to our errors." By contrast, the corresponding original text read, "Whether or not we are morally culpable, we need God's help to respond rightly to our errors." Another dictated phrase read, "we desire to respond to our mistakes in a manner that is just and at times gone," substituting for the original phrasing, "just and that honors God." The dictated version recommended "time to prior fully reflect," whereas the original recommended "time to prayerfully reflect." The dictated version recommended that the reader rely on "the workup," whereas the original text advised reliance on "the Word of God."

Illustrative Extraction

Drawing from the author's accumulated list of actual errors detected (and corrected) during dictation of clinical notes over the past three years, the following fictional clinical encounter was constructed:

Sue me is a tobacco lorry student whose husband is serving in a rack. She had planned to go to loss cool but lost her skull her ship when her grades went from AIDS to seize due to mammary loss and fear of pelvic speaking. She explains that she was Thursday when she fainted while singing intercourse. Her minstrel migraines are triggered by lying, and Ecstasy Tylenol no longer relieves her pain. She requests something from eternal medicine to lemonade the pain in her 4 heads, even if it requires a mother operation to cut a nurse. Funniest topic and Nero logical examinations demonstrate a mobster or Russian with like cremation and a moderate sermon in her ear but otherwise no active apology. The physician am the thighs with the patient and prescribes a cycle of fear in orange shoes as well as coarse old stories and a diet rich in accidents.

The intended words, in contrast, read as follows:

Sumi is a baccalaureate student whose husband is serving in Iraq. She had planned to go to law school but lost her scholarship when her grades went from As to Cs due to memory loss and fear of public speaking. She explains that she was thirsty when she fainted while singing in the chorus. Her menstrual migraines are triggered by wine, and Extra Strength Tylenol no longer relieves her pain. She requests something from internal medicine to eliminate the pain in her forehead, even if it requires another operation to cut a nerve. Funduscopic and neurological examinations demonstrate a zoster eruption with lacrimation and moderate cerumen in her ear but otherwise no active pathology. The physician empathizes with the patient and prescribes acyclovir in orange juice as well as a course of oral steroids and a diet rich in antioxidants.

The list of dictated misrecognitions also includes a pastor with "queasy ethical responsibilities" rather than ecclesiastical responsibilities. Another dictation yielded a

man who felt "an urge likened to confronting her bare" in place of an adrenaline surge likened to confronting a bear.

Discussion

The term "typo," short for typographical error and of 19th century origin, refers to a procedurally simple yet sometimes serious mistake in transcription, such as the omission of the third letter "d" in the surgical phrase, "the patient was prepped and draped," for example. Voice recognition computer blunders can be far more complex and perplexing. A term for this novel twist in textual rendering has yet to be invented.

The results of this small experiment illustrate that misspellings that alter meaning have the potential to cause medical error. The software also contains the potential to redirect the meaning of the text in ways the speaker does not intend and could not foresee.

This study identifies four categories of dictation error: (1) misspellings that do not alter the meaning, (2) misspellings that alter the meaning but do not affect understanding, (3) misspellings that change the meaning of the text in ways that potentially could cause medical harm, and (4) misspellings that could be perceived as egregious or offensive. The third and fourth categories, even when unintentional and unnoticed in time for correction, may reflect badly on the character of the physician.

Studies comparing error rates of voice recognition software to standard dictation have focused on the practice of radiology. McGurk and colleagues found an error rate of 4.8% of voice recognition reports as compared to 2.1% of transcribed reports in a large teaching hospital, with 52.1% of the errors affecting understanding.[16] At another academic center, Pezzullo and colleagues found that voice recognition reports took 50% longer to dictate despite being shorter in length and, in addition, contained an average of 5.1 errors per case. 90% of the reports contained errors prior to report sign-off, as compared to only 10% of transcribed reports. After proofreading and sign-off, 35% of reports still contained errors. Additionally, all radiologists surveyed reported increased fatigue and feelings of frustration when using the voice recognition system.[17] The complexity of the text also influences the error rate. Chang and colleagues found an error rate of 36% in non-computer radiography (magnetic resonance imaging, angiography, ultrasound, computed tomography and nuclear medicine) reports as compared to an 11% error rate in more straightforward plain film reports. Nonsense phrases were found in 5% and 2% of those reports, respectively.[18]

Economic forces are hastening the entry of voice recognition technology into clinical practice.[19] Future gains in computer processing speed and software enhancements will likely further improve its accuracy. Until then, healthcare professionals who use this technology are obligated to understand its limitations, anticipate its potential for error, and exercise vigilance in detecting and correcting error in order to prevent harm to patients. One neuroradiologist writes that his personal "conviction is that the final product of one's effort, the signed report, should be the responsibility of the author and no one else. The degree to which one makes the effort to ensure its quality... reflects the nature of that individual."[20] In the reality of medical practice, however, the physician who is pressed for time, distracted by frequent interruptions, and faced with the additional task of transcription faces the dilemma of how to divide his or her time between the

cumbersome task of proofreading and correcting notes and the primary duty of caring for patients. Pertinent to this dilemma is a study of voice recognition technology that found the task of proofreading and correcting the text to be "surprisingly difficult" and demanding of time.[21]

Transcriptional and medical errors are not exclusively personal but are also ascribable to systems and processes. Medical practices and hospitals that implement this technology are obligated to provide resources such as up-to-date equipment and quiet areas for dictation to minimize the potential for voice recognition errors, and when making schedules and setting productivity targets to take into account the added burdens on healthcare professionals' time and the effort required to use the technology effectively. Responsibility rests ultimately in a balance of shared institutional accountability and individual responsibility.[22]

Ethical assessment of voice recognition dictation requires, moreover, a realistic appraisal of technology. Technology invariably introduces not only benefits but also new sources of error and the potential for unintentional harm. Accordingly, the report of the Institute of Medicine emphasizes "that ALL technology introduces new errors, even when its sole purpose is to prevent errors."[8]

The CMDA statement on medical error[15] that was used to test the fidelity of voice recognition dictation in this study distinguishes three types of error. First, there are errors for which we are not directly responsible. An example of such an error would be the patient who inadvertently takes a pill from the bottle of his spouse's medication prescribed by another physician. Secondly, there are errors for which we are responsible but not morally culpable. In such cases the physician is considered responsible, but lacks any intent to harm and is neither reckless nor negligent. An example of this would be the prescribing of a drug that results in an unforeseen allergic reaction. Thirdly, there are errors for which we are both responsible and morally culpable. An example of such an error would be failing to notice an incorrectly copied insulin order of 10 times the intended dose.[23]

Whether or in what circumstances medicolegal deliberations will afford physicians greater latitude for unintentional errors resulting from imperfect voice recognition systems is, as yet, an open question.[24] When patients are harmed, culpability may at first be presumed, whether or not it exists. In ascertaining the relative culpability of the dictating physician versus the possibility that the nature of the technology is to blame, comparison to the familiar examples of a notepad, typewriter, or secretarial transcriptionist are inadequate. This is because the errors that voice recognition software inserts into a clinical note are more frequent as well as categorically different in content. Voice misrecognition creates copious opportunities for unintentional errors, some of which are wildly unpredictable. Even so, when a consequential error occurs, if the note is otherwise carelessly constructed, numerous minor incidental errors could cast doubt on the physician's good intent and carefulness in general.[18]

In medicine, one must be cautious not to trust too much in automated systems. Technology always has the dual potential for help or harm. There has never been a greater need for precision in a doctor's handwriting, even if its form has evolved to vigilance preceding the final mouse click.

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CLINICAL ETHICS DILEMMA

A PHYSICIAN'S COVENANT

ANONYMOUS

Editor's Note: *This column presents a problematic case, one that poses a medical-ethical dilemma for patients, families and healthcare professionals. As it is based on a real situation, identifying features and facts have been altered in this scenario to preserve anonymity and to conform to professional medical regulations. In this case, the department chairman is given information that demands a decision.*

Column Editor: Ferdinand D. Yates, Jr., MD, MA (Bioethics), Professor of Clinical Pediatrics, State University of New York at Buffalo, and Medical Director for Neighborhood Community Center.

Question

What are the responsibilities of a department head in supervising the quality of work provided by the department members?

Case Presentation

Dr. Jones was the vice president for medical affairs at a large northeastern hospital. His role made him responsible for general administrative oversight of 567 physicians, including recruitment and quality assurance.

Some new physicians had been recruited for several different departments, and the new pulmonary recruits were often board certified in Pulmonary, Critical Care and Sleep Medicine, and most were looking for positions that accommodate their interests. Dr. Simpkins was recently hired under this scenario, with his primary appointment being in Critical Care Medicine.

Two years after Dr. Simpkins was hired, Dr. Garrett— the Department Chair of Sleep Medicine—approached Dr. Jones and asked to meet with him regarding an urgent matter. When Dr. Garrett arrived at the meeting, she produced a three-inch-thick pile of documents outlining and providing evidence that Dr. Simpkins was consistently exhibiting what seemed like inappropriate work in his Sleep Medicine duties. Dr. Garrett noted that Dr. Simpkins frequently missed meetings, filed incomplete test requisitions—requiring additional work for his staff—and failed to respond to pages in a timely manner. She also stated that she had spoken to him about each of these failings on numerous occasions. He always answered affirmatively, promising to rectify these failings, but in actuality he had made no changes.

Dr. Garrett then showed fifteen examples of inconsistent histories, inadequate examinations, and, most disturbingly, fabricated entries in the medical records, which she noted were a sample of his work from only the past two months. Dr. Garrett claimed that Dr. Simpkins had listed physical weights, neck circumferences, and Epworth Sleepiness Scale scores that differed significantly from values documented by his own technical and nursing staff. Furthermore, she alleged that he not only failed to list

important medical comorbidities, but also (based on nursing and concurrent medical notes) listed tobacco habits incorrectly. Dr. Garrett believed that Dr. Simpkins' work was putting patients at risk of receiving inappropriate evaluations, diagnoses, and treatments.

In addition, Dr. Garrett had reviewed Dr. Simpkins' work schedule and billing practice pattern. He had seemingly billed at levels that were unsupported by his documentation, and high-level consults had been billed for inappropriately short patient time slots. Dr. Garrett opined that not only was the medical work and documentation unprofessional and inaccurate, but it could be construed as being at variance with the requirements of Medicare and Medicaid, and that the hospital might be accused of insurance fraud.

Dr. Jones approached Dr. Stanley, Department Chair of Critical Care Medicine and the department head to whom Dr. Simpkins primarily reported. Dr. Stanley downplayed the gravity of the situation, stating that Dr. Simpkins "was a very bright, very nice, young doctor." He further intimated that Dr. Garrett was overly compulsive, and clearly had a grudge against Dr. Simpkins. He then related that Dr. Garrett had approached him on several occasions, complaining about these issues, and that he doubted they were true based on his general knowledge of Dr. Simpkins.

Dr. Simpkins was out of the country, and could not be reached. However, based on the compelling evidence, Dr. Jones convened a meeting with the hospital's chief executive officer, chief counsel, risk management director, and Dr. Stanley in order to discuss the allegations.

Questions:

1) What are the responsibilities of any professional caregiver who observes what may well be inappropriate or improper care, or improper billing?

2) If harm befalls a patient under these conditions, who may be held responsible?

Discussion

In a manner that is consistent with the Hippocratic Corpus, physicians cannot "look the other way" if they believe that another caregiver is putting patients at risk or is falsifying medical documentation. If supervising doctors, as in the present case, are aware of the potential dangers to which a physician may be exposing his patients, such supervising doctors are ethically responsible to address the problem and report to appropriate administrators.

One of the hallmarks of a true profession is its self-policing nature. When professionals do a poor job of monitoring their own behavior, outside regulatory agencies frequently intervene. In medicine, not only are the health and life of patients endangered, but the credibility of the profession itself is also at risk.

A major tenet of ethics throughout time has been the protection of vulnerable persons (See Lewis, Appendix.) For the supervising professionals in this scenario to not fully investigate the allegations against Dr. Simpkins would be a breach of centuries of ethical thought and—in the Judeo-Christian worldview—a sin (James 4:17).

Denouement

On his return to the United States, Dr. Simpkins was questioned regarding his professional medical care and billing practices. He failed to provide an appropriate explanation for many of the healthcare issues in which unethical and inappropriate actions seemed apparent. His privileges to participate in Sleep Medicine were immediately curtailed in the wake of the investigation, and a thorough review of his other clinical work was performed. Questions regarding the correctness and appropriateness of his billing practices were forwarded to the Compliance Department for a full review. Because of his poor oversight of Dr. Simpkins, and because of his failure to act appropriately with due diligence regarding the concerns raised by Dr. Garrett, Dr. Stanley was relieved of his leadership position.

Editor's Comment

Leadership can take many guises. But, perhaps, lacking a universal definition, we often know it when we see it—or, more importantly, when we don't see it. If our current medical leaders refuse to lead from an ethical perspective, our future medical leaders may have little courage or ethical mooring for future medical-ethical conflicts.

We should be grateful for medical leaders who are astute in recognizing inappropriate behavior and are willing to make a proper report.

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COMMERCIALIZED MEDICINE CONTRA CHRISTIAN-HIPPOCRATISM

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Abstract

Although many prominent writers—from Plato to Chaucer to Steinbeck—have contended that physicians exhibit a love of money, the impact of commercialism on medicine, especially contemporary American medicine, is becoming increasingly explicit. Over the last two decades, medicine has undergone something of a corporate transformation, evidenced by the growing numbers of for-profit corporate providers such as nursing homes, health maintenance organizations, mental health facilities, and dialysis units. The trickle-down effect of business on individual practitioners is enticing physicians to follow suit, thereby altering the definition of professionalism. Medical doctors have increasingly prioritized business in their practice models, resulting in a novel approach to professionalism dubbed "entrepreneurial."

The profound change in physician focus has led to disconcerting patient outcomes. Spinal surgery in the elderly with spinal stenosis, for instance, has not only been performed for substantial reimbursement but, in its now augmented application, has shattered the Hippocratic admonition to "Do no Harm." The procedure is associated with increased morbidity in a particularly vulnerable demographic. The entrepreneurial paradigm for physician practice has become an issue in stark contrast with the Christian-Hippocratic tradition, intruding even upon care for those at the end-of-life. Physicians with a commercial bias seem to be an extension of contemporary cultural "myths" that emphasize capitalism, science, and genomics. The ethical fallout from such entrepreneurial medicine includes a diametrically opposed perception of normative medical professionalism that is prevalent throughout dominant and, possibly, Christian culture.

