REPORTS OF THE INSTITUTE FELLOWS 1976 - 1977
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Reports and Papers from Twenty Institute Fellows

September 1977

Chairman of the Institute
Edmund D. Pellegrino, M.D.
President
Yale-New Haven Medical Center
Professor of Medicine
Yale University School of Medicine

Executive Director of the Institute
Ronald W. McNeur, Ph.D.
Executive Director
Society for Health and Human Values

Edited by Thomas K. McElhinney, Ph.D.
Director of Programs
Institute on Human Values in Medicine

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CONTENTS

Preface
    Edmund D. Pellegrino vii

Introduction ix

Part I The Reports

Biographies of the Fellows 3

Agich, George John 7

Benjamin, Martin 11

Brody, Howard A. 15

Cebik, L. B. 19

Costello, Daniel E. 23

Dyer, Allen R. 25

Graber, Glenn C. 31

Hausman, David B. 35

Hendrick, George 39

Hunter, Kathryn, Montgomery 41

Larson, Laurence A. 43

Margolis, Clorinda G. 47

Osterman, Steven D. 53

Parmett, Steven R. 57

Purtilo, Ruth B. 59

Rizzo, Robert F. 61

Rocereto, LaVerne 73

Schroeder, Fred E.H. 77

Self, Donnie J. 79

Somfai, Béla 87
CONTENTS (cont.)

Part II The Papers

Persons and Placebos: Philosophical Dimensions of the Placebo Effect - Howard A. Brody 91

The Significance of Death for the Living
L. B. Cebik 95

Health Professional-Health Consumer Value Systems: Implications for Policy Analysis
Daniel E. Costello 113

Reflections on the Fiduciary Doctor-Patient Relationship - Allen R. Dyer 129

Is Social Evolution a Moral Inversion?
Allen R. Dyer 145

Analogies and Disanalogies Between the Concepts of Physical Health and Ill-Health and Mental Health and Ill-Health - David Hausman 151

A Beginning Study of Some Uses of Alternative Healing Systems by Patients in a Metropolitan Health Center - LaVerne Rocereto 157

The Construction of a Value-Metaphysics in Dietrich Von Hildebrand's Thought - Béla Somfai 173

The Dilemma of Artificial Life Support, An attempt at clarification - Béla Somfai 195

Index 201
This is the third report from the fellows of the Institute on Human Values in Medicine. This group of twenty fellows was selected by the Institute Board in April of 1976 and held fellowships in the years 1976 and 1977. In Part I of the Report, short biographies of the fellows and descriptions of their fellowship experiences are given; while nine papers prepared by the fellows are included in Part II.

The Institute is justifiably proud of its fellowship program which has to date supported 77 persons. The applications of these fellows were competitively assessed from a large pool of applicants. In addition to the reports of their work given in this volume, in February of 1977 the twenty fellows in this group met together with the Institute Board to discuss their experiences and to gain acquaintance with others who are pursuing human values work.

The fellowship reports show that these persons are engaged in substantial human values work related to the education of health professionals. Through the fellowships faculty and a limited number of students have been able to pursue an interest in humanities and human values in medicine, thus enhancing the number of persons with training in this area. In addition, some human values programs have been initiated or helped in their early development through the work of an Institute fellow. The group of fellows contributing to this Report is well qualified to continue the growing movement of human values work in health professional education.

Edmund D. Pellegrino, M.D.
Director of the Institute
INTRODUCTION

All persons holding a fellowship from the Institute on Health and Human Values are required to submit a statement describing their activities during the fellowship period. Since these reports contain many reflections about the nature of human values programs, and the participation of the fellows in clinical training as well as in the classroom, the reports have value beyond the immediate use of the Institute. The Institute therefore offers this third Report of the Institute fellows.

The similarity among the several reports in Part I derives from the fact that the fellows are responding to questions presented to them by the Institute. As an aid to the reader the questions asked of the fellows are listed below:

1. What did you do during the tenure of your fellowship, and how does this compare with what you had planned to do when you applied?

2. Has your understanding of your subject developed as a result of your work under your fellowship? If so, in what way?

3. What effect, if any, will your fellowship work have upon your teaching or any other professional activity?

4. Will you offer any new courses as a result of work done during the fellowship period? If so, please describe them briefly.

5. If you completed an article, book, or monograph, what are your publication plans?

6. Expressed roughly in percentages totalling 100 per cent, what proportions of the fellowship period did you spend at your own campus, at other institutions or locations in the U.S., at other institutions or locations abroad?

