Response to Farr A. Curlin and Daniel E. Hall

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Date: 05-18-05 10:15

Doctors Curlin and Hall have written a clear-headed paper surveying many of our current challenges in the area of health and medicine. In the space allotted, I cannot cover offer a comprehensive reaction to their essay; rather, I shall illuminate a number of central points as these occurred to me when I was reading their essay.

First, there are always forces at work — and in a democratic society these forces may function ‘underground’ before they rise to the surface as explicit concerns — challenging hegemonic orders of things. There has been a subterranean current in our culture for decades now seeking alternatives to what the authors call “medical hegemony” and others have tagged “medicalization” or “the professionalization of medicine.” Alternative medical treatments—holism, ‘new age’, traditional — have long been practiced by marginalized groups — often marginalized by choice. Now, as Curlin and Hall point out, this discontent has bubbled to the surface. Concomitant with a decline in trust in other major institutions of American society, we have witnessed in the past several decades a growth in mistrust in medicine as currently practiced. This disgruntlement isn’t simply about medical costs but about medical practices themselves.

Second, one must ask why medicalization is under sustained criticism and assault. One answer, surely, is contained in Curlin and Hall’s conclusion that, although conventional medicine long ago demonstrated a superior ability to cure, it seemed not to heal. What do I mean? Even as we have made great scientific and medical headway against illnesses that entail terrible human suffering, our existential suffering continues. Despite its claims of moral neutrality as to the sorts of lives people were living, it became clear that a particular view of the human person seeped through medical practice. As part of what might be called “secular morality,” medicine incorporated rising standards of what counts as healthy, hence what constitutes a normative ideal of what it means to be fully a person — even as any such ideal was buried under claims to neutrality. But standards of health and illness are not just neutral diagnoses of conditions on objective medical criteria. Such standards take on a potent normative dimension and shape the contours of our assessment of what is a good life, a healthy life, a life worth living. If I am correct in this, and if we keep moving in our current cultural direction, it seems likely that, over time, the remaining inhibitions and prohibitions embedded in our moral institutions as these have been shaped by Judaism and Christianity, will slowly but surely give way.

Third, again if I am correct, it means that accepting the unwell, those who need constant care, those with disabilities, will become for us an ever more onerous task. Why can’t we cure them? We will lose the ability to appreciate that a person who is incurable might well be healed, whole in spirit. This leads me to the unhappy conclusion that our liberal culture, a good and brilliant culture in so many ways, is not in a strong position to sustain support for the unwell (as in incurable), particularly if that takes the form of prolonged illness or disability. Our medicalized quest for control and prevention pushes us toward the elimination of certain conditions and that, in turn, may even invite, at some terrible future moment, elimination of persons on the grounds that, although they may belong to the human species, they are not full fledged members of the secular moral community.
Fourth, and finally, we cannot leave to medicine the final say on our understanding of the dignity of the human person and in what that dignity consists. Medicine, as in medicalized, cannot tell us who is and who is not within the boundary of full moral concern. Inevitably, questions of health, disease, cure, and healing lead us back to first order questions. I am happy to endorse our authors’ call for an “openly plural medicine” that does justice “to the mystery and meaning of the human condition.” But there is a fly in the ointment, namely, that our law to a great extent already encodes the medicalized version of who we are and, indeed, when life ends or begins. It is not at all clear to me that the law will support and nurture this plurality. All one need do is look at the Terry Schiavo case to be filled with horrible premonitions about these issues. That case was a denial of care in two respects: denial of care to Terry Schiavo on the word of an estranged husband with a common law wife and two children; denial of the possibility of giving care to her devoted family who pledged to nurture her until she died a natural death. She was, after all, taking and using nourishment, breathing on her own, and so on. It took her two weeks to die — the length of time it would take a “normal” person. Many of us need to be fed — as babies, as infirm elderly. But as soon as a certain narrow notion of “rights” enters that incorporates the normative vision that “I,” if I could choose, would rather be dead than alive using a breathing tube, I am in danger of having food and hydration withheld. Because I cannot be “cured” it would be better were I dead — despite the fact that receiving care might not only heal a troubled body and spirit but heal as well the spirits of those who yearn to give care.