Introduction

> In Medicine the magnetism of money is a corrupter. It draws us toward self-gratification and away from concern for the welfare of the patient. For more than 2 thousand years we have relied on a countervailing force to blunt the corrupting power, namely professionalism, crudely described as personal responsibility to put the best interests of the patient uppermost…So is medicine a business or a profession?[1]

In the complex environment that is the medical world, wherein professionals from various backgrounds routinely agree to disagree, a consensus has been reached on one irrefutable issue. Medical costs have been unabatedly rising for decades at a rate that, in this troubled economy, cannot be sustained. This financial arc has caused a crisis, including renewed utterance of the dirty "*r*" word—rationing. Fifty percent of the annual increase in medical costs has been attributed to new medical technologies or to increased use of prior technologies.[2] Yet, new technologies keep arriving with higher

price tags, whether or not they are proven safe or even marginally beneficial. This is the trouble plaguing healthcare reform: that despite agreement that spending is out of control there has been no reduction in sight for the ever-rising pace of expenditures. Furthermore, justice has already been sacrificed in anticipation of comprehensive cost cutting. Approximately 50 million Americans have been pushed outside the pale of medical insurance, while countless others are under-insured and forced to exhaust their life savings in the event of serious illness. Half of all personal bankruptcies in the U.S. are a consequence of health care debt.[2] Upcoming substantive budgetary cuts will have a deleterious impact on the allocation of ever scarcer resources, access to specialty care, and perhaps the dignity of life itself.

Competing interest groups have begun to argue over *who* should sacrifice in order to bend a previously unbendable cost curve. This contentious dialogue has included insurance and pharmaceutical companies, hospitals, government agencies (Medicare and Medicaid), Federal and State, as well as other for-profit entities (HMOs, dialysis and mental health care facilities). There has even been talk by corporations, who are prominent and profitable in the marketplace, of voluntarily contributing to austere financial penalties! Unfortunately, one group has remained relatively silent, uncomfortably conspicuous only through reticence. The professionals who write the orders that translate into the prohibitive expenses of medicine, the physicians themselves, have been less than forthright about their opinions. What suggestions they have shared seem disingenuous. As a group, they primarily blame malpractice for rising costs—a minimalist explanation for a multi-faceted problem—or, even worse, they offer to support financial reforms only on the condition that physician incomes are spared.

Recently, a minority of physicians have begun to speak out on the rising cost of medicine. Dr. Howard Brody has challenged his colleagues to identify the top five tests or treatments they prescribe whose elimination would reduce costs without depriving patients of benefit. In Brody's words, "unfortunately the myth that physicians are innocent bystanders merely watching health care costs zoom out of control cannot be sustained."[3]

The corollaries of "Top Five" lists must be discussed. What is Brody really asking for? Limiting selected treatments and tests could possibly deprive physicians of income. Despite that risk, Brody's clarion call has elicited constructive responses from onocologists, primary care doctors, and, in adumbrated form, nephrologists.[4,5,6] However, the inertia inhibiting the institution of the results proceeding from Brody's "Top Five" will be unprecedented. The push back can only be overcome if each segment (including physicians) of America's variegated healthcare colossus agrees to rigorous, collective, and ethical sacrifice. We must not be deterred from this necessary task, for, unless the medical cost curve is bent, the toughest allocation decisions in American history will have to be made, and soon. These decisions, in John Kilner's words, would literally determine "Who lives and who dies."[7] However, if the past can be counted as a guide, a caveat must here be inserted. Previous decisions have embraced social value criteria. Today, a veneer of "Quality Adjusted Life Years," or the "Complete Lives System," resuscitates the same tired proposals that punish the vulnerable. [8,9] Within a "social value paradigm," the elderly, those persons who are disabled and poor, will disproportionately shoulder the sacrifices constituting future rounds of budgetary restraint.

If upcoming allocation decisions were to emanate from a Christian-Hippocratic tradition, the vulnerable would find advocates within the medical profession itself. This is why medicine's silence is disconcerting. Could it be that physicians stand to lose too much with reform measures that would change their bottom lines? If that were the crux of an almost palpable silence, a 180-degree turn in physicians' ethos has occurred. Has commercialism and self-interest distracted physicians from their sacred responsibility towards patients?

At a "white coat" ceremony for Physician Assistant students that took place over a decade ago, the keynote speaker chose the title, "Heritage of Service: The Physician Assistant Profession and the Threat of Commercialism."[10] In 2007, the "Cambridge Quarterly of Healthcare Ethics" published a Special Section entitled "Commercialism in Medicine." It contained a robust collection of essays (by bioethicists, physicians, and a health policy lawyer) with explicit intent to "subject the question of commercialism in medicine to ethical scrutiny."[11] If secular sources are concerned about the deterioration of professionalism wrought by commercialism, where is the Christian Bioethical response to this critical topic? One of the Cambridge contributors says, "Money is a cruel god, not worthy of devotion…the cruelty lies in the way money overpowers all other values and thereby uproots physicians of the deep rewards of recognizing themselves as part of a healing process."[12]

The remainder of this treatise will debate a disconcerting proposal: that the corporate transformation of medicine has become *the* impediment to healthcare reform. The contingent of this assertion—that the transformation has become a siren for medical professionals as well—requires sober reflection and prescription. A prioritization of commercialism in medical practice, if such is the reality, may represent what is arguably the greatest erosion of medical professionalism since *Roe v. Wade.*

Commercialism as Antithesis of Medical Professionalism

> In the opening pages of *The Republic,* [Plato] questions his audience about how to distinguish the goals of various activities. Physicians, he notes, accept money for engaging in healing. Should medicine then be called a business? This would be silly, he says, because a physician can do the work of healing even if he does not take money for it. Medicine has one goal, business has another. Plato's concern about mixing medicine and money making echoes through the history of medicine.[11]

In his prescient work entitled *The Social Transformation of American Medicine*, published in 1982, Paul Starr expressed concern over a novel juggernaut: corporate control of U.S. Healthcare. His observations led to a neologism, the "Corporate Transformation of Medicine." This term may be defined as "the transformation of the U.S. Health Care System from a professional service for the sick and injured into one of the country's largest industries."[13] Arnold Relman proposes this evolution is "the most important socioeconomic change in the last half century of health care in our country,"[13]

> A major reason for the decline of medical professional values is the growing commercialization of the U.S. Healthcare system. Healthcare has become a $2 trillion industry, largely shaped by the entry and growth of innumerable private

> investor-owner businesses that sell health insurance and deliver medical care with a primary concern for the maximization of their income.[14]

Starr predicted that the unchecked incorporation of business templates into practice would primarily involve hospitals, ancillary services (extended care facilities), and third party payers. With a veritable explosion of for-profit healthcare entities, his observations have been obviously borne out. However, he did not focus energy on physicians' changing roles in this brave new medical marketplace. However, Arnold Relman has, more recently, done just that by intimating a metamorphosis that parallels the transformation of healthcare: that of physicians evolving into corporate players.

> …the current focus on money-making and the seductions of financial rewards have changed the climate of U.S. medical practice at the expense of professional altruism and the moral commitment to patients. The vast amount of money in the U.S. medical system and the manifold opportunities for physicians to earn high incomes have made it almost impossible for many to function as true fiduciaries… Medical professionalism cannot survive in the current commercialized healthcare market. The continued… intrusion of market forces in the practice…will inevitably undermine the ethical foundations of medical practice and dissolve the moral precepts that have historically defined the medical profession.[14]

Since this treatise primarily addresses physicians—not the systems in which they function—it must identify instances of blatant physician commercialism. Though there are a myriad of examples of physician commercialism available in peer review literature, some are exemplary.

Consumer Reports ranks spinal surgery as the most overused treatment in America. Evidence Based Medicine demonstrates that decompression surgery (the simplest and least invasive of 3 surgeries) is superior to medical care. However, trends have proven that surgeons are recommending invasive procedures of unproven efficacy instead—even if escalations in surgical intensity are dangerous.[15] In the first 11 months of 2007, 32,152 Medicare recipients underwent surgery for lumbar stenosis (narrowing of the spinal canal). These recipients were grouped according to the level of surgery performed: (1) Decompression alone, (2) Simple fusion (limited to 1 or 2 disc levels), or (3) Complex fusion (operative intervention covering more than 2 disc levels; a surgery requiring both anterior and posterior approaches). Although, overall, surgeries for spinal stenosis declined in number from 2002-2007, complex fusions increased 15-fold (from 1.3 to 19.9/100,000 beneficiaries). In addition, the more invasive surgery increased elderly persons' life threatening complications almost 3-fold. Hidden within the heightened human risk was a disparity in hospital costs and professional fees. Decompression alone cost $23,724 (with a physician fee of $600 to $800), but complex fusion totalled $80,888 (corresponding physician fee was approximately $6,000 to $8,000!). What drove this unnecessary surgery? An editorialist opined,

> Newer and more complex technologies are being used for patients with little specific indication…The proliferation of risky and expensive practice beyond reasonable supporting evidence is commonly mentioned as a fundamental failing of medical practice in the United States…*conflicting economic incentives are clearly at work in spinal surgery…* the efficacy of basic spinal techniques must

> be assessed carefully against a plethora of unproven *but financially attractive alteratives.*[16] (emphasis added)

Another example engaging the "business" of back surgery was recently published in the Wall Street Journal.[17] The business aspect was completely occupied by a "commercialized" surgeon, as opposed to a for-profit "system." A 48-year-old patient died on April 7th, 2011 after spinal fusion surgery. He had undergone a complex 360-degree spinal fusion requiring 2 simultaneous surgical approaches—from his abdomen and back. Two spine surgeons who reviewed the case after the patient's demise noted that he was a "poor candidate" for the procedure. The patient's surgeon did not apprise the family or patient that he was part owner of SPINAL USA, the company manufacturing the device implanted during surgery. The family was sent a bill totaling approximately $11,000. This procedure has increased in frequency from being the 37th most commonly performed operation (1998) to the 16th (2008). The 360-degree fusion accounts for $10 billion in annual medical spending and surgeons can be reimbursed both for their surgical expertise as well as for product development, implantation, or testing. In this tragic instance, business concerns interposed a fatal conflict of interest—one unheard of only a generation ago. By definition, physicians "have a conflict of interest when they have an obligation to act in their patients' but have incentives to act in their own interest or the interest of other parties."[18]

Similarly commercialized practices exist for cognitively impaired elderly persons who receive tube feedings. For-profit hospitals perform more tube placements for artificial feeding in the cognitively impaired elderly than not-for-profits do. The procedures are reimbursed, but have not been demonstrated to meaningfully benefit patients. It is hard to escape the conclusion that these procedures are performed for money.[19, 20] Although the study focused on hospitals' business status (whether they were for-profit or not) physicians placed the feeding tubes despite peer review data contrary to their efficacy.

The emergence of for-profit healthcare, with increasing utilization of expensive technological hardware, has vaulted medicine into a corporate environment. Although physicians have never been immune to greed, today's commercial temptations are arguably without precedent.

Physician-Commercialism Intruding at the End-Of-Life

Despite its many benefits, palliative care is underutilized throughout American Medicine. Recent data has expanded upon gains consequent to palliative care. Temel and colleagues studied two patient groups with incurable, stage 4-lung cancer (non-small cell).[21] Both groups received standard care, that is, palliative chemo- and radiotherapy. However, one group also benefitted from early palliative care. The patients who received this early palliative care lived an average of 11.6 months compared to 8.9 months for those without it. There were also additional benefits. Those receiving palliative care spent less time in the hospital and emergency room, received less chemotherapy, and scored better on quality of life instruments. Their total costs were less as well. The editorialist commented, "Despite the increasing availability of palliative care services in U.S. Hospitals and the body of evidence showing the great distress to patients caused by symptoms of the illness, the burdens on family caregivers, *and the overuse of costly,*

ineffective therapies during advanced chronic illness, the use of palliative care services by physicians remains low" (emphasis added)*.*[22] Multiple explanations have been offered to explicate this paradoxical undervaluation. However, recent data exploring other modes of care applied at the end-of-life are pertinent and strikingly different in philosophy.

Kwok and coworkers examined national patterns of surgical care in the U.S.A. in elderly fee-for-service Medicare beneficiaries during the last year of their patients' lives.[23] One million eight hundred thousand and twenty-nine such persons died in 2008. Approximately 32% underwent a surgical procedure in the year before death, 18% in the last month of life, and 8% in the last week. There was geographical variation in surgical intensity as documented previously in the Dartmouth Atlas. Germane to the Dartmouth data, different geographical areas provide varying degrees of intensive services, potentially accruing greater expenses, but not improving survival. Kwok and coworkers noted that a greater number of surgical procedures in some decedents "might suggest discretion in health-care providers' decisions to intervene surgically at the end of life." Such discretion could reflect physician reimbursement as a dynamic in opposition to patient interest. The editorialist stated, "Kwok's and colleagues' findings are especially relevant because surgical procedures are highly reimbursed and, therefore, *surgeons and hospitals are often financially motivated to operate regardless of the patient's preferences or goals*" (emphasis added)*.* [24]

Rather than providing an end-of-life model permeated with compassion, pursuing the good of terminal comfort within a nexus of palliative care, commercialized medicine is guilty of favoring reimbursement over patient wellbeing. To balance such a serious charge, another viewpoint should be considered.

Referring to the article immediately above, an author accused the publishers of "distorting science to make their argument."[25] Her reasoning was analogical; she compared this medical data to Babe Ruth's 1333 strikeouts—considered in a vacuum without his other accomplishments. Could it be that focusing on dying rather than surviving Medicare beneficiaries undergoing surgery is akin to ignoring Babe Ruth's home runs? She attempts to foster the analogy by demonstrating beneficial outcomes consequent to surgery in the elderly. This is a proverbial straw man! The authors in the pattern of surgery study never imply that the elderly in general fail to benefit from surgery. Rather, they specifically pursue the idea that elderly and immanently dying patients might undergo surgery without a reasonable expectation of benefit. Their data is all the more robust as an empirical extension of the aforementioned Dartmouth Study.[26]

The Dartmouth Atlas of Healthcare is a long-running project that uses Medicare data to examine variations in the way healthcare is administered geographically. The most recent iteration has been summarized recently.[26] Dartmouth evaluated 235,821 Medicare patients with advanced cancer who died between 2003-2007. Seventy percent of such patients in Detroit were hospitalized in their last month of life while only 46.3% in San Angelo, Texas were hospitalized. An average of 29% of these patients died in a hospital; in Manhattan, New York the number was 46.7% while in Mason City, Iowa only 7% died in hospital. Despite advance directives requesting a dignified death at home, some patients are admitted for burdensome procedures and, subsequently, die in the hospital. Although surgery should sometimes be performed on the elderly, the question remains as to whether its utilization on the terminal, immanently dying reflects a physician's bias towards reimbursement. Though many variables contribute to

the geographically skewed volume of what may be overly aggressive care, this author contends that part of the contribution comes from the commercialization of medicine in the form of its physicians.