7. Did your institution contribute any funds for travel, supplies, research assistance, or any other such ancillary purpose, to help you with your work under the fellowship? If so, please indicate amounts.

8. To what extent will you be able to apply (and perhaps extend) your fellowship work upon returning to your regular position? What assistance, if any, will you receive for this time from your institution or from other sources (including released time, research or secretarial assistance, etc., as well as grant assistance)?
9. What is the possibility that your professional activities and leadership at your institution will result in a program (as opposed to occasional courses) of teaching about human values in relation to medicine and the other health professions?

As a further assistance to the reader a brief index will be found at the end of this volume. I would like to thank the fellows for their cooperation in preparing their reports, Mrs. Helen Eddy for copy editing and proofing, and Mrs. Lucille Weber and Mrs. Edna Boulden for their work in production of the manuscript. The art work for the cover was done by Gene Harris.

Thomas K. McElhinney, Ph.D.
Director of Programs
Institute on Human Values in Medicine
PART I

THE REPORTS
GEORGE J. AGICH

George J. Agich, Ph.D., is Assistant Professor of Medical Humanities at the Southern Illinois University School of Medicine in Springfield, Illinois. His fellowship project was a study of the relationships between theoretical and descriptive concepts in psychiatric medicine. He studied these relationships by reviewing the literature on schizophrenia and by working with psychiatrists. Dr. Agich's fellowship was held from 1 July to 31 August 1976.

MARTIN BENJAMIN

Martin Benjamin, Ph.D., is an Associate Professor of Philosophy at Michigan State University in East Lansing, Michigan. From 1 September to 31 December 1976, Dr. Benjamin spent time in a clinical setting at the College of Human Medicine of Michigan State University. Dr. Benjamin has been one of the faculty at Michigan State working on relationships between the health professional schools and the humanities departments.

HOWARD A. BRODY

Howard A. Brody, M.D., has been the only person to receive two successive Institute fellowships. During the period of his second fellowship, from July, 1976, to June, 1977, Dr. Brody received the M.D. degree and completed his doctoral work in philosophy. His work has been done at Michigan State University in East Lansing, Michigan, where he has collaborated with Dr. Benjamin on many of the projects involving the health professions and the humanities.

L. B. CEBIK

L. B. Cebik, Ph.D., Associate Professor of Philosophy, was one of two fellows from the Knoxville campus of the University of Tennessee who studied in the clinical residency program at the University of Tennessee Center for the Health Sciences in Memphis from 21 July to 20 September 1976. A paper on "The Significance of Death for the Living," prepared while Dr. Cebik was an Institute fellow, is included in Part II (below).

DANIEL E. COSTELLO

Daniel E. Costello, Ph.D., is Director of Health Communication Research at the Vanderbilt University School of Medicine in Nashville, Tennessee. Dr. Costello spent a month in May and June of 1976 conducting a study of value attitudes of staff persons at the National Cancer Institute and the National Heart and Lung Institute, both located in Bethesda, Maryland. The report of his fellowship is given in Part I (below) while the data and analysis which were obtained are described in Part II (below).
ALLEN R. DYER

Allen R. Dyer, M.D., is an Assistant Professor in the Department of Psychiatry and Community Health Sciences and Assistant Director of the Psychiatry Inpatient Service of the Duke University Medical Center in Durham, North Carolina. He is also a doctoral candidate in religion at Duke. During the six month period from 1 July to 31 December 1976, Dr. Dyer did research in the philosophy of medical practice and medical ethics. He concentrated on ambiguities in the philosophy of biology.

GLENN C. GRABER

Glenn C. Graber, Ph.D., Associate Professor of Philosophy at the University of Tennessee in Knoxville, joined Dr. Cebik in clinical study at the University of Tennessee Health Sciences Center in Memphis from 21 July to 20 September 1976. Dr. Graber used his experience in the clinical setting to provide data for his reflections on medical ethical problems.

DAVID B. HAUSMAN

David B. Hausman, Ph.D., is an Associate Professor of Philosophy at Southern Methodist University in Dallas, Texas, who spent the period from 15 May to 15 September 1976, in a study at the University of Texas Southwestern Medical School. Dr. Hausman, with the cooperation of a child psychologist, Dr. Martin Gluck, and with the permission of the patients who were involved, reviewed counseling encounters. Dr. Hausman was seeking to understand the concept of health in contemporary medicine through an analysis of health professional-patient encounters.