I applaud our doctors for their thoughtfulness. I wish there were more like them.
In their current essay for the Religion and Culture Web Forum, “Red Medicine, Blue Medicine: Pluralism and the Future of Healthcare,” Dr. Farr A. Curlin and Dr. Daniel E. Hall warn that, although an “extensive moral consensus” supported American medical practice through much of the twentieth century, this consensus “now appears to be disintegrating.” The two physicians provide a usefully succinct historical and social analysis of this change, and I am writing to suggest ways in which “the startling disagreement within our society about the proper scope and ends of medicine” is symptomatic of a broader disagreement affecting all of the professions.

Beginning in the mid-nineteenth century and for more than a century thereafter, the nation’s various moral and religious traditions gave a broad endorsement to the advancing technical effectiveness of American medicine. This consensus was especially strong, Curlin and Hall note, when “technology was applied to a limited scope of medical problems such as the treatment of acute illness and injury, the prevention and treatment of communicable diseases, and the surgical removal of diseased organs.” They argue that two intertwined developments have challenged this consensus, one technical and the other ethical. Technologically, biomedical science is now able not simply to treat acute, organic illnesses but also to regulate sexual function, enhance physical capacities, and reshape bodily form. Medical technology has gone beyond the treatment of illness within a consensus concerning human nature and is now applying pressure at the boundaries of cultural understandings of human nature and human flourishing. Ethically, meanwhile, powerful cultural currents flow in the direction of “an ethic of self-actualization,” in which individual persons ought to have autonomy in deciding what their medical needs are in light of their particular goals for their individual lives. Curlin and Hall suggest that physicians have generally responded to this situation by conceiving of medicine as a morally neutral “technical practice whose application is to be guided by the autonomous choices of patients.”

This retreat from ethical practice to technical expertise is by no means peculiar to medicine. Consequently, in education, law, religion, psychiatry, and other fields there have been numerous appeals over the past fifteen years for a renewed public philosophy of the profession that clarified the ethical assumptions of professional practice and guided professional response to the diverse moral commitments of patients or clients. In Democracy’s Discontent: America in Search of a Public Philosophy (Harvard University Press, 1996), the political scientist Michael J. Sandel spoke of the contemporary United States as a “procedural republic” that avoided deliberation about the aims of government. If one imagines a republic of the professions, it could be said that there, too, we have a “procedural republic,” which avoids deliberation of comprehensive professional aims and, instead, emphasizes morally neutral expertise employed at the service of clients who supply their own individual purposes and moral goals. Into this deliberative void concerning the public philosophy of the professions, numerous interest groups (religious and otherwise) have introduced strongly worded assertions of the normative values that ought to guide practice. This has created the appearance of cultural conflict implied in the title of Curlin and Hall’s essay, “Red Medicine, Blue Medicine.”

Given this analysis, I think that any fruitful, public development of the assertion by Curlin and Hall that
“medicine is, at root, a moral practice” requires a crucial first step. That step is a probing, interdisciplinary discussion among the professions regarding their tacit assumptions about human nature, agency, and flourishing. The fact that these assumptions are very frequently unspoken does not erase the fact that they are implied in actual technical practices that supposedly are morally neutral. Furthermore, each profession encounters persons in its distinctive way that accentuates certain aspects of a person’s humanity and downplays other aspects. Thus, the law emphasizes the person as an agent who is responsible for the consequences of specific acts. Medicine, meanwhile, often encounters persons faced with health difficulties that arose from circumstances largely beyond their own control. This means, for example, that the physician, the lawyer, and the rabbi will bring a plurality of perspectives—invaluable perspectives—to the situation of a dying patient and her family.

These different vantage points on the human are bound up with different professional practices. No one of them is a full expression of the public role of the professions in American life. Collaborative understanding of this “moral pluralism” of the professions is, I believe, the current challenge throughout professional education. Some purchase on this professional pluralism is indispensable to wise engagement with the broader pluralism in the culture as a whole. Curlin and Hall provide an important model from contemporary medicine of how this rethinking of the professions as moral practices might proceed.