Whys and Wherefores? Culture's *Mythos* and Contingent *Ethos*

Heretofore, the content in this treatise has been general, addressing American physicians as one homogenous group within a complex matrix of corporate medicine. A part of the original intent of this study was to scrutinize information within a Christian worldview, which effort will occupy the remaining discussion. If the physicians of prior generations were not as commercialized as they now are, what makes physicians the way they are today?

Allen Verhey observed that myth is essential for any culture in the mapping of its world.[27] No matter how myth is defined or, as is more likely, denied, Verhey claims that it is inescapable. Every culture, religiously imbued or not, informs its *ethos*, its moral nature or set of beliefs, through its *mythos*. Of the various myths inhabiting America's zeitgeist, four prominently mesh with medicine's burgeoning commercial culture: the Baconian, genetic, liberal, and capitalistic. Each, when taken to its pragmatic conclusion, forces Tertullian's "Jerusalem and Athens" dichotomy; they are inconsistent with an integrated Christian Worldview.

In his chapter entitled, "Every *Ethos* implies a *Mythos*," Verhey contours the Baconian myth,

> It is little wonder that the thing to do is to reach for the latest technique or the nearest tool in an effort to put an end to suffering. Our enthusiasm for technology, and for the art of altering nature as a response to suffering, has blinded us to the limits of technology. The Baconian account of knowledge simply arms compassion with artifice, not with wisdom. It trains compassion to eliminate suffering, not to bear it, not to share it.[27]

Knowledge, in Bacon's view, is power over nature. The contingent myth suggests mastery over nature inevitably brings wellbeing in its train.[27] It easy to fathom how this myth animates medical practice, especially technologically biased care at end-of-life.

By itself, the Baconian myth does not verify commercialism as the only motivation for end-of-life care. Patients themselves share in this myth by signing consents. However, as aliens, Christians must be in this world, not of it. Verhey pointedly says to a Christian audience: "We reject the myth that has grown up around our scientific and technological powers, that nature is the enemy and that technology will deliver us from finitude and mortality to our flourishing. We reject the claim that science and technology need no larger vision."[27] The larger vision that should illuminate medical practice—from both physician and patient perspective—is that nature will be redeemed at the Second Coming, not before. Death is inevitable and will not be conquered by science. According to the Dartmouth Atlas' empirical observations, technological aggressiveness does not guarantee survival. This myth, in part at least, may lead to a misdirected, but profitable, medical ethos.

The myths of capitalism and genetics can be united by the example of the Human Genome Project. Verhey's illustration, inextricably connected to medical ethics, derives much from such a union,

> [The capitalism myth] was on display in the Human Genome Project. It became increasingly clear that the growth in genetic knowledge and power was connected *to the financial incentives* that fueled it. The project of capitalism transformed scientific knowledge into a marketable commodity.[27]

and,

> Those at the forefront of investment in genetics—the United States, the European nations, and Japan—*expect lucrative returns in commercial applications* by their biotechnology industries.[27]

These myths reflect cooperation between capitalism, genetic technology, and medical commercialism. Peer-reviewed data, such as that addressing recent *Avastatin* (bevacizumab) debates by the F.D.A. in the U.S.A., are consistent with this financial synergism.

Finally, what of the "myth" of a liberal society? In the midst of religious and moral diversity, the project of liberal society is to keep the peace. Verhey's next observation exposes this myth,

> Because people disagree widely and deeply about their religious and moral convictions, a liberal society insists that we bracket those convictions, that we set aside the myths and stories by which people live, and that public moral discourse attend only to the requirement of the maximum freedom for each member of the society…a liberal society demands protection of individual rights.[27]

Does Verhey accurately frame contemporary culture's *mythos*? Can his frame be superimposed on medical culture despite its claim of professional integrity? A recent editorial suggests that he is uncomfortably accurate.

The Wall Street Journal critiqued a Lancet publication composed by a 37-expert commission and entitled "Delivering Affordable Cancer Care in High-Income Countries."[28] This Op-Ed piece probed the heart of healthcare reform. The commission criticized Oncology's "Culture of Excess" in an $895 billion dollar war on the world's "cancer burden." A new-targeted cancer therapy (Sipuleucel-T) had been developed for prostate cancer. The cost of therapy would be approximately $100,000 per person. Patient benefits were modest, Sipuleucil-T is not life saving, but would add profits to the therapy's developer. The newspaper attacked the commission's unwelcome incursions into "rationing and price controls"—implying these choices belong elsewhere. Moral outrage was not expressed on behalf of Sipulceil's future recipients; rather, the bastions of capitalism reacted to perceived threats assailing medicine's corporate bias. The parentheses found below are this author's and are meant to juxtapose Verhey's cultural *mythos*. The Wall Street Journal editorial observed, "We ought to have no business determining value, since the choice properly belongs to the patient, his family and caregivers (Liberal Society myth)." "Costs will come down and benefits will improve as genomic science allows doctors to better target therapies…" (Baconian and Genetic myths). Government is now burdened by moral dilemmas that properly belong in

the realm of individual choice" (Liberal Society myth again). The conclusion of the editorial was intended to be cynical, claiming that "[the commission's] findings are long on laments that the 'rapid development of new technologies' and other innovations are helping to drive the world's $895 billion-and-growing cancer burden" (Capitalist, Baconian, and Genetic myths reprised). This amalgamated mythos expects a cure for cancer through science, technology, and genetics.

What does Verhey's testimony contribute to "medical commercialism" theory? What does it not contribute? It does not prove cause and effect between dominant culture's *mythos-ethos* and physician commercialism. While it provides a plausible, worldview-sensitive guide for pervasive cultural thoughts and actions, it cannot discern individual contributions from diverse segments of culture. It is not designed to do this. Many other voices populate a complicated healthcare reform equation. Patients and their families have come to expect all that technological care has to offer. They also expect it to be paid for. For-profit corporations, by nature, populate medicine to make money. Research and development programs are designed to lead to patents and profits. But, fundamentally, Brody[3] is right. Physicians inhabit and practice within a dominating scientific, capitalistic, genomic, and liberal *mythos.* Despite other contributors, whether comprised of patients or for-profit entities, it is these physicians who write orders and who are reimbursed for their volitional provision of technology, genomics, and science. If strict allocation decisions limit these therapies, physicians will suffer financial penalties. Biblical anthropology warns us: beware of the consequences of our shared fallen traits in economic matters.

A Concluding Postscript: How Should We Then Live?

> Very few of [my father's] patients paid promptly, & a good many never paid at all…There was never an end to worrying about money…The practice of medicine was accepted to be a chancy way to make a living & nobody expected a doctor to get rich, least of all the doctors themselves…the rest of my father's colleagues lived from month to month on whatever cash their patients provided & did a lot of their work for free…Medicine was the best of professions…but not a good way to make money.[10]
>
> - Thomas Lewis, regarding his father's New York City medical practice, 20 years before the Great Depression.

The above manuscript attempts to implicate American physicians in a corporate transformation of their medical practices, inferring that such a transformation is inconsistent with Christian-Hippocratism. Further, it suggests that commercialized practice contingent to the transformation is an impediment to healthcare reform. Not surprisingly, it also contends that physicians are personally responsible for the commercial actions delineated. The proof that has been provided in the form of peer review studies is suggestive, but not definitive. There are many questions remaining, including many that are, at present, unanswerable.

Should we assume Verhey's "*mythos-ethos"* framework—separating behaviors expected from dominant vis-à-vis Christian culture—is fully appreciated by Christians in general, and by Christian physicians in particular? Are Christian physicians conscious of the myriad ways their practice may be intruded upon by commercialism? There is

no data available that provides an unequivocal answer. However, certain investigations imply that, other than expressing pro-life conscience in public, Christians in medicine do not exemplify aversion to the dominant culture's ethos.[29] Studies have also demonstrated this contemporary community of believers does not provide a greater volume of indigent care.[30] Although undue extrapolation from these limited sets of data is unreasonable, further reflection upon commercialism in medicine is warranted—especially for Christian healthcare workers.

How does one avoid the trap of commercialism in medicine? Certain environments (H.M.O.s for example) make it nearly impossible, yet certain Hippocratic behaviors must be recaptured any time an opportunity arises. Palliative care must be broached both early and in transparent fashion in order to oppose Baconian, scientific, and genetic mythology. If palliative care removes opportunities for the reimbursement of physician-driven technology, so be it. Whatever procedures are provided must be warranted and in patients' best interests. Are these efforts supported by evidence-based medicine? Is there any chance they are solely done for reimbursement? A personal quality review of services rendered to those in the last months of life should be de rigueur for all believers. Were billable procedures performed because they were absolutely necessary? Furthermore, every believer should compose a "Top Five" list. Each of us renders charges that can be obviated without harming patients. This list will decrease income, but will also remove commercial considerations from some decisions.

Some have suggested that disconnections between traditional religious morality and economic behavior are common in the American workplace. This accusation has historically been part and parcel of American culture. However, it is also suggested, and commonly believed, that "learned professions" were not culpable in this regard. This is no longer true. Christian physicians need to find consistency and holism for their faith. Commercialized practice is just as foreign to medicine's integrity as abortion. As Boli once proposed, "We fail to recognize that a moral order grounded in the sacred operates in the economic realm. This failure leads us to underestimate the difficulties of aligning economic behavior in accordance with other moral orders (notably, traditional religious morality). [31] Alignment of practice with Christian ends is difficult, but is more necessary than ever in today's economic climate.

Each believing physician should have an indelible image of healing that is gleaned from the Gospels—completely removed from any commercial considerations. The image should force a comparison—Christian healing versus today's dominant medical ethos. Drawing such a distinction between Christian healing and the dominant cultural ethos is quickly becoming an either/or proposition, especially when procedures can harm patients. However, in the end, medical practice is neither a living nor a job, it is a profession and a sacred vocation. Our spiritual response to this calling, as we care for those created in His image, cannot be removed from sacred authority and its message about the dangers inherent in materialism. Our practice must completely reflect the beliefs and economic stewardship portrayed in the Gospels if medicine is to be authentically held captive to Christ. Such a Gospel-centered healing practice has nothing in common with commercialized medicine.

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CODES OF ETHICS IN HEATH CARE: VIRTUES VERSUS RULES

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Abstract

I want to present a case that the health care professions should understand and use their codes of ethics as descriptions not only of the professional characteristics necessary to fulfill the care for people (which is the moral purpose of medicine), but also of the kind of person who can perform and persevere as a caregiver in a tragic profession. The various codes of ethics depict morally lofty professionals who are concerned with the honor and integrity of their professions as well as the well-being and dignity of their patients. Yet, it is possible within each dimension of health care that persons devoted to their respective codes experience untended and grievous results in their practices. We should not look at the codes as though they safeguard practitioners from such results. Rather, we should see them as the expectations upon people who remain committed to health care, even while suffering undesired losses in practicing it.

The Crisis in Codes of Ethics

Talk of the crisis in codes of ethics has become commonplace. Such codes are said to be ineffective, little understood or used, and not nearly as influential as one's own personal values. For instance, in 2009 D.C. Mallory, P. Sevigny, et al. questioned eleven focus groups of physicians in six culturally different countries concerning their perceptions of their profession's code of ethics. The findings were not optimistic about the influence of the codes. They state,

> Two findings were particularly interesting. The first was the apparent emphasis placed on personal values and the perceived impact of culture on the interpretation of these codes. The second was that at no time did any of the respondents from these international focus groups put forward the view that their specific medical code of ethics, in particular, was helpful in clarifying the unknown or ambiguous—at best, medical ethics codes were tolerated, as they did not seem to interfere with the predetermined ethical intent of the physician.[1]

This lack of effectiveness on the part of the physicians' code does not lead Mallory, Sevigny, et al. to conclude that the physicians are not interested in ethical guidelines, however. In fact, they find that physicians looking for ways to explain and justify their actions appeal to the ethical guidelines laid out by their culture or their own consciences, but they do not look to the medical codes for instruction or illumination in their daily practice unless such codes match their own value system. In light of their research, it is fitting for Mallory, Sevigny, et al. to close their article with the admonition that "This finding points to the need to re-evaluate the purpose, content, and delivery of codes, value statements, missions, and credos, in order for them to be more functional tools in the promoting ethical conduct."[2]

Sarah Cox, Douglas Cripps, et al. reach a similarly sobering conclusion. Relying on previous data (some of which comes from the above mentioned article), they find that most practitioners in therapeutic recreation (the area of their specialty) do not consult their professional codes. Instead, the practitioners see their professional codes as, at best, "artifact[s] of professional status." [3] If professional codes are viewed merely as artifacts they certainly fail as informative and descriptive ethical guidelines. The "speculative" quality of the codes, the way in which they function as something the professional looks at but does not integrate into its practice, became obvious to Cox, Cripps, et al. in their own focus group study. They asked the participants, "to what extent does [the] code of ethics assist you in your ethical deliberations?" The data fell into three themes: 1). a lack of awareness of the code, 2). a lack of education/training in ethical treatment of patients, and 3). other codes supersede the professional one. From these themes, they conclude, "a code of ethics has very little use in practice."[4]

Pessimism concerning the effectiveness of codes of ethics is not limited to medicine and other health care professions, it is seen across the board in other professions as well. John Dobson has analyzed the effectiveness of codes of ethics in business and other disciplines. He believes that such codes lack effectiveness because they are trumped by the more powerful and underlying influence of neo-classical utilitarianism. It is assumed that people always act according to their self-interests and that, hence, people's personal codes are more likely to be shaped by consequentialist reasoning than by the principles laid out in professional codes of ethics. In fact, Dobson reasons, the professional codes "may be no more than a legalistic gloss over the real ethos that pervades the organization."[5] Furthermore, because they act as a gloss at best, professionals are somewhat schizophrenic about which code truly represents their activity—the rationalistic and lofty ideals of the profession and organization's code of ethics or the pervasive "neoclassical economic rationality" which most people have acculturated as their real ethical guideline.[6]

Dobson's observations raise an important question: why should the professions write codes of ethics and expect them to be obeyed if such codes are not only ineffective in shaping actual ethical actions but are also unable to challenge an underlying rationality that can possibly shape the practitioner in ways somewhat contrary to the ethical purposes of medicine and health care? If codes truly function as more artifact than ethical curriculum and are superseded in relevance by other values systems, perhaps the reason for their ineffectiveness lies in how they are conceived. Codes typically present themselves as sets of principles that represent proper behavior in certain situations, and as such they attempt to provide a manual for professional behavior. Thus, when we use a code as a manual we intend it to be practically useful. However, if the above commentators are correct, most practitioners already follow a *de facto* operating manual (i.e., utilitarianism), which may or may not be consistent with the moral purposes of their profession. We must examine critically whether codes of ethics should even be conceived, written, and applied as steps in a manual, for, if we truly treat codes in this way, they become rules to follow rather than descriptions of the kind of person who would want to be ethical in the practice of their profession. Some insights from Tom Beauchamp and James Childress will help us make clear this distinction.