GEORGE HENDRICK

George Hendrick, Ph.D., is Professor and Head of the Department of English at the Urbana campus of the University of Illinois. Dr. Hendrick has developed connections between leading homeopaths of the nineteenth century and Thoreau, Emerson, Hawthorne, and other literary figures. His fellowship, from 20 May to 20 August 1976, provided time for research at libraries in London and Harvard, primarily concentrating on Henry James, Sr., Emerson, and Dr. J. J. G. Wilkerson, a homeopathic physician. He is completing a book on this topic.

KATHRYN MONTGOMERY HUNTER

Kathryn Montgomery Hunter, Ph.D., is Associate Professor of English at Morehouse College in Atlanta, Georgia. She is working with the newly developing medical school at Morehouse; therefore she requested a fellowship which would permit her time to visit medical schools with humanities programs. She visited these schools in the spring of 1977.
LAWRENCE A. LARSON

Lawrence A. Larson, Ph.D., is a Professor of Botany at Ohio University in Athens, Ohio. In July of 1976 Dr. Larson spent a week at a bioethics conference at Dartmouth University in Hanover, New Hampshire. He also spent time at two Ohio conferences on bioethics. These experiences were funded so that Dr. Larson might have more information for the course in bioethics which he teaches.

CLORINDA G. MARGOLIS

Clorinda G. Margolis, Ph.D., is Associate Director of Consultation and Education Services of the Community Mental Health Center and Associate Professor in the Department of Psychiatry and Human Behavior at the Jefferson Medical College of Thomas Jefferson University of Philadelphia, Pennsylvania. Dr. Margolis' fellowship, from 1 July to 30 September 1976, involved time spent in the Endocrinology and Obstetrics and Gynecology Departments of the medical school where she participated in clinical activities and contributed to discussions of value issues in clinical practice.

STEVEN D. OSTERMAN

Steven D. Osterman, A.B., graduated from Yale College May 1977, as a Scholar of the House in ethics and public policy. While initially interested in the area of social justice and domestic health care, his plans underwent considerable evolution. In the end, his fellowship - from 1 May 1976 to 1 May 1977 - included not only the work at Yale and Harvard originally envisioned, but a two-month sojourn to India and Bangladesh as well. Mr. Osterman indicates he eventually plans to pursue his interests in health and human values, "fate willing," in medical and law school.

STEVEN R. PARMETT

Steven R. Parmett, A.M., is a medical student at Harvard Medical School in Cambridge, Massachusetts. Mr. Parmett spent the time from 1 June to 1 September 1976, in a study of classical Hebrew sources for insights to ethical problems in medicine; e.g., whose lives to preserve when not all can be preserved.

RUTH B. PURTILO

Ruth B. Purtilo, M.T.S., is a doctoral candidate in religious studies at Harvard University, Cambridge, Massachusetts. Ms. Purtilo is a qualified physical therapist who has worked in several hospitals in the United States and overseas. Her fellowship, from 22 September 1976 to 15 June 1977, was to help support her doctoral studies. When these are completed she intends to teach physical therapy and medical ethics, probably in an allied health school.
ROBERT P. RIZZO

Robert P. Rizzo, Ph.D., is an Associate Professor of Religious Studies at Canisius College, in Buffalo, New York. From 7 June to 18 August 1976, Dr. Rizzo spent time in clinical training at the Children's Hospital in Buffalo. He gained experience in a clinical pastoral program and material for the course in Bio-Moral problems which he teaches at Canisius.

LAVERNE I. ROCERETO

LaVerne I. Rocereto, Ph.D., is Associate Professor of Nursing at the University of Pittsburgh in Pittsburgh, Pennsylvania. Dr. Rocereto spent the period from 15 June to 31 August 1976, interviewing patients at the University Health Center Hospital about their use of lay healers and folk remedies. Dr. Rocereto is gathering this information in order to help nurses and other health professionals understand the alternatives to scientific medicine used by their patients. A report on the survey and its results is given in Part II (below).

FRED E. H. SCHROEDER

Fred E. H. Schroeder, Ph.D., is Professor of English and Humanities coordinator at the Duluth campus of the University of Minnesota. Dr. Schroeder spent the month of August, 1976, in a reading program in the history of American medicine with a special interest in the rural and family practitioner. Dr. Schroeder teaches a course on rural family life at the Duluth Medical School.