Statutory Rules Versus Virtues

Beauchamp and Childress highlight a fault in the use of professional codes. Though they admit that professions "often transmit moral guidelines," which are used to "specify and enforce obligations for their members," the professions hope that their members will be "competent and trustworthy." Thus, "[t]o avoid moral confrontation and legal struggles, some professions codify their standards in order to reduce [conflicts over professional standards or with persons outside the professions]."[7]

Yet, Beauchamp and Childress think that the codes tend to oversimplify moral requirements and try to safeguard the professional from culpability and legal reactions. The idea is that if practitioners follow the codes, we (as practitioners) are ethically and, consequently, legally safe from criticism and reprisal if the practice goes wrong. They then assert the challenging conclusion that "The pursuit of professional norms in these circumstances may do more to protect the profession's interests than to introduce a broad and impartial moral viewpoint."[8]

Beauchamp and Childress express a legitimate concern about the formation and implementation of codes of ethics—do we comply with codes because they are rules that protect us against challenges (litigious or otherwise) or because they nurture individuals to embody the virtues necessary to carry on in morally difficult professions? For some, the codes exist "to protect the profession's interests," while for others they represent "impartial moral viewpoints."[8] This contrast marks a serious divide between two different ways of estimating the role of ethical codes. If codes serve only as protection, they act as statutory rules. If codes express a moral viewpoint, they explain the character of a certain kind of moral person. Consider the following contrast between codes as statutory rules and moral virtues:

A. Codes as Statutory Rules:

1. are restrictive about what should not be done;
2. if broken, punished by reprimand, exclusion from membership, fine, or imprisonment;
3. compliance motivated by desire to avoid reprisals;
4. failure to comply can lead to malpractice and possibly criminality;
5. backed by an authoritarian enforcer;
6. presuppose obedience by the participant;
7. the ideal complier is the autonomous agent who assents to their necessity.

B. Codes as Moral Virtues:

1. are constructive concerning what should be done;
2. if broken, one feels shame for letting down the profession;
3. compliance is motivated by desire to contribute to the honor of the profession;
4. failures are accidents within a difficult profession;
5. are backed by the moral force of an honorable profession;

6. presuppose a coherent moral tradition;

7. the ideal complier is the noble professional who embodies the virtues.

The two justifications for the codes differ greatly in their purposes and motives.

First, consider a justification for codes as statutory rules. This justification draws its power in society from an underlying metaphor: the body is a machine and health care is a contractual transaction. Codes seen as statutory rules rely upon a legalistic understanding of the codes to account for why we should hold such codes to be binding upon their subjects. Within this justification, codes are like contract laws, which hold people accountable to agreements and promises. Though these laws are not immutable and do not necessarily rest upon a sense of natural law, they are authoritative because they reveal a significant aspect of our society—the force of the market. Of course, the word market is large and often ambiguous, but it generally refers to the way people conduct interactions and exchanges according to a particular quantifiable measurement of social power, i.e. money. As soon as money becomes part of the agreement and contract, people act to protect and guarantee their interests as much as possible.

Codes as statutory rules reflect this sense of contractual arrangements. That is, just as we expect to know whether a mechanic or auto-dealer will provide the services and products we desire, we want to know whether a physician or pharmacist will do the same. We assume that they will honor their perceived end of the contract and bargain, and we expect codes to assure us of that assumption.

It is certainly reasonable to expect contracts and negotiations to abide by acceptable rules, and it is desirous for a stable society to insist that providers honor their contractual obligations and promote themselves as faithful and truthful people with regard to these contracts. However, something is left out if we apply this metaphor to health care. The issues of health, whether physical, emotional, or social, are not so transactional. Though we know, for example, that automobile and home repairs rest on mechanistic rules and that, hence, it makes sense to hold those who provide these services accountable for knowing the rules and assuring their results, issues of human health are far more complex than can be explained in this way. Health cannot be characterized by a machine, which is governed by causal laws of clear cause and effect. The unpredictable and unfortunate happen to the human body and psyche not only because mistakes happen here as they would to operating or repairing a machine, but because of the nature of human identity as body and soul.[9] I do not mean to imply that we have two substances, one material and the other an immaterial soul, and that, consequently, we can scientifically explain the first but not the second. Rather, because a mechanistic and materialistic explanation does not sufficiently explain the human experience, it is more accurate to account for our identity as humans in terms of both body and soul rather than as body only. I do not pretend that the word soul is free of ambiguity (and, frankly, the word body is also ambiguous), but I do think it is useful (just as the word body is useful). The admission that we are also a soul recognizes that elements of our identity exist which escape a mechanistic, materialistic explanation. Society is growing in scientific and medical knowledge of what it means to be human, and this growth comes from empirical research, but we are also more aware of what we do not know and what we cannot predict about the human experience, particularly in relation to human health.

This is why treating codes for health care as statutory rules misses the mark. Its underlying metaphor does not allow us to admit the existence of inexplicable and the unintended consequences. Our experiences of health, illness, and dying do not conform to mechanistic rules; our bodies are not cars in need of repair. Hence, it follows that we cannot manage or control the issues of health care as though they were merely contracts and power negotiations.

Consider a justification for Codes as Moral Virtues. Its appeal comes from the way it expresses its underlying metaphor—that of a covenant. I use the word virtue in the narrow, Aristotelian sense of referring to the particular human characteristics necessary to fulfill human purpose within a community. These characteristics are honed out of trial and error in accordance with what actually fulfills the human goal and desire of reaching life's completion as a person in community. Of course, some communities do not foster this sense of virtue, though they may require certain dutiful behaviors (for example, a mob family may require loyalty, but this would not be a virtue because the family itself could not be virtuous. It does not contribute to a good greater than its own greed and dominance). However, a community of honor and nobility is committed to a good that, in principle, enables all people within the community to reach a sense of purpose and fulfillment. Such a community would be virtuous, engendering and requiring virtuous people to enact its moral purpose.

What keeps a virtuous community cohesive and committed to its own perpetuity is an understanding of the nature of a covenant as something that works toward the moral good of all. A covenant community presupposes that certain people take upon themselves tasks and assignments that express the moral purposes of the community. We typically call such tasks and assignments "professions", rather than simply "jobs". Professions express the community's moral goals and, hence, are accountable to the larger calling of the society's existence as a moral reality (promoting a sense of good as well as human purpose). Not only do they perform highly technical skills, they reflect the moral underpinnings of society.

A sense of professional vocation has characterized the practice of health care since the time of the Hippocratic oath. Health care is more than a job requiring certain skills; it is a necessary function within society that helps it to achieve its moral purpose, the promotion of human health and well-being. We not only expect health care providers to be interested in contracts and negotiations, but we also expect them to be interested in the totality of the human experience, for it is intertwined with the provision of health care. Because the human experience can be neither reduced to algorithmic, causal rules nor managed by mechanistic laws, health care providers must be committed to goals larger than the mere exercise of their skills. In other words, they must be people who understand and are committed to the professional nature of their work and the way that work promotes the health and well being of persons in society.

The above list of Codes as Statutory Rules does not express this sense of professional calling. However, the list of Codes as Virtues does. The common thread among the statements in the second list is the force of a community held together by a moral covenant that requires certain portions of its populace to perform necessary and highly trained tasks so that people can reach their comprehensive purposes in life. Such

a code cultivates the kind of person necessary to support a covenant-community. Such a community is then enabled to establish and promote human fulfillment and well-being.

Of course, the way I have explained the two estimations of codes of ethics makes the Codes as Moral Virtues the more attractive list, but there is a good reason for this—the covenant metaphor better expresses what we experience as persons with comprehensive goals in a community than does the metaphor of a machine. We need such a code to prepare and sustain its adherents to perform and persevere in a profession that inevitably experiences tragedy, not necessarily because of mistakes, but rather because of the natural limitations of dealing with illness and morality.

The Tragic Dimension of Health Care

The inevitability of non-culpable errors in the practice of the health care professions indicates a tragic dimension to their practice. The word tragedy has several meanings, but I use it to refer to those grievous situations in which bad outcomes result from good people's good decisions. This happens in the medical professions.

Consider the contrast between such non-culpable inevitability and medical malpractice. Practitioners who commit malpractice are guilty of not providing the service that they were expected to provide. Courts determine malpractice guilt when practitioners perform medical care badly, not merely because bad results follow from their actions. Proper medical practice is typically established by what is called the "standard of care." This phrase has technical meanings, both legal and professional, and refers to what a prudent practitioner would do under certain circumstances. Here, a prudent practitioner would not simply make defensible judgments, but would base such judgments on the precedence of previous medical practice in similar circumstances. The profession does not base its standard of care upon guaranteed results but upon the best, established practices. It is instructive to note that health care rests its norms of practice upon the best possible way (based upon practice and research) to treat a situation, rather than upon the assurance that results will always follow. Such a course of action knows that unforeseen and unpredictable results can follow even from what has been established as the best possible standard of care. What determines good medicine is not elimination of the possibility of tragic consequences, but the performance of acceptable and tested practices.

For example, we do not (or at least should not) assume that medicine fails because cancer patients die after taking chemotherapy. It is our common experience that such unwelcomed and grievous deaths occur in spite of the best that medicine can provide. However, we would think doctors fail if they do not practice what has been accepted as the standard of care in such circumstances. Sometimes the best professionals, acting according to their best knowledge and skills, cannot prevent unintended and deleterious situations from occurring. Each branch of health care can tell countless stories in which the practitioner follows the dictates of established and best care and still causes unwanted conditions, either directly or indirectly. Because the stakes are so high in health care, the emotional toll on a practitioner can be enormously heavy. It takes someone with courage, fortitude, patience, and practical wisdom to join and contribute to such professions.

Stanley Hauerwas, Richard Bondi, and David Burrell aptly describe the tragic dimension to the practice of medicine. For them, medicine is a "moral art" that is

difficult to categorize as either care for the patient or faithful application of knowledge and technology. However, the most forceful aspect of medicine as a moral art is "that medicine is moral art because it must be guided by convictions that sustain the effort to care in the face of death."[10] There are natural, temporal, and economic limits to involvement with the caring for and curing of patients that even sophisticated and powerful modern technology cannot remove. In fact, this limitation characterizes all people before death. Medicine has to face this tragic dimension as a profession.

Because of this natural limitation, we should not expect more of medicine than it can provide. It cannot remove the tragic nature of life from our experience and, thus, it cannot remove tragedy from its own professional purpose. If a patient dies or suffers a disease, health care has not necessarily failed. Furthermore, we assume too much of medicine if we guarantee success in every effort. Patients and diseases do not necessarily follow simple, mechanistic, causal patterns. They have histories that are filled with unpredictable occurrences and idiosyncrasies. No one person can map out all the forces and aspects that come to bear on a patient, and it is hubris to believe one can.

Moreover, medical codes of ethics do not require the professional to be omniscient or omnipotent. They do, however, require that the practitioner uphold the honor of the profession and respect the patient's dignity. One must have a certain kind of courage, fortitude, and patience to endure in a profession that overtly intends to care and cure the patient, but which also naturally loses patients. Thus, medicine holds both great opportunities and built-in disadvantages, and it takes a moral community that is committed to its moral art to nurture professionals to persevere in such a demanding and troubling profession.

At this point, Hauerwas, Bondi, and Burrell are apprehensive: "For if medicine requires a moral community sufficient to sustain it as a tragic profession, then no such community seems to exist. In other words, I am suggesting that no moral community exists to provide medicine with a story sufficient to guide and sustain its activities."[11] This is a troubling assessment, since codes as virtues presuppose moral practitioners, who, in turn, presuppose a moral community that knows how to teach the virtues.

Though the Hippocratic Oath is often extolled as the paragon and paradigm of medical ethical codes, we should not treat it as though it represents a set of abstract ethical principles that are either pertinent for all time or readily applicable to all ethical dilemmas in medicine and health care. Rather than a set of abstract principles exemplifying universal ethical truths, the code originally represented the requirements of a certain community of people who called themselves doctors and who were committed to the art of health care. The moral demands of the health care professions called for a code of ethics around which the professionals could learn how to act as the kind of moral beings they should be in the practice of their particular work. The codes did not, and do not now, create the moral demands of the professions. They express the professions' compelling moral forces.

Charles Hemingway and Douglas Querin capture this relationship clearly when they say, "[Codes] are not simply boilerplate documents that exist in the abstract. They are living, breathing documents with real-world implications."[12] Hemingway and Querin reach this conclusion after demonstrating the inadequacy of assuming that codes function in the same way as criminal, civil, and administrative laws. Laws operate under

the warrant of the state's authority and are indifferent to the specific necessities of the profession. According to Hemingway and Querin, to treat the codes of ethics as though they had the precedence and power of coercion of criminal, civil, and administrative laws is a mistake and misuse of the codes. Rather than treating the codes as laws, we should understand and handle codes of ethics as "consensus standards of conduct, reflecting the aspirations, expectations and obligations of each profession."[13] That is, the codes do not create the ethics of the profession. Instead, the real-life moral obligations of the profession's practice create the need to articulate codes expressive of the profession's moral purpose. We write codes of ethics so that we can retain and be faithful to the compelling moral practices of the profession.

For this reason, it is more consistent with the practice of medicine and health care to see codes as inspirational of human performance in the actual practice of medicine rather than as prescriptive of the correct procedural steps needed to assure success and to safeguard against mistakes.[14] They are inspirational because they represent the kind of person the practitioner should be when she or he functions according to the best purposes of the profession. Codes of ethics should codify the necessary requirements for practitioners to carry on the continual learning, wisdom, and skill of a profession that is not reducible to a set of abstract, prescriptive rules. They must express what has been learned in the maturation of a profession designed to help patients overcome their illnesses, maintain their health, and come as close as possible to live out a natural course of life. The codes should become clarions for vocational integrity rather than merely safeguards against mistakes, legal challenges, and social opprobrium. They should express the moral qualities of those people who can carry on in a tragic profession whose aims for healing and health sometimes go unmet. Though it is necessary to include within a professional code regulative rules that guide practitioners in specific concerns and dilemmas, they must be couched within the larger and more important concern of describing the kind of person who must sustain a profession that inevitably deals with the tragic consequences it creates.

Medical Codes in a Conflictive, Pluralistic Society

The codes as virtues presuppose lively and coherent moral traditions. Do such traditions exist? They do not, according to H. Tristram Engelhardt in *Global Bioethics*, and because such is the case the effort to make the codes of ethics normative (that is, morally obligatory) becomes an exercise in futility.[15] He argues that two features specifically dominate the modern experience and make forming consensual, normative codes of ethics highly unlikely. First, modern philosophy, from David Hume and Immanuel Kant forward, emphasizes the inter-subjectivity of our knowledge of the world rather than its objectivity. Our minds shape our ideas about the world based upon our sensory experiences. Ideas, then, are subjective, and when we discuss the world with others the most we can do is appeal to the credibility of our own perspectives. However, we cannot give supra-subjective normative claims.