DONNIE J. SELF

Donnie J. Self, Ph.D., holds a joint appointment as Assistant Professor of Philosophy at Old Dominion University and Assistant Professor in the Department of Psychiatry at the Eastern Virginia Medical School. Dr. Self's fellowship, from 1 September to 31 December 1976, permitted time for him to gain clinical experience at the Norfolk General Hospital. He also did research to develop an instrument to evaluate the quality of humanistic health care.

BÉLA I. SOMFAI

Béla I. Somfai, Ph.D., is Associate Professor of Theology at Regis College in Toronto, Ontario, Canada. His fellowship from April to May, 1976, covered part of his expenses while a visiting professor of humanities at the Medical College of Georgia in Augusta. Dr. Somfai has provided two articles which are found below (Part II).
1. I had planned to spend my fellowship time researching the development of the concept of schizophrenia by reviewing some of the primary sources and identifying and reading in the secondary literature. My focus was to be the interrelationship between description and theory, that is to say, between diagnosis in terms of symptoms and classification of symptoms, on the one hand, and scientific and causal explanation, on the other hand. The purpose of this research was to gain a clear idea of the role of values in structuring the clinical diagnosis of schizophrenia and in structuring its explanation and therapy. In particular, I was concerned to identify how psychiatrists have justified the symptoms of schizophrenia, the scope of the symptoms, the classification of symptoms (nosology), and the theoretical frameworks that purportedly explain the disease. An additional goal was to gain some insight into the origins of the values involved—whether they were peculiar to medicine and psychiatric practice or whether they were more generally found in other domains of human experience.

I searched the Titus Harris collection in the History of Psychiatry and the History of Medicine collection of the Moody Medical Library at the University of Texas Medical Branch at Galveston for primary source material relevant to the concept of schizophrenia. My research focused on Emil Kraepelin, who first articulated systematically the concept of dementia praecox; Eugen Bleuler, who modified this concept and introduced the term "schizophrenia"; and Adolph Meyer, who offered a social and psychological concept of the disorder. Together, these authors provided the base line for my research in the secondary literature. That research sought not only articles on these authors and the history of schizophrenia, but articles on the general problem of diagnostic labeling, classification of psychiatric diseases and syndromes, and theories of schizophrenia.

My fellowship time was thus divided between two kinds of work. First, research in the primary and secondary literature, which has yielded me a selective bibliography. And second, reading in the primary and secondary literature, which has yielded me considerable reference material for my writing and teaching.

2. My understanding of the subject has developed in both depth and breadth. I was able to spend over half of my time reading in the primary literature. Accordingly, I have become very familiar with the work of Kraepelin, Bleuler, and Meyer. In addition, I read extensively on the problems of psychiatric diagnosis, classification of psychiatric diseases and disease syndromes, and theories of schizophrenia.

One central realization that came in the course of my work was that
psychiatric theory is both epistemologically naive and ethically uncritical. Part of the reason for focusing on the work of Kraepelin, Bleuler, and Meyer—in addition to their importance in the development of the concept of schizophrenia—was their relative sophistication with respect to epistemological questions. Given the variety of practical and theoretical approaches to schizophrenia and the confusion in psychiatry over the "problem" of schizophrenia, careful and critical review of the areas that I outlined earlier is required not only to clarify the concept of schizophrenia—as many psychiatrists apparently intend—but for searching examination of the nature of psychiatric medicine. Although in many circles psychiatry is regarded as the one medical specialty wherein value considerations are paramount, the literature on the concept of schizophrenia, except for the criticisms of the antipsychiatrists and the radical psychiatrists and some sociological studies, is silent on these matters. As the result of my fellowship work, I feel the keen need for philosophical input in psychiatric discussions. What I regarded as an epistemological sophistication in Kraepelin, Bleuler, and Meyer was paralleled by an absence of direct consideration of value issues in these authors. In addition, in recent literature I find little evidence of epistemological sophistication, on the one hand, and still less sensitivity to the need of a critical examination of value issues, on the other hand.

3. My fellowship tenure came at the beginning of my new position as an Assistant Professor in the Department of Medical Humanities of Southern Illinois University School of Medicine, Springfield, Illinois. My new duties include teaching in our humanities program as well as teaching medical ethics in the psychiatry clerkship. In regard to this teaching, knowledge gained from my fellowship work will be applicable in two general ways. First, it will give me a strong background from which to enliven general questions about the value presuppositions and implications of, for instance, mental status examinations, diagnostic labeling, and various psychotherapeutic approaches. Second, it gives me a special competence in the area of schizophrenia for further course work both in the Department of Medical Humanities and in the Department of Psychiatry. I am, for instance, planning to offer an elective course for third-year medical students this spring on the nature of psychiatric explanation and evaluation; and a large portion of the material in that proposed course will be on schizophrenia.