Secondly, modern society is defined more by diverse norms than by a shared set of moral beliefs and practices, and these norms often profoundly conflict with one another. Instead of reaching comprehensive norms through the advance of democratic governments and scientific advances (which was the promise of the Enlightenment), society has become even more morally fractured. For this reason, Engelhardt resists any

attempt either to define a consensus or to try to create one. If it were possible to claim society has reached a consensus, it would be too vapid to be worth anything. To seek to form a consensus would be to actually force one group's norms upon others. These two features lead Engelhardt to the following conclusion:

> [T]here is no universal, rationally justifiable, moral perspective, or even common notion of the reasonable, that could provide the basis for deliberative democratic polities or their governance. Instead, there are at best procedural modes of collaboration that allow negotiation and limited agreement, as in the markets. The paradigm for political discussion becomes not that of the Socratic seminar, but that of a limited market in which these are peaceable exchanges of political agreement.[16]

Engelhardt is not necessarily happy about this lack of consensual norms. Without a normative moral tradition, bioethics is much harder to do, since, in such a case, it would lack a clear understanding of the moral bases of the healthcare profession, bases such as respect of the patient's autonomy, dignity, and wellbeing. However, in light of the plurality of norms in society, Englehardt is willing to promote what he calls "libertarian cosmopolitanism" over against "liberal cosmopolitanism." The latter believes that it is possible by scientific, secular reasoning to formulate universal, content-rich moral norms upon which we can build bioethics. Yet, in the present pluralistic society in which bioethics operates, where profoundly different views exist among equally rational people concerning abortion, euthanasia, the rights of embryos, access to medicine, genetic engineering, and sexuality, this is more promise than product. Hence, it is wrongheaded to attempt to develop codes of ethics upon the assumption that, guided by secular reasoning, we can reach a consensus on moral norms.

In contrast to liberal cosmopolitanism, the goals of libertarian cosmopolitanism are more modest and realistic. As Engelhardt enjoins, discussions on bioethics should not be treated as though they were Socratic dialogue, in which rational people meet, work out their conceptual misunderstandings, and reach a shared opinion on content-full moral truths. The more accurate and fruitful model is that of the *marketplace*, in which people collaborate enough to reach their ends. The marketplace concept admits and accepts the intractability of pluralism and attempts to form an amicable means of discourse.

> These moral views involve divergent understandings of appropriate governance, one endorsing, a limited polity spanning persons and communities divided by their concrete views of justice but united by the market and the state as the protector against unconsented-to force, and the other endorsing a social democratic polity bound in a single totalizing vision of justice. [17]

If Engelhardt is right, what are the ramifications for our estimation of the force of codes upon a profession? Is it possible to build and support a code of ethics, one that requires and promotes a virtuous professional, within libertarian cosmopolitanism?

On one hand, Engelhardt is obviously right—pluralism defines our experience of living in modern democracies, where different groups often hold incompatible views on important ethical issues. The attempt to reach a consensus within this conflictive situation assumes a shared ethical basis that is probably not there. Also, obtaining a consensus would require a strong authority with the power to mandate and enforce, practices which would flow crosscurrent to a modern democratic society.

How does a pluralistic society estimate the codes of the medical professionals? Since codes would not necessarily express binding moral norms (such do not exist in a pluralistic society) they would act as statutory rules to guide the health care providers, protecting both society from providers and providers from society. Because the codes would articulate the threats and consequences of the misuse and mishandling of the professions, they would aid a vast and diverse society in trusting health care providers. Hence, the most we can say of the codes in what Engelhardt calls the "libertarian cosmopolitanism" is that they represent statutory rules.

However, if such is the case and the codes represent merely statutory rules, they could be expressive of a community of professionals committed to the honor of their profession and respect of the dignity of the patients. Though such lofty language is written into the codes, in real practice the codes act as statutory rules, not virtues. It is fitting that Engelhardt likens libertarian cosmopolitanism to a marketplace, where people negotiate their settlements and a warrant exists to safeguard the negotiations. This society must maintain a tolerance and respect for others so that people who have different and, at times, mutually exclusive ethical viewpoints can engage each other. However, such engagements and relations must remain superficial and unbound by the sharing of moral norms.

Nevertheless, as we saw above, the codes must be virtues. Only certain kinds of people can perform professional duties in a profession that is not only intellectually, emotionally, and personally demanding, but which is also tragic. People who see their profession safeguarded by rules will eventually grow weary, especially when their profession must endure the great suffering and death of its patients in spite of, and possibly even because of, its best efforts. Libertarian cosmopolitanism neither requires nor inculcates professional virtues to endure. Virtues such as courage, fortitude, patience, and practical wisdom emerge within a community of people defined by and committed to a moral purpose, such as the perpetuation of a noble culture, the quest for social justice, or the protection of righteous fellowship. Such goals are not easily maintained because they are comprehensive definitions of a group and also because they resist specific definitions. Virtues do, however, exert powerful expectations upon their members. To undergird and sustain the overriding goals of the group, citizens develop the patterns necessary for the materialization of those goals.[18]

It may be the case that the medical professions cannot learn the virtues necessary to continue their own codes from a libertarian cosmopolitanism point of view, but Engelhardt suggests that within our modern, pluralistic society, pockets of people develop and apply moral norms relative to their own goals (though not shared by society as a whole). The practice of health care represents such a pocket, defined and committed as it is to a moral norm. If medicine were to lose this purpose, it would lose its distinctive place as a practice of moral art, which its various codes of ethics attempt to demonstrate. In this light, the codes of ethics not only express the moral legacy of a profession with a very moral purpose, to assist people in their illnesses and suffering, they aim to educate the appropriate behavior necessary to continue such a profession. Because the codes are contextualized to the profession, they contain the conditions of ethical behavior for anyone seeking to join the profession. The important thing is not that the individual must bring his or her own ethical guidelines into the profession and thereby make it more

ethical, but that the moral integrity of the profession forms the ethical guidelines of the individual as a practitioner in the profession.

For this reason, John Lere and Bruce Gaumnitz correctly highlight what is at stake in writing a professional code. After demonstrating the shortcomings and near insouciance of codes as compliance lists designed primarily to prohibit breaking the law, they state, "One way to improve code effectiveness is to avoid including positions that are generally held in society… Therefore, statements expressing views commonly held in society such as 'be honest' an 'obey the law' are unlikely to further the goal of a company or organization wishing to change the alternative chosen by a decision maker."[19] It is more appropriate to tailor the guidelines to the relevant and unique moral demands of the profession. Of course, we should be honest, but professional codes should do more than state the morally obvious. They should state what is needed to be the kind of professional who is compelled to be honest when dealing with the health, the life and death concerns, of others.

The Practice of Health Care as Ethical Training

Health care practice may be one of the best examples of how professions develop virtues to sustain their purpose. The development of virtues not only furthers a profession's integrity, it can model for other professions, social units, and institutions the importance of developing virtuous persons.

Albert Jonsen and Stephen Toulmin in *The Abuse of Casuistry* make such a case about medicine. "No professional enterprise today is closer to moral practice, or better exemplifies the special character of 'practical' inquiries, than clinical medicine."[20] They argue that medicine is a unique science in that it utilizes the universal laws established by biochemistry and biology while always focusing on concrete cases where best judgment must be exercised in relation to the context. Thus, the practice of medicine relies on both scientific knowledge and practical wisdom. Without either, medicine could not fulfill its specific goal of bringing healing to particular patients.

A good practitioner learns prudence from others, from previous examples and cases. Medical prudence is not like geometry, in which one works out proofs by following established and necessary rules. Rather, medical prudence uses analogical reasoning, by which one sees comparisons, syndromes, and patterns. A practitioner learns by example and experience to develop such reasoning. Yet, his or her judgments sometimes do not produce the desired healing or cure. Medicine is a tragic discipline, and as such it requites a certain kind of individual to continue practicing such a delicate and telltale profession.

> For this reason Jonsen and Toulmin see something special about the practice of medicine. Medicine is a useful model for the analysis of moral practice in several respects. Clinical medicine is prototypically 'practical' both in Aristotle's sense of the term and also in contemporary usage; . . . In moral as in medical practice, the resolution of practical problems draws on a central taxonomy of type cases, and the pattern of argument by paradigm and analogy is once again at work. Last but not least, when medicine is practiced conscientiously as well as skillfully, it becomes a prototypically *moral* enterprise. A doctor who diagnoses correctly and who prescribes successfully behaves meritoriously, not merely

> because his actions are *effective* but equally because, given his relationship to the patient, these kinds of actions are *appropriate*: that is, they fulfill his *duty* as a physician--so much so that one might even regard clinical practice as a 'special case' of moral conduct generally.[21]

Jonsen and Toulmin's main point is that, like medical judgments, moral decisions do not follow axiomatic, universal rules and principles. They rely on taxonomic analogies and paradigms and upon a tradition of previous decisions that best express the community's moral purpose.

Robert Veatch offers a valuable insight into understanding how codes of ethics are expressive of societal moral purposes. He contends that we should see the importance of codes of ethics within the larger social forces of the "social contract."[22] Medicine and the health care professions emerged within the societal evolution in progress towards a greater realization of human well-being and flourishing. The same social dynamic that has given rise and articulation to both societal values and an understanding of aims and norms has also compelled the professions to become necessary and contributing institutions within this shared sense of being in a coherent and consciously accepted community. The notion of a social contract, though it has been philosophically and politically influential since Rousseau, Hobbes, and Locke, is ambiguous. However, it does help us to understand why certain institutions and professions, such as those contained within the domain of health care, are indispensable for social well-being. For a society to preserve and improve the quality-of-life of its citizens, such institutions and professions must fulfill their obligations to contribute significantly to the overall moral purpose of society—human flourishing. In particular, medicine and health care carry a significant burden, since they not only serve the society with their technical skills and knowledge, they enable society to respond with some sense of control to the tragic dimensions of life. Society needs models of professional virtue to help it learn to live with tragedy.

The influential writer William May comments on this need in his 1975 article entitled "Code, Covenant, Contract, or Philanthropy." Among the several illuminating distinctions he makes, the most helpful for our present interest is the line of distinction which he draws between what he calls "the code ideal as philanthropy" and "covenantal indebtedness."[23] When medicine and health care approach their work as though they are philanthropically contributing to society out of their knowledge and skills, they display four characteristics: (1) a condescending and gratuitous attitude, (2). a contractual approach to patients, (3) a reluctance to exceed what is expected of them from such a contract, and (4) a defensiveness and over-protectiveness with regard to mistakes and challenges. The basic fault of expressing the professions as philanthropic gifts to society is that such a view reverses the social contract. Instead of the professions serving the larger and more important moral identity of society, society is made to conform to the largesse and aims of the professions. When this reversal occurs, as tends to happen, the professions, especially in health care, diminish their actual moral force in the society. Their skills and technological accomplishments become professional goals and, nearly, ends in themselves to which society should always assume respect. Instead of becoming expressive of the more fundamental social moral progress, they can become abstract professionals who exercise a disproportional power over individuals, the economy, and the general societal sense of human purpose.

Mays contends that the health care professions should see themselves, rather than as enactors of philanthropy, as parts of a covenant.

> As opposed to the ideal of philanthropy that pretends to wholly gratuitous altruism, covenantal ethics places the service of the professional within the full context of goods, gifts, and services received; thus covenantal ethics is responsive. As opposed to the instrument of contract that presupposes agreement reached on the basis of self-interest, covenantal ethics may require one to be available to the covenant partner above and beyond the measure of self-interest.[24]

Codes of ethics must express and define for the profession how to be a person who exemplifies a covenant with others within the limitations and demands of the profession. Moreover, medicine has a particular concern. It must manifest in its practice the wisdom and courage needed to sustain and continue a profession that, though it is highly trained and valued by society, sometimes cannot stop tragedy from occurring.

Because medicine and the health care professions have emerged from the social contract, they should see themselves as covenantal partners with society, helping it to fulfill its basic aims for human well being and flourishing. Consequently, their codes of ethics should expect their participants to live up to the profession's essential role in society. For this reason, we would lose much if we treated codes of ethics as statutory rules and not virtues. The following would be the worse case scenario: the medical professions would become another market competitor within a conflictive and pluralistic society, hemmed and protected by rules to which the practitioner complies in order to assure the public that he or she is following the accepted guidelines. Yet, because of the strain on the medical practices, what we know of medicine would probably greatly change. Instead of seeing patients as part of a larger social covenant, we would view them merely as negotiators in a business contract. Instead of emphasizing the patient's dignity (a normative claim which a pluralistic society struggles to recognize and define), medicine would emphasize efficiency and success. Powerful technologies would impose obtainable standards of health and longevity upon patients, who would probably be viewed more as malleable agents than as inviolable individuals with their own unique histories. The moral art of medicine would shift to the art of technical prowess. The virtues would become irrelevant to a profession that assures success because it first changes the patient into an agent who can be molded into something that can be healed and cured. The patient becomes a "broken machine" in need of medical repair.

Conclusion

I have tried to show that the codes of ethics for the medical professions should be treated as the necessary virtues needed to fulfill the purposes of the professions. Medicine demands a great deal from the character of its practitioners. They must not only master certain knowledge and technical skills, but they must also be able to endure in a tragic profession. Furthermore, since tragedy befalls all lives, we can learn from the moral arts of medicine how to cultivate the necessary virtues to preserve and remain committed to a morally purpose-driven life. Other professions may provide similar modeling (teaching and ministry for example), but in dealing with matters of health, life, and death, medicine does so in a particularly poignant way, that is, when it uses its codes as virtues and not merely as statutory rules.

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NARRATIVE AND A CHRISTIAN BIOETHICS

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Abstract

Contemporary scholarship draws attention to the necessary relationship between medicine and narrative. In a field often beset by the demands of money and efficiency, many medical programs are recovering a more holistic approach to medical practice. These programs focus on life as narrative, and they tailor their medical education to conform to this philosophy, installing writing and literature as integral parts of their curriculum. Following the renaissance of narrative in the medical field, this article seeks to situate bioethical decision-making within both a narratival and a Christian framework. The philosophy of narrative espoused by Paul Ricoeur establishes the basis for the relationship between narrative and medical ethics, as the mimetic act connects narrative and lived experience. The narratival character of each patient's life determines the role of the physician—one of understanding, interpreting, and writing narrative. Narrative thus serves as a means of ethical reasoning in medical practice, as physicians indwell patients' stories while simultaneously recognizing the patient's alterity. Drawing on the work of theologian and ethicist H. Richard Niebuhr, this article ultimately articulates an approach to bioethical decision-making that both preserves the particularity of each ethical dilemma and also submits to the claim of God as sovereign author of each story.