In addition, my new position has obviously provided me with new colleagues, some of whom are very interested in collaborating on research in schizophrenia. There is a distinct possibility that sometime in the future I will be a member of a research team studying the teaching of psychiatric interviewing procedures. Two clinical faculty members have indicated an interest in collaborating with me on articles dealing with the value presuppositions and implications of clinical research in psychiatry and family therapy.
4. As already indicated, I am planning to offer an elective course in the Department of Medical Humanities on psychiatric explanation and evaluation. Briefly, this proposed course will deal with the nature of disease explanations, the specific character of psychiatric disease explanations, mental illness conceived as myth, and finally the human and social value impact of psychiatric labeling. In addition, I am in charge of establishing a seminar program for faculty and staff of the Southern Illinois University School of Medicine. I want to offer a revised version of a course on schizophrenia that I offered in the Institute of the Medical Humanities of the University of Texas Medical Branch as one seminar in this program. The course dealt with the value and ethical implications of the various therapeutic approaches to schizophrenia. I plan to supplement this course with material gathered during my fellowship research.

5. I have not yet completed an article for publication. However, I will be working on a draft of the manuscript that I began during the fellowship period, on Eugen Bleuler's concept of schizophrenia and its impact on contemporary attitudes toward the disease. I will surely inform the Institute when I have something ready for publication and I will give full acknowledgment to the Institute on Human Values and Medicine of the Society for Health and Human Values and the National Endowment for the Humanities grant that supported my work.

6. I spent 50 percent of my fellowship time—one month—in Springfield, 45 percent at the University of Texas Medical Branch in Galveston, and 5 percent at the Rice University in Houston.

7. Southern Illinois University School of Medicine did not contribute any specific funds to support my work on this fellowship. However, the Department of Medical Humanities made available to me the regular secretarial assistance that I would have had as a member of that department not on fellowship.

8. I have already received a leave from my regular position—which I had assumed only two weeks prior to the commencement of my fellowship—in order to take the fellowship. This is an obvious indication of the commitment of the Department of Medical Humanities and the Southern Illinois University School of Medicine to sustain my research interest. I already indicated that my fellowship work will have a direct impact upon my teaching and upon further research. My immediate writing plans have been largely reoriented as the result of my fellowship work. I have already mentioned the paper on Bleuler's concept of schizophrenia, but, in addition, material gathered during my fellowship will enable me to revise an earlier paper of mine on the nature of psychiatric explanation.
9. My new position in the Department of Medical Humanities is in a program dedicated to teaching human values in relation to medicine and the other health professions. My addition to this program, I hope, will result in an expansion of its scope. In particular, I expect to do a considerable amount of work in close cooperation with the clinical faculty of the Department of Psychiatry and do work in the residency program in psychiatry.
MARTIN BENJAMIN

Study Undertaken During Fellowship

A. Most time was given to acquiring experience in a number of areas of medicine that generate problems involving human values and ethical analysis. All this study was conducted under the guidance of faculty members of the College of Human Medicine of MSU and included:

1. Attending pre- and post-clinic conferences conducted by Janice Lindstrom, M.D., and James Higgins, Ph.D., of the Genetics Clinic at MSU.

2. Attending clinical conferences conducted by various physicians under the direction of Ruth B. Hoppe, M.D., and David M. Holden, M.D., of the Family Health Center at MSU.

3. Attending pediatrics rounds at St. Lawrence Hospital under the direction of Myron Faber, M.D., and Elizabeth Seagull, Ph.D.

4. Attending clinical conferences conducted by Myron Faber, M.D., and Marvin Reimer, M.D., of the Adolescent Medicine Clinic at MSU.

5. Attending pre- and post-clinic conferences conducted by Arthur Kohrman, M.D., of the Endocrinology Clinic at MSU.

6. Attending psychiatric conferences and rounds at Ingham Medical Center conducted by Sumer Verma, M.D. These were of two kinds: (1) requested consultations on patients hospitalized for problems other than psychiatric ones; (2) treatment of patients hospitalized for problems diagnosed as being psychiatric in origin.

7. Attending oncology rounds conducted by Leif G. Suhrland, M.D., at Sparrow Hospital and Ingham Medical Center.

8. Visiting a few selected patients and sitting in on an ethically sensitive conference with parents of an infant with biliary atresia at the invitation of Dan English, M.D., at Ingham Medical Center.

B. The activities above often involved my participation in discussions with medical faculty, residents, and students of problems involving human values and ethical reasoning.

C. In addition, I participated as a panelist and moderator at twice-monthly, medical ethics case conferences conducted at Sparrow Hospital and Ingham Medical Center; presented a seminar on "Non-therapeutic Experimentation in Young Children: A Dilemma and Possible Resolution" to the Department of Human Development;
participated in a 10-week faculty seminar on the Impact of Technology on Health; and attended monthly medical humanities seminars.

D. In early December I was made aware of a Grants Notice from the Bureau of Health Manpower which indicated a preference for fiscal year 1977 to fund "grants for projects to encourage and assist in the development of programs emphasizing the cognitive aspects of human values, medical ethics, and humanistic medicine approaches to the education of students in the health professions including medicine, nursing, and physicians' assistants." I was encouraged by people in the College of Human Medicine to devise a training program that could be integrated into their curriculum and would be in accord with the requirements of the granting agency, and to submit it by the deadline, 3 January 1977. I spent most of December on this and was supported in my efforts by the Deans of both the College of Human Medicine and the College of Osteopathic Medicine and the Director of the School of Nursing. All three, as well as the Assistant Provost for Health Programs, wrote letters in support of the project.

E. The listing above compares fairly well with what I proposed to do in my original application to the Institute. There are, however, two significant differences. First, I was not able to do as much as I had hoped with members of the nursing faculty. My most direct involvement with the special problems that arise in nursing occurred in a medical ethics case conference devoted to the problems that arise for nurses in administering palliative treatment to a defective newborn who is being allowed to die; and in a meeting with nurses in the oncology unit at Ingham Medical Center in which they discussed the ethical and psychological problems of their particular roles with a psychiatrist and me. The second exception is that I had not anticipated the availability of training grants emphasizing human values and medical ethics or that I would be spending so much of December working on a proposal. Although this was not stated in my original application to the Institute, I felt it was in line with the spirit of the fellowship and the work of the Institute inasmuch as a successful proposal would provide the opportunity to have my work extended for three years in the form of establishing a program in an area with which the Institute is concerned.

Effects

A. Understanding

The work I did under the fellowship deepened my understanding of the complexities of medicine and the problems of human values and ethical reasoning that arise. This is probably the only generalization I can make about what I learned. Although I learned much else, most of it is embedded in the variety of concrete and particular cases that arise in medical practice and are thus not given to easy summary or generalization.
With one exception my study and research interests remain the same. I plan to continue working on various moral problems that arise in the practice of medicine with an emphasis on those ethicometaphysical problems which focus on the nature and moral import of the concept of a person. The exception is that Dr. Potchen's faculty seminar on the Impact of Technology on Health made me uncomfortably aware of the seemingly intractable problems generated by the combination of: (1) advances in medical knowledge and technology; (2) the uncritical acceptance, by both medical professionals and the public, of the assumption that more medicine means improved health; and (3) present modes of financing and distributing health care. I would like to do further work on these problems which, at the moment, seem to me to defy solution.

B. Teaching

Before the fellowship period began I had taught an undergraduate college course in Moral Problems in Medicine for three terms. This was a very successful course and I do not plan any large changes. I do, however, believe that as a result of the clinical experience I gained during the fellowship period my lectures and paper assignments will be deeper, more detailed, and hence truer to the complexity of the subject matter than they were in the past.

If, however, the proposal submitted to the Bureau of Health Manpower is funded, there will be a considerable change in my teaching. The proposed project, which I would direct, aims at integrating training in the cognitive aspects of human values and ethical reasoning into the curricula of both medical schools and the school of nursing at MSU. This would take me out of the Philosophy Department and into the medical complex for three years and would involve my: (1) conducting faculty seminars; (2) developing materials and strategies for identifying, analyzing, and evaluating problems of human values and ethical reasoning embedded in current course offerings; and (3) developing and teaching a number of new mini-courses tailored to the needs and curricula of these three schools. My experience during the fellowship period will be invaluable, especially during the first stages of such a large undertaking. It should be added, too, that I would not have been able to design a plausible project in December had it not been for the experience obtained with the aid of the fellowship during the preceding three months.