Introduction

In 2009, Columbia University in New York introduced the first graduate program in Narrative Medicine under the leadership of Rita Charon, an English PhD and practicing physician. This new Master of Science program can be completed in less than two years for a full-time student and features a rather unconventional curriculum for a medical program.[1] Students in the program take courses like "Close Reading and Reflective Writing in the Clinical Context" and "Co-Constructing Narratives." Their capstone projects might include clinical practicums "that include teaching, witnessing or serving as a teaching assistant" or they may include workshops like the Columbia University Oral History Summer workshop.[2] While Columbia's program is the only one of its kind as of yet, points of intersection between the disciplines of literature and medicine have existed for years. Officially, the discipline of literature and medicine began in 1972 at Pennsylvania State University College of Medicine. By 1995, one-third of all medical schools in the nation were teaching literature courses. Also, an abundance of literature is being published at the intersection of medicine and literature, including the Johns Hopkins journal *Literature and Medicine.* [3]

The curriculum of Columbia's Narrative Medicine program is structured to further that specific program's mission statement:

> Narrative Medicine fortifies clinical practice with the narrative competence to recognize, absorb, metabolize, interpret, and be moved by the stories of illness. Through narrative training, the Program in Narrative Medicine helps

> doctors, nurses, social workers, and therapists to improve the effectiveness of care by developing the capacity for attention, reflection, representation, and affiliation with patients and colleagues. Our research and outreach missions are conceptualizing, evaluating, and spear-heading these ideas and practices nationally and internationally.[4]

In short, the goal of Columbia's Narrative Medicine program is to improve healthcare through instilling "narrative competence" in its students. For Charon, this competence means the ability to "follow the patient's narrative thread, to make sense of his or her figural language, to grasp the significance of stories told, and to imagine the illness from its conflicting perspectives."[5] In short, skill in narrative medicine leads to an increased ability to listen to and comprehend stories of illness and to empathize with the patient through imagining the patient's experience of the illness.

Such an innovative program, while seemingly avant-garde, is actually a self-conscious recognition of the fundamentally narratival nature of our human existence. The synergies between narrative and medicine, literature and healthcare have always been abundant, but somewhere in the course of the development of medical practice, these intersections were neglected. Anne Hunsaker Hawkins and Marilyn Chandler McEntyre point to the fragmenting of higher education as the point at which medical education was stripped of its humanistic aspect, noting that, "[h]istorically, training in medicine, as in the other professions, commonly included reading in the domain of 'philosophy'—a category that comprised most of what we now call the humanities."[6] Because of the intense specialization in which those in academia now find themselves locked, and with the corporatization of medicine, a rich understanding of what it means to live, to suffer, to die, to be human has been lost to many medical programs. The revival of this interest in narrative and medicine, however, is promising. The essentially narratival quality of human existence suggests that the tie between medicine and narrative is a fundamental one, which, when grounded in response to God as author, can restore much of what is lacking in medical practice and aid in articulating a Christian bioethics.

Paul Ricoeur and Narrative

The work of Paul Ricoeur, the twentieth century French philosopher, provides insight into the fundamental connections between narrative and bioethics. Ricoeur draws heavily on the Aristotelian notion of *mimesis*. Often, the term *mimesis* is used in the Platonic sense of an imperfect imitation of a higher, perfect reality. On the other hand, Aristotle and, thus, Ricoeur, use the term in an expanded and active sense. Ricoeur writes, "If we continue to translate *mimesis* by 'imitation,' we have to understand something completely contrary to a copy of some preexisting reality and speak instead of a creative imitation."[7] For Ricoeur, the creative act of mimesis is threefold, consisting of mimesis_1, mimesis_2, and mimesis_3. This concept of three-fold mimesis can help to frame a discussion of narrative and bioethics.

Mimesis_1 is the stage of preunderstanding of the world of action; it is the stage which presupposes narration.[8] For Ricoeur, one element of this preunderstanding is temporality. He notes the correlation of telling and time saying, "Time becomes human to the extent that it is articulated through a narrative mode, and narrative attains its full meaning when it becomes a condition of temporal existence."[9] The act of communication

is by nature temporal. We speak temporally, one sentence following the next. We write novels, poems, and text messages temporally, one character after another. Likewise, we read these same novels, poems, and text messages in sequential order, each syllable taking up milliseconds.[10] Not only our communication but our experience, too, is temporally bound. One moment succeeds another in a person's lived experience, so it follows that all of experience is by nature a sort of narrative in process, or to put it another way, human life is characterized by the "pre-narrative quality of human experience."[11] For Ricoeur, all of our life is always already becoming narrative, existing in a prefigured state.

While mimesis$_1$ is prefigured experience, mimesis$_2$ serves a mediating function between the first and third stages, or what precedes fiction and what follows it.[12] It in this stage that "emplotment" takes place; elements previously existing in the field of action are configured into narrative. For Ricoeur, "emplotment" differs from mere "plot" in that it is an active configuring of events which comes about in the act of narration.[13] Ricoeur here draws on the Aristotelian notion of *muthos,* by which Aristotle refers to narrative composition. Plot, as we often use the term, conveys a static, pre-existing story. The Aristotelian notion of *muthos*, however, "means more than a structure in the static sense of the word, but rather an operation, namely, the structuring that makes us speak of putting-into-the-form-of-a-plot (emplotment) rather than of *plot*."[14] The acts of writing and interpreting involve the stringing together of disparate events and elements, the synthesis of the heterogeneous, into a cohesive story. This active synthesis of unrelated, possibly even discordant, events, characters, circumstances is "emplotment," and it is this action that gives narratives their intelligibility.[15] The only way that we can understand a narrative as meaningful is through its configuration in a plot. Ricoeur writes that a story contains, "on the one hand, a discrete succession that is open and theoretically indefinite, a series of incidents…on the other hand, the story told presents another temporal aspect characterized by the integration, culmination and closure owing to which the story receives a particular configuration."[16] A narrative is, in one sense, boundless because time always extends beyond the beginning and end of the narrative. However, we can understand narratives because they are also closed, configured with a beginning, middle, and end. An autobiographical account, for instance, has a beginning and end which gives it an enduring quality, or a configuration.

Ricoeur discusses mimesis$_3$ as marking "the intersection of the world configured by the poem and the world wherein real action occurs and unfolds its specific temporality."[17] As previously stated, in the recounting of events in narrative form, experience is not merely signified in a one-to-one representation. Rather, narrating is itself an essentially creative act in which two worlds intersect. Philosopher Richard Kearney writes that the combination of *mimesis* and *mythos* offers "a newly imagined way of being in the world."[18] The act of narration opens up new worlds at the same time as it refers to past experience in the recounting. When a narrative is emplotted, there must be an other who encounters the narrative, and, thus, the sphere of narration and of practical action collide. Ricoeur's discussion of history provides an example of this type of openness. He writes, "Between living and recounting, a gap—however small it may be—is opened up. Life is lived, history is recounted."[19] Applying this to narrative, it is in the gap between life and narrative that narrative can be approached by the other, and, thus, affect practical action. As discussed in the previous paragraph, one of Ricoeur's conceptions of time in the narrative is that it is closed in its configuration. Yet the qualities of openness and

indefiniteness about which Ricoeur also speaks allow for this type of opening of the story to new possibilities and intersections with the sphere of practical action.[20] He writes, "the reader belongs at once to the work's horizon of experience in imagination and to that of his or her own real action."[21] In the reading of a work of literature, one's horizons are open to the possible imaginary world created by the author. The reader inhabits that world while at the same time inhabiting his own world of action.

In Ricoeur's work, narrative theory also coincides with the concept of personal identity. He explores the concept of identity as sameness (*idem*) and identity as selfhood (*ipse*).[22] *Idem* relates directly to the permanence of one's identity in time, but Ricoeur specifically distinguishes it from *ipse*, or the concept of selfhood. He explores the relationship between these two through the notion of character, which is "where the problematic of *ipse* becomes indiscernible from that of *idem*, and where one is inclined not to distinguish them from one another."[23] For Ricoeur, a person's character presents itself as a permanent *idem* with stable, unchanging identity, but at the same time a person's character is developed in time as habits are formed temporally and then become traits.[24] Within the concept of character, the *ipse* is "covered by" the *idem*, though one's selfhood still consists of the *ipse*. Ricoeur also points out that the nature of the *ipse* or of selfhood is formed by its fidelity, or association with the external, with "values, norms, ideals, models, and heroes…"[25] So at the same time that character presents itself as a unified, stable identity, it is actually made up of both the passage of time and its attachment to things outside of itself. This affiliation of the *ipse* with the external brings us to another point about Ricoeur's conception of both narrative and personal identity.

Significantly, for Ricoeur, the completion of this narrative identity, and, thus, personal identity, is an intersubjective activity. For Ricoeur, the self exists only in relation to other selves. He writes, "it is in discourse that all messages are exchanged. In this sense, discourse alone has not only a world but an other."[26] Here Ricoeur distinguishes between a structuralist concept of language with its self-containing systems and rules and discourse, written or spoken language. We can see this played out in Ricoeur's thoughts on reading. As Richard Kearney points out, "no matter how distinct in style, voice or plot, every story shares the common function of *someone telling something to someone about something.*"[27] Thus, it is only in an intersubjective realm that narrative exists. In discourse one always confronts an other, even in the invisible reader of a text.

Narrative as a Mode of Ethical Reasoning

Multiple scholars have proposed that narrative has an essential function as a mode of ethical reasoning. Every narrative functions within some kind of ethical framework—is written or told within an implicit set of ethical principles. Thus, narratives bring up the question of the ethical obligations of a story—what it should say or should not say and how it should say or should not say it. For instance, a history book is generally written under an ethical mandate to tell the truth. It is assumed that works of history will have reference in reality.[28] A fantasy novel, on the other hand is written without this necessity for accuracy in reference to actual events, but it does operate under its own ethical principles of true-to-life-ness.[29] In the opening up of a world, a fictional narrative is at the very least functionally obliged to be true to the rules of that world. If one's characters begin acting in uncharacteristic ways, a narrative will fail.

But a narrative is ethical in other ways also. In its temporal openness and in the creative activity of mimesis as well as in the intersubjectivity of narrative creation, narrative and, thus, hermeneutics always has an ethical component. Ricoeur writes, "I would say, anticipating the course of these studies, there is no ethically neutral narrative. Literature is a vast laboratory in which we experiment with estimations, evaluations, and judgments of approval and condemnation…"[30] For Ricoeur, narrative always involves ethical judgment. But it is not just in abstract judgments that ethical behavior takes place. Rather, narratives affect a person's action in the sphere of reality. Ricoeur says,

> the models of actions elaborated by narrative fiction are models for redescribing the practical field in accordance with the narrative typology resulting from the work of the productive imagination. Because it is a world, the world of the text necessarily collides with the real world in order to "remake" it, either by confirming it or by denying it.[31]

Ricoeur describes the intersection of the world of narrative with the world of reality. Fiction is not passive or stagnant. Rather, in the mimetic act it opens up a world of possibility which is necessarily juxtaposed with the practical field of action. It is this moment of collision that gives narrative its ethical dimension, as one is free to visualize the world otherwise. The world created in a fictional narrative necessarily shapes the way that we configure our own reality in the sphere of action; it affects the way that we emplot the elements in our own lives for recounting. Richard Kearney explains this moment by way of the Aristotelian notion of catharsis saying, "It is this curious conflation of empathy and detachment which produces in us…the double vision necessary for a journey beyond the closed ego towards other possibilities of being."[32] In short, the act of receiving and interpreting a narrative allows for the imaginative act of empathizing to take place and one's reality to be reconceived in new configurations based upon the other world that one has inhabited. This happens all of the time, as "texts," –histories, novels, personal anecdotes, sacred writings—shape our hermeneutic for our own experience and alter the way that we will act in it and recount it.

In his book, *Narrative Ethics*, Adam Zachary Newton elucidates his own vision of the ethical function of narrative, or narrative as ethics. Newton writes that a narrative ethics is "concerned with the intersubjective dynamics of narrative, and their ethical implications, independent of the 'moral paraphrases' which they many invite or which can be ascribed to them."[33] A narrative has an ethical component in that the story encourages some type of behavior in its receivers. This message, or "moral," could be intentioned by the author or teller or drawn out of a story by its readers or hearers. Newton accuses both formalists and moral philosophers of erring by holding this view.[34] According to Newton, a narrative ethics is not about the "moral of the story" or the ethical message the author seeks to communicate or even that which the reader draws out of a text. Instead, he writes, "One of the things that artworks do, then, is to send us away from them… [they] chasten a too hasty temptation to extract, or to be overwhelmed by, their 'moral' value."[35] Here Newton opposes the concept of narrative as merely example. He corrects the notion that narrative's main ethical function is to reflectively create parallels that we then apply to our own moral lives.

Newton notes that the first ethical function of narrative resides in its alterity, drawing here, as elsewhere, on Emmanuel Lévinas, a twentieth century French-Jewish philosopher. In his *Totality and Infinity*, Lévinas centers his ethics on the intersubjective

relationship of a face-to-face encounter. In this encounter, the face of the Other "resists possession, resists my powers."[36] Following Lévinas, Newton proposes that a narrative's ethical function is, first, not exemplarity but separateness. Using *King Lear* as an illustration, Newton writes that "it is first meant to be confronted: an audience stands before such a play, stands before its characters' brute separateness…to acknowledge them as being, standing, and suffering apart."[37] In confronting a narrative, one must recognize the complete separateness of its characters from oneself. Before anything else takes place after a collision with narrative, narrative calls for acknowledgment of otherness, what Newton eventually describes as "tact," in which one "allows texts first to speak, to tell their whole stories before it responds."[38] Newton is here condemning an overhastiness to draw moral conclusions without first tactfully hearing out the other.

To clarify, Newton is not opposing Ricoeur here.[39] He is not arguing that narrative does not have a mimetic function as Ricoeur describes it. Nor is he saying that the world of narrative and the world of reality do not touch while Ricoeur clearly does, speaking of collision, movement between text and action, and refiguring the world in light of narrative. He writes that fiction "offers up for encounter—not simply for contemplation—hard facts of distance, separation, and alterity…"[40] There is, for Newton, an actual ethical encounter when one partakes of a narrative, just as in Ricoeur *mimesis* is characterized by encounter. Newton's encounter simply consists first in otherness and separateness. Newton describes an infinite ethical movement into and away from a text. He writes that reading "takes the form of a constant drawing-nearer; and yet, paradoxically, the closer we approach the text, the farther away from it we get, and the more exorbitant our responsibility toward it consequently becomes—an infinite movement."[41] At the same time that we grow closer to a text, we are propelled away from it by its otherness and we also have an ethical obligation to respond to it.