Future Prospects

At the very least, my undergraduate college course in Moral Problems in Medicine will be much more nearly "authentic" that it has been in the past. In addition, both my interaction with physicians and nurses at future medical ethics case conferences and my research should be less naive about the day-in-day-out practice of medicine.

There is, too, the possibility that my work may play a role in the development of a program of teaching about human values in relation to...
medicine and other health professions. There are two possible programs that may soon develop at MSU. The first, the training program in human values and ethical reasoning for medical and nursing students, would be funded for three years by HEW. This program has been described above. A second possibility for a program comes from within the university. After a pair of site visits from representatives of the Institute on Human Values in Medicine to MSU, there is strong interest from the Deans of the Medical Colleges and the Dean of the College of Arts and Letters in establishing some sort of Division of Medical Humanities at the University. I was involved in both site visits and am serving as the principal faculty "bridge" between the Medical and Humanities faculties and administrations. If such a Division of Medical Humanities materializes I will, I believe, figure in both its conception and initial staffing.
The following is the final report for my fellowship for the period of June 1, 1976 through May 31, 1977.

1. Activities: In September of the fellowship year I received my M.D. degree from Michigan State University and from that time until the present have been occupied as follows: 80 percent time as a graduate student in the Department of Philosophy, completing the dissertation requirement for the Ph.D.; 20 percent time as (unpaid) clinical instructor in the Department of Family Practice, involved in patient care and in student teaching.

The dissertation, entitled "Persons and Placebos: Philosophical Dimensions of the Placebo Effect," was completed and accepted by the committee. The Ph.D. was awarded in June, 1977.

I was also involved in a number of activities not directly related to my Ph.D. studies, although of importance to the development of medical humanities programs and to my own career goals:

A. I continued to act as coordinator for the twice-monthly medical ethics case conferences held in Lansing area hospitals, and am now working to form a committee to continue these conferences after I leave the area.

B. With James Potchen, M.D., Chairman of Radiology, I coordinated a monthly medical humanities seminar series.

C. I assisted in coordinating Institute on Human Values in Medicine Resource Team Visits involving Edmund Pellegrino, Bernard Towers, David Thomasma, and Stuart Spicker, to Michigan State in December and January. These visits and the reports that followed were extremely useful in pointing the direction for greater organization of medical humanities efforts on this campus.

D. I was invited in October to speak before the medical student body at the Medical College of Ohio at Toledo, and have continued to consult with a student planning committee on development of an ongoing medical ethics program there.

E. Also in October, I participated in a "Conference on Philosophy, Law, and Medicine" at Kalamazoo College-Western Michigan University, financed by the Michigan Council for the Humanities.

F. I was invited to speak as part of a panel discussion for the conference, "The New Genetics and Society," at Albion College, March, 1977, also financed by the Michigan Council for the Humanities.
2. Understanding: My research on the philosophical problems involved with the placebo effect has been extremely rewarding, and has suggested many additional lines of inquiry relating to philosophy, ethics, and medicine. Perhaps most important is that I found it impossible to deal adequately with the placebo effect unless empirical data, ethical issues, and the mind-body relation were all dealt with in a mutually illuminating fashion. I think in this respect the placebo effect represents in microcosm the general set of issues to be found in philosophy of medicine; my research can therefore serve as a model of one approach to this subject.

Having the opportunity to work with the Department of Family Practice helped to ensure that my clinical skills would not be totally neglected while completing the Ph.D. I did have the chance to begin development of a patient value and expectation questionnaire that could serve as part of the medical record to assist the physician in ethical decision-making; this research project will be pursued following the conclusion of the fellowship period.

3. Professional Activities: I still intend, following completion of a residency, to seek a position that will allow me to offer courses in medical ethics and philosophy of medicine to graduate students. The completion of my degree work, plus the teaching experience I gained under the tenure of my previous fellowship period (1975-76), places me in a very advantageous position to pursue these goals. Finishing a residency will allow me to continue seeing patients and will help give me an ongoing perspective of the realities of clinical medicine that I feel will be essential if I am to do quality work in this field.

4. Teaching: As a resident I will have little or no opportunity to teach courses. However, my studies have better prepared me eventually to offer courses in the philosophy of medicine, particularly in the mind-body problem as it relates to medicine.