This ethical obligation implies a Levinasian intersubjectivity in Newton's thought, which he reveals through both forthright language and explication of certain narratives. He writes, "For Levinas, 'ethics' describes neither ontic nor deontic categories…ethics, rather, originates from the opposite direction—from the other to me, in the sensible experience of the face which he or she presents to me."[42] Following Levinas, Newton believes that ethics proceeds from the presence, or the "face," of the other rather than espousing a deontological approach. Newton's objective in his book, then, is to show that this intersubjective definition of ethics relates not merely to individuals but to narrative. In reading or hearing a narrative, one is confronted by the presence of an other from which one experiences an ethical call to respond. Newton writes, "Cutting athwart the mediatory role of reason, narrative situations create an immediacy and force, framing relations of provocation, call, and response that bind narrator and listener, author and character, or reader and text."[43] Narratives, for Newton, simply are ethics. Our every encounter with them is ethical because of this intersubjectivity. A narrative is present, or to use Newton's own phraseology, "ex-pressed, propelled outward."[44] Its givenness in the world is where its ethical nature lies. Just as any person that I encounter elicits an ethical response from me— to ignore, to encourage, to touch, to consider— so the projectedness of narrative into the world implies the same ethical calls of the other toward me as I encounter it.

Narrative and Bioethics

As we have seen in the work of Ricoeur, the very nature of human existence is narratival because it is temporal. To resummarize, time is articulated through a narrative mode, and narrative achieves meaning when it is put forth temporally.[45] This is a natural place to note the foundational intersection of bioethics and narrative. Because the practice of medicine is focused on people and because to be human is to be in time, story abounds in medical practice. From the explanation of the progression of disease in a case study to the patient's own articulation of illness in the consultation room, narratival discourse characterizes the practice of treating illness. Inasmuch as patients and medical practitioners exist in time, their lives can only be articulated in narrative form. Each patient, with his or her own story of suffering, is prefigured as narrative due to his or existence in time, configures his or her life in narrative form, and then has his or her narrative refigured by the person who encounters the narrative. What bioethics needs, then, according to scholars like Rita Charon, is a better understanding of how to interact with the narratives of patients as opposed to merely dealing with abstract statistics.

Not only does bioethics resonate with the temporal nature of narrative, but the process of bioethical decision making is inherently intersubjective. Turning to clinical situations, Laurie Zoloth and Rita Charon highlight the intersubjectivity involved in the process of bioethical decision making: "The conversation one has with another—the patient, the family, the nurse, the intern—rests on the intersubjective pact, that is, the agreement that one is not completely alone in interpreting this construction of reality."[46] In entering into a medical situation in which ethical decisions are required, one is joined in the work of interpreting the situation by others to whom the patient is bound. The patient's story is connected to family members, cultural influences, belief systems, and even the narratives of medical personnel. Thus, the narrative of each patient is communal, intertwined with those of many others.

The intersubjective bioethical encounter, in which the patient, physician, and other parties encounter one another, is first characterized by the estrangement emphasized by Newton. Zoloth and Charon write, "While there at the bedside, we feel the tension of our estrangement and the necessity of our engagement while we register the plight of those suffering disease and those suffering with the responsibility for caring for the sick."[47] Just as Newton notes that narrative first repels those who encounter it by its complete otherness, so Zoloth and Charon realize that those in illness are "suffering apart" in Newton's words. Yet, at the same time that the person is encountering the otherness of the sufferer, he or she experiences an ethical call to engage with the other. This is the same movement that Newton notes when he speaks of the "infinite movement" that draws readers into a text at the same time as they move farther from grasping it in its otherness. In a clinical setting, one approaches the patient to meet an ethical demand to respond to the other, but one is also completely alienated from the patient's suffering. In estrangement from the patient, one acknowledges the ethical claim of the other. In drawing nearer to the patient, one experiences an empathetic act in the vein of Aristotelian catharsis.

Though it is characterized by estrangement and a movement away from the complete otherness of the other in his or her suffering, a narrative bioethics also emphasizes the infinite movement toward the other. In *Teaching Medicine and Literature*, Anne Hunsaker Hawkins and Marilyn Chandler McEntyre propose that "[e]thical issues raised in stories,

plays, and poetry can introduce students to narrative as a mode of ethical reasoning… Learning to read stories with an appreciation for the relation between narrative and ethics can prepare students to better listen to their patients."[48] They note that narrative imagination can help one to understand issues from various perspectives. As opposed to a deontological approach to ethics, a narrative approach allows one to inhabit the stories of others and, thus, to better understand the situation when making decisions. Ricoeur, as noted above, considers the ethical component essential to narrative, as every narrative calls for "estimations, evaluations, and judgments for approval or condemnation." A narrative approach to medicine acquaints the student with his or her role as a participant in the patient's act of recounting and configuring his or her narrative and prepares him or her for ethical action in that sphere. The study of literature in particular gives students an opportunity to experience this, as they make ethical judgments in the worlds opened up by literature.

This movement toward the other, in which the decision makers inhabit the narratives of the patient and those caring for the patient, promotes empathy in the decision making processes. Hawkins and McEntyre state, "A course in literature and medicine can train the empathetic imagination. All literature courses ought to do this. All medical training ought to include this."[49] They write that studying medicine in conjunction with literature gives students a greater capacity for compassion and an ability to "imagine the other." It is in studying literary narratives that one can inhabit the stories of others. This ability is especially important for those who practice medicine, a vocation of care. It is precisely the narrative structure of literature that provides this opportunity of indwelling the experiences of others who are completely different than oneself. It is in the mimetic act as Ricoeur describes it that such new worlds of experience are created, and it is in the reading and interpreting of narrative that the world of narrative collides with the world of the reader's reality. Thus, students reading Tolstoy's *The Death of Ivan Ilyich* or meditating on Donne's "A Hymn to God My God in My Sickness" find their own realities shaped by these recountings of suffering and pain. Their capacity to imagine and empathize increases and their practice of medicine is altered as they are able to truly care about their patients even in their complete otherness.

Ricoeur writes that narrative calls for "a very sophisticated form of *understanding*" that enables one to grasp the configuration of a story and to understand its workings.[50] This type of narrative competency is essential to an effective, holistic practice of medicine. Rita Charon articulates the reason why such an understanding is necessary in the field of medicine: "[d]octors enter these complex narrative situations having to imagine what the situation must be like from the inside. To do so requires, in addition to imagination, a fluency as reader and receiver of accounts of others."[51] Because of the narratival character of their practice, which involves manifold events, characters, and narrative voices as well as complex settings and themes, doctors need to be able to comprehend narrative. When meeting with an other in the medical setting, the doctor needs to be able to enter into such a complicated narrative imaginatively, prepared to explore and seek to understand the configured world of the other.

One reason for the narrative approach to medicine in general and bioethics specifically is epistemological. In their book *Teaching Literature and Medicine*, Anne Hunsaker Hawkins and Marilyn Chandler McEntyre argue that

> a literature and medicine course organized by genre may focus students' awareness of literary genres as ways of knowing…An emphasis on the relation of genre and epistemology may brings students to a more complicated understanding not only of how narrative or poetry or autobiography shapes, and indeed constitutes, experience but also of the ways the lab report or case history limits, predetermines, and organizes language in the clinic or hospital setting.[52]

According to Hawkins and McEntyre, exposure to the intersection of narrative and medicine leads to a greater understanding of the way in which recounting a narrative "organizes" language.[53] They believe that an understanding of *muthos* in Ricoeur's sense of the word, as active emplotment or a configuring of events into an intelligible narrative, is important for the pre-medical student. They note that the varying configurations of different types of literature both shape and constitute experience. A poem and an autobiography reconstruct experience very differently, but they also constitute two very different experiences for readers, which then shape the practical sphere of those readers. Likewise, varying configurations of medical data or patient history affect not only the way that the facts are perceived but also the realm of practical action that is indwelt by the medical personnel who receive them. An understanding of the way methods of recounting shapes experience can help medical personnel be aware of the way their reception and interpretation of information is shaped by the format in which it is presented.

In the encounter with a patient's life story, whether through a clinical consultation, a case study, or another form, a mimetic act takes place as the patient's story is understood in its configuration and as it thrusts itself into the realm of practical action of those making bioethical decisions. The act of writing can aid in interpreting this mimetic process. Often, Rita Charon writes in the clinical setting as a way to work through diagnostic situations. She notes, "when done with skill and care, [narrative writing practices] become powerful hypothesis-generating acts, enabling the writer to give expression to half-formed impressions that can lead to clinically useful perceptions."[54] In the same way that writing can contribute to diagnosing a patient's disease it can also contribute to uncovering a solution to a bioethical dilemma. As previously mentioned, since the three-fold mimetic act involves refiguring the stories one encounters, it allows the hearer to inhabit the narrative he or she is encountering. Thus, in bioethical dilemmas, writing can help the decision maker to inhabit the world of the patient or others involved, to see from their perspective, and to consider factors that might otherwise go unnoticed. In writing this way, one encounters the other and attempts to dwell in his or her world, drawing nearer to the reality of who the other is while at the same time recognizing more and more the separateness of the other and thus his or her ethical claim on the person encountering the narrative of his or her life, as Newton describes.

Articulating a Christian Narrative Approach to Bioethics

A narrative understanding of bioethics cultivates empathy and understanding in the practice of medicine. It values the concrete person in the intersubjective relationship, respecting the separateness of the other while at the same time entering into his or her world. In doing these things, a narrative bioethics resonates with Christian teaching which seeks to honor the other and promotes such virtues as charity and selflessness. In light of these intersections, we should seek to situate bioethics within both a narrative and

a Christian framework. Ultimately, a Christian narrative bioethics must be rooted first and foremost in response to God, the ultimate author.

One physician and religious ethicist, Margaret E. Mohrmann, seeks to articulate a Christian narrative bioethics in her book, *Medicine as Ministry*, bringing narrative into the realm of bioethical decision-making and attempting to do so specifically from a Christian perspective. Mohrmann frames her understanding of Christian bioethical decision-making with the concept of "writing the next chapter." She writes, "I suggest that we can offer more to those we serve by consciously adopting the metaphor of story, so that we can see the process of healing as a process not of solving problems, but of giving narrative form to the events."[55] For her, as for Charon, the concept of writing plays a crucial part in bioethics. To move ahead with ethical dilemmas is less like rendering prescriptive moral judgments and more like imaginatively inscribing the rest of a patient's story. However, writing the next chapter has several constraints. Mohrmann says, "First, it has to be part of the hero's story and no one else's."[56] The one envisioning and configuring the story cannot make the story to fit his or her own life and belief. Secondly, Mohrmann writes that the next chapter must fit with the themes already established in the patient's narrative. There is an element of coherence with the patient's past which those involved in making treatment decisions must consider. Third, the next chapter of the narrative "should be able to lead the story on to other chapters that are to follow."[57] In the act of "writing" the next chapter, the one involved with writing should consider how the decisions made will allow for the future well-being of the patient.

Setting up her theological ethics, Mohrmann suggests that we look at illness in light of the relationship of the Trinity and in light of the narrative of Scripture. In regards to the Trinity, Mohrmann stresses the self-giving love among the persons of the Godhead. Mohrmann writes that "The essential and eternal nature of God, the God who is love, is perpetual self-giving and self-receiving."[58] This understanding should shape our medical ethics as we seek first to love the other and receive love from the other. Mohrmann's view of Scripture of "a narrative that reveals God's way with the world and with us."[59] Mohrmann goes on to argue that the Christian community looks to Scripture as its moral resource.

> Jesus is alive; it is the living Christ who is our present help in moral discernment. We can derive rules and principles from scripture, but we must not deceive ourselves that they alone are intended to determine our actions and encompass our ethics. Rather, biblical rules and principles are intended to inform and to structure the process of moral discernment that we, as a community centered on the living Christ, are required to undertake.[60]

Mohrmann believes that it is the narrative of Scripture which should help us to discern how to act in ethical dilemmas in the sense that we should be transformed by it and engage in our own place within it. She advocates allowing the narrative of Scripture to cultivate a certain way of thinking and acting towards God and neighbor.

While attempting to articulate a Christian, narrative approach, Mohrmann ultimately falls into a dilemma. In a narrative bioethics, in which one confronts the other and inhabits the world of the other in an attempt to understand and refigure their stories, one can succumb to a relativism in which intersubjectivity leads to a situation similar to the interpretive realm of différance discussed by Jacques Derrida. When Derrida writes, ""There is nothing outside of the text,"[61] he means that everything is interpretation and

notes the open boundaries of a work. In the intersubjectivity of a narrative approach, one may become trapped in this kind of "Derridean" world in which everything is interpretation and no truth exists in a situation. This is an inevitable problem for pursuing a Christian narrative bioethical approach because of Christian claims to truth.

If we consider Mohrmann's approach to be a typical way of synthesizing bioethics and a theological approach to narrative, then the obvious concern surfaces: that of succumbing to a situation ethic. Mohrmann herself anticipates this concern in the first chapter of *Medicine as Ministry.* Mohrmann's narrative ethics is situational in that it holds to the necessity of making bioethical decisions in the context of the concrete person, not in abstraction. She does not seek to separate her ideas completely from the notion of a situation ethic. She writes, "We always act within specific situations, and we must always be aware of and responsive to the details of those situations; the circumstances must be a vital part of what forms our moral decisions. In that sense, Christian ethics is very much situation ethics…"[62] Though she still seems to espouse a situation ethic, Mohrmann takes pains to differentiate hers from the situation ethics of Joseph Fletcher. Fletcher is the original articulator of an explicitly situational ethic; he argues that love for the other is the only ethical standard for action. Mohrmann, however, argues that Fletcher's ethic doesn't allow enough room for the reality of dilemmas in which a decision must be made between two moral principles. She argues that in situations of conflicting moral principles, sometimes one must be chosen at the price of the other, and what is necessary at that point is mourning for our finite and fallen condition, in which we are constrained and unable to undertake both actions and fulfill both principles.

A situation ethic is valuable for a Christian narrative bioethics in some ways. In articulating an approach to bioethics that is both narratival and Christian, one must hold both to the insights of particularity and intersubjectivity which narrative brings to bioethics. Mohrmann's concept of a narrative ethics, which involves writing the next chapter in coherence with the previous chapters of a patient's life, is helpful in this way. She is careful to preserve, along with Adam Zachary Newton, a sense of the complete separateness of the other. We are not to exert our own control over the other, submitting him or her to our authorial whims. Such an approach already begins to temper the relativism that can characterize a narrative approach to bioethics. While Mohrmann still maintains an interpretive stance along the lines of Derridean différance, in inhabiting the world of the other one is not free to make any ethical judgments he or she wants but should seek consistency with the narrative world of the other. Thus, Mohrmann's narrative approach is grounded in the concrete person of the other and is not open to all interpretations but is constrained by the contours of the other person's life. This narrative scheme for ethical decision making guards against objectifying the patient's disease and isolating ethical dilemmas from their narrative contexts. On the contrary, it emphasizes the holistic life of the patient, striving to consider factors such as the patient's values, beliefs, and past experiences in configuring the next chapter of a narrative.

Wendell Berry makes a similar point in his short story "Fidelity." In this story, an older man, Burley Coulter, becomes ill, and his family has him hospitalized. Soon, however, they realize that their decision to put him in the hospital does not cohere with the trajectory of Burley's life. In the end, Burley's son takes him from the hospital to allow him to die in the context of his own family and his own land. "Fidelity" culminates in the communal sharing of the life story of Burley Coulter. Berry emphasizes Ricoeur's

idea that narrative identity is intersubjectively created. One of the characters, an attorney, Wheeler Catlett, tries to explain this to the detective on Burley's case, saying, "To whom and to what does Burley Coulter belong? If, as you allege, Danny Branch has taken Burley Coulter out of the hospital, he has done it because Burley belongs to him.[63] As Christians made in the image of a relational, trinitarian God, we must recognize the intersubjectivity of bioethics. A patient is not simply his or her own but belongs to a web of other characters in his or her story, including those he or she encounters in the medical scenario, and the medical decisions made should consider those factors. In this way, a Christian narrative bioethics should embrace its situational character.

However, while understanding and seeking coherence with the communal narrative of the other, for the Christian, being rooted in the story of the other is not enough, because God is the author of the ultimate story, to whom we should first respond and to whose narrative we should first seek to conform. Though patients are constrained by their own concrete situations, in seeking to be faithful to the stories of the patient one must first take into account the authorship of God. The words author and authority both derive from the Latin *auctor*, which means promoter, originator, or author.[64] An understanding of God as author must inform the way that we approach bioethics narratively, looking to God as both the promoter, originator, and, thus, the ultimate *author* of our own life narratives and the ultimate *authority* over them. It is God who ultimately emplots our lives, drawing meaning from the seemingly heterogeneous in His own sovereignty. A narrative approach to bioethics can be dangerous if it becomes willing to sacrifice principles of God's authored revelation even for the sake of coherence with a patient's story. Though Mohrmann seeks to construct a Christian bioethics and articulates some important elements such as empathy and concreteness, her sense of an ethical response to God gets lost in her desire to preserve these elements in the narrative approach.

Mohrmann is right to frame medical professionals' interaction with patients as the intersubjective act of narrative, but response to God as author is the first imperative for a narrative ethics. H. Richard Niebuhr's response theory lends traction to this idea. At the end of *Christ and Culture*, Niebuhr proposes that one must draw one's own conclusion about how to relate to culture through "existential as well as relative decisions."[65] Niebuhr writes that there are four ways in which the individual Christian's decisions are relative: they depend on incomplete knowledge of the individual, they depend on "the measure of his faith and unbelief", they depend on one's position in history and society, and they are concerned with relative values.[66] For Niebuhr, no matter how much one seeks the absolute Christian answer, one cannot escape the relativism of one's own decisions because they are always constrained by these factors. Thus, an individual must make ethical decisions based on what is true in his or her relative situation.

For Niebuhr, the idea of relative and existential decisions applies not just to the relationship of Christ and culture, however. Niebuhr's work *The Responsible Self* more explicitly fleshes out Niebuhr's moral philosophy as a whole. Like Adam Zachary Newton, Niebuhr forgoes both the teleological and deontological ethical framework. Instead, Niebuhr uses a framework of responsibility—man as answerer or responder. Niebuhr speaks of three elements involved in the image of responsibility. The first is the element of response. All moral action is a response to action upon us. Second is the element of interpretation. When we are acted upon, we see this action as a part of a larger system.[67] One acts based on one's idea of how he or she is being acted on. Finally,

the third element of responsibility is the anticipation of reaction to one's reaction.[68] It is like an ongoing conversation. One acts with an awareness that one's action will cause another's action. The final element is that of social solidarity. One responds to action upon oneself in a "continuing community of agents," rather than responding in isolation or to an action that is outside of a certain community.[69]

While Mohrmann's approach to bioethics—writing the patient's story—emphasizes an ethic of intersubjectivity in which patient's stories are written communally, Niebuhr's scheme, while still relativistic, both preserves intersubjectivity and places greater, more explicit emphasis on one's response to the triune God as the center of such an ethic.[70] The image of man as a responder is an essentially intersubjective image in which one responds to an other in community, not in isolation. In Niebuhr's thought, all response to others is first rooted in one's response to God. He writes

> By that action whereby I am I in all the roles I play, in reaction to all the systems of action that impinge upon me, I am in the presence of the One beyond all the many. And my response to every particular action takes the form of response also to the One that is active in it.[71]

Niebuhr notes that in responding to actions upon ourselves, we respond to God. Thus, we are accountable to more than just our intersubjective relationships with one another. Rather, our decision making is characterized first by a response to God. While his ethics is certainly relative, Niebuhr does believe in an absolute. He says that our decisions, while relative and existentially free, are made in the presence of "the absolute, the God of Abraham, Isaac, and Jacob, of the living rather than the dead, the one who in Christ binds all times together…"[72] Thus, while our decisions and lives are relative, they are made in relation to the absolute: God as revealed to us in Christ.

A narrative framework for bioethical decision-making should take this into account. When a response to God is the centerpiece for decision-making, then one's response to others will be most fitting. In the gospel of Matthew, Jesus says that the two greatest commandments are "Love the Lord your God with all your heart and with all your soul and with allyour mind and with all your strength" and "Love your neighbor as yourself."[73] These two must be prioritized appropriately in medical practitioners' engagement with patients. In confronting the narrative of a patient's life, the person making medical decisions must first realize that he or she is confronting a narrative authored by God and, thus, should respond to the patient in light of his or her response to God. God does not merely inform the ethical decisions of medical personnel. Rather, it is response to God that orders all of our interactions with the narrative of patients.

This understanding provides the basis for honoring the patient, for listening to the patient, for entering his or her narrative imaginatively and empathetically, for acting with all charity towards him or her. It also provides the basis for constraints in the practice of medicine. That God, to whom we respond in all of our actions, is the author of life and the authority over all creation means that the physician must set boundaries on the directions he or she takes the narrative of anyone's life. The physician knows that some endings of life (taking life, for instance) would be distorting the narrative of the patient and, thus, should not be pursued because they are an offensive and sinful response to God. The physician knows that the author of life created people as bodily creatures, constrained by limits and thought it worth it to redeem those same bodies. Thus, the physician, responding to the authorship of God, will treat the body with respect and not subject

it to treatment which objectifies it and dishonors it. In short, the medical practitioner will interpret each individual, intersubjective narrative encounter as an intersubjective encounter with the author of life.

Conclusion

The intersections between narrative and bioethics, demonstrated through the philosophy of Paul Ricoeur and the work of Adam Zachary Newton, compel us to articulate a Christian bioethics that is formulated narratively. A narrative bioethics leads us to empathize with the other, to confront his or her otherness in suffering, to recognize the intersubjective, relational context of the patient's story, and to honor the patient in his or her concreteness and particularity. When grounded first in response to God, the author of life, a Christian bioethics allows us to engage the story of the other as rooted in our engagement with God's much larger story. It is only in this ordered interaction that we can demonstrate our love for both God and other by making decisions that honor both.

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23. Ibid.
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28. In *On Stories,* Richard Kearney differentiates between the "story-element" and the "history-element" in nonfiction, specifically in cases of psychoanalysis. He does not suggest that these are easily separable but writes, "The two strands—fiction and fact—are, admittedly, almost always interwoven in the narrative text; but that does not mean that these strands can never be, at least partially, disentangled and distinguished." Ibid., 37.
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53. Although Hawkins and McEntyre are specifically discussing the intersection of *literature* and medicine. I use the word "narrative" to maintain consistency throughout the rest of the paper. I do not find that the term narrative is problematic, since all literature is subsumed under narrative in the philosophical sense of Ricoeur, narrative being recounted temporal experience. However, it would be unacceptable to use the term literature to refer to all of narrative, because not all of narrative is constituted as literature in the sense in which Hawkins and McEntyre are using the word.
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66. Ibid., 234.
67. Niebuhr, *Christ and Culture,* 62.
68. Ibid., 63.
69. H. Richard Niebuhr, *The Responsible Self* (New York: Harper & Row, 1963), 65.
70. Niebuhr's response theory fortifies a Christian narrative bioethics by prioritizing our response: first we seek coherence with God's narrative and in light of that understanding we can seek coherence with the narrative of the other. Niebuhr's view of Scripture, however, leaves something to be desired. Ideally a Christian narrative bioethic would have a higher view of the nature of Scriptural revelation than both Niebuhr's and Mohrmann's.
71. Niebuhr, *The Responsible Self*, 122.
72. Niebuhr, *Christ & Culture*, 249.
73. Matthew 22:34-40, New International Version.

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BOOK REVIEWS

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"Consciousness is a wonderful thing…Surely consciousness is a wonderful thing, and we are privileged to partake of it" (1, 188). So begins and ends *The Wonder of Consciousness: Understanding the Mind through Philosophical Reflection* by Harold Langsam, in which the author introspectively develops a non-reductive theory of the nature of consciousness. Langsam highlights not only the intelligibility of consciousness (that it can be known *a priori*) but also the fact that consciousness is a necessary condition for many awe-inspiring aspects of human life, such as rationality, perceptual knowledge, emotional responses, feelings, desires, and perception of value. It is consciousness that enables us to intimately relate to and actively engage in the world, thereby enabling the world to reveal itself to us.

Written from a first-person perspective in an engaging and easy-going style, Langsam inspires wonder in the midst of philosophical rigor. Rationalism, non-reductionism, foundationalism, and direct realism are the fundamental presuppositions of his argument. He is supportive of dualistic notions, without specifically claiming to be a dualist, arguing that mental properties are a new kind of fundamental property radically different from reductive physical properties. Moreover, he claims that mental states have causal powers: the categorical properties of experiences, conscious beliefs and desires, rational intuitions, pain, pleasure, and feelings all intelligibly ground causal powers that give rise to knowledge. Hence, our lives do not consist in a mere arbitrary sequence of events resulting from brute causation, but are the intelligible result of previous events and their associated mental states.

The wonder of consciousness is that the world is revealed to us through intelligible acts of consciousness. According to Langsam, consciousness intimately relates us to the external world by attaching to observable properties in the world and intelligibly producing a phenomenal, "what-it-is-like" experience—an instantiation of the observable property *for* the subject. The phenomenal properties of both perceptual experiences and bodily sensations then ground the causal power of these experiences to produce beliefs. Likewise, consciousness reveals to us the world of abstract objects through rational intuition and logical connections, and is therefore required for rationality. Knowledge is made possible as consciousness enables us to form attitudes toward the world of propositions and to hold them in rational ways. Just as both attitudes and desires are conscious acts, feelings are our conscious emotional responses to the values we perceive in the world, values that supervene upon observable properties and are present independent of those feelings. Consciousness, therefore, also enables us to participate in the value of the world. Through our consciously mediated beliefs, feelings, and desires, "we have an intimate stake in the way the world is and the ways it could be." (188)

In a world increasingly ruled by reductive physicalism, where mystery and wonder have been replaced by processes and data, *The Wonder of Consciousness* is a welcomed addition to the current literature on the philosophy of the mind. While a challenging read for the philosophically uninitiated, it is refreshingly readable and inspiring. If you have ever wondered about consciousness, enjoyed "pondering the imponderable" of consciousness, or find a non-reductive argument for the nature of consciousness appealing, *The Wonder of Consciousness* is highly recommended.

Reviewed by Susan M. Haack, MD, MA (Bioethics), MDiv, FACOG, a consultative gynecologist at Hess Memorial Hospital and Mile Bluff Medical Center in Mauston, Wisconsin, USA.

Thinking About Christian Apologetics: What It Is and Why We Do It

James K. Beilby. Downers Grove: InterVarsity Press, 2011.

ISBN 0-830-83945-3; 214 PAGES, PAPERBACK, $17.00

The Christian faith may actually fare better if some Christians *stop* doing apologetics, even if they are exceptionally skilled at demolishing arguments that challenge the faith. Beilby's work on meta-apologetics—an investigation of the nature, method, and goals of any apologetic enterprise—offers several striking, yet refreshing, statements like these. How one understands apologetics matters a great deal to how apologetics is practiced. All too often Christian apologetics has focused on developing robust arguments to the exclusion of more fundamental considerations such as the nature of truth, epistemological questions, the relationship between faith and reason, and the nature of doubt and disbelief. Beilby's book does a masterful job of unpacking the unspoken with some deceptively simple and crucially important questions such as, What makes apologetics Christian? How does one determine success? Can apologetics generate belief? What is the relationship between apologetics and evangelism, theology, and the philosophy of religion?

Beilby's work is suffused with a refreshing epistemological humility that is theologically grounded both in God's otherness and humanity's sinfulness, and which avoids the more pessimistic epistemology of some Reformed approaches to apologetics on the one hand, and the more rationalistic approaches to some evangelical apologetics on the other, for God's existence simply cannot be proved. Yet, he rightly notes, "there is no problem if Christian apologetics focuses on the rational dimension of faith as long as it acknowledges that the rational dimension is only doing part of what Christianity is" (169). Amen. Beilby also includes two interesting chapters devoted to the history of apologetics, which are a welcome intrusion. Unfortunately, he gives the reader no warning that he is taking this path, nor does he offer any warrant for this historical detour—though doubtless such warrants exist—or take the time to describe how these chapters fit in with the rest of his book. He does, however, draw some helpful insights from his survey at the end of the chapter dealing with contemporary apologetics; the reader who skips these chapters will be missing something.

The final chapter entitled "Doing Apologetics Well," is a wonderful treatment of the nature of Christian belief, truth claims, and disbelief. Once again, Beilby reminds us that too often apologetics assumes an unacceptably thin account of the skeptic, antagonist, or doubter. Arguments will only go so far. While apologetics often focuses exclusively on the numerous intellectual causes of unbelief, it too often ignores the affective and spiritual causes of unbelief that often defy rational argumentation. One's emotional and relational quotients are probably more valuable than one's intelligence (IQ), though this should not be an excuse for shoddy argumentation. In short, one's character matters more than one's arguments. Beilby concludes with a helpful bibliography divided by subject matter, including more poorly argued 'new Atheist' works amongst more formidable challenges to the faith. To construct a bibliography, of course, inevitably invites criticisms over who is left out: here the works of David Bentley Hart (*The Doors of the Sea*, *Atheist Delusions*), certainly deserve to be included. Apart from these minor shortcomings, this book deserves a place amongst the argument-heavy apologetics texts currently in use. Indeed, it should ideally be read before such texts are even opened.

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