5. Publications: The dissertation is the primary work resulting from this fellowship period.


6. Location: 100 percent of my fellowship period was spent at Michigan State University.

7. Support: My home institution provided general office facilities and some secretarial support during the fellowship period; I received no stipend.
8. I will be entering a three-year residency in family practice at the University of Virginia Hospitals, Charlottesville, on July 1. While most of my time will be thus occupied, I will have the opportunity to participate in the medicine and society program organized at the University by Dr. Thomas Hunter.

9. At Michigan State plans are proceeding rapidly toward organization of a formal program for the humanities in the health sciences, involving the Colleges of Human, Osteopathic, and Veterinary Medicine, the School of Nursing, and the College of Arts and Letters. This is largely the result of the Institute resource team visit mentioned in 1-C above.
1. Activities

The plan of study for the fellowship consisted of participation in a clinical residency at the University of Tennessee Center for Health Sciences in Memphis, Tennessee, as developed by the Program in Human Values and Ethics. Activities were to include extensive contact with medical situations in (a) a general medical setting; (b) a multidiscipline child care center focusing on mental retardation; and (c) mental disability care. The last named item was altered to permit me to experience care delivery at a research hospital specializing in children's cancers. This was consistent with my specific interests in research and technology in medicine, as well as with other interests of a broad nature.

Specifically, the schedule included during the first month extensive rounding in a VA hospital, with experience in the following units: ambulatory care, emergency room, surgery, pathology, psychiatric and psychological services, social services, intensive care, and emergency resuscitation unit. Each service was experienced on a multiday basis, allowing me to follow cases rather than merely contact them. In addition, special provision was made to permit the interviewing of a terminal patient and family on an extended four-day basis. Seminars, consultations, informal discussions, and personal research completed the round of activities for both this month and the second. The second month included a week of special research on problems noted during month one; a week at the Child Development Center and two weeks at St. Jude Children's Research Hospital. During the Child Development Center experience, a case was observed during the week's multidiscipline diagnosis through all relevant services, including pediatrics, psychology, audiology, speech therapy, dental, cardiology, nutrition, and other specialties. Consultations and discussions with staff preceded the disposition and informing conferences. The stay at St. Jude's included in-patient ward rounding and out-patient clinics, as well as research and psychiatric services. Patients observed and interviewed ranged from those in confident remission to those aware of their terminal condition. The staff of the hospital was most open to serious discussion of ethical issues, which they keenly felt in their unique medical situation.

2. Understanding

Understanding could hardly fail to develop in the course of this intensive program of activities. In the sense of situational appreciation, the close contact with medical situations permitted me to focus on elements that have traditionally been claimed to make medical decision-making difficult, and to test their validity. Rather than time being the essential factor in creating problems, social and institutional structures appear the key factors. In the sense of factual knowledge,
understanding increased vastly as to the nature and scope of medical operations. The intensive research into basic information leads me to believe that an uneducated public is perhaps the largest problem health care delivery faces, one that can only be overcome through the introduction of medical teaching in the primary grades. In terms of understanding the ethical dimensions of problems faced in medicine, innumerable experiences concretized theoretical issues with a flood of reality. My own interest in ethical issues is structural rather than personal; for example, I took great interest in problems such as policies that dictated diagnostic surgery where no therapeutics could be done (with the consequent disabling of patients where only a few months or years of active life remained) and reactions to policies giving some role to patient and family wishes with respect to use of heroic measures. Such problems illustrate the ethical work still to be done.

3. Effects

The effects of the experience upon my teaching and research are many, but two major ones are the following: First, I suspect that I shall be giving greater emphasis to the role of public education at all levels from children to adults as a means of solving many structural issues in health care delivery through public participation in decision-making. This is reflected in my participation in a grant to the Tennessee Center for Human Values and Health Sciences from the Tennessee Committee for the Humanities (affiliate of N.E.H.) for a series of conferences on Health Care Delivery in Tennessee. The basic guidelines for state-based grants are that they centrally involve the humanities, that they involve questions of public policy, and that active dialogue between humanists and professionals or citizens be the chief means of education. This is but one aspect of this emphasis, but one that other states ought to make use of, since health care delivery and other medical ethics problems have strong public policy components and all the other features that make them appropriate for funding by state-based programs of N.E.H.

Second, my experiences have strongly suggested that the time has come for a full-scale study of the role of the medical ethicist in the clinical (as opposed to the classroom) setting. Specifically, what is needed is a nationwide study of (1) the job role of the ethicist in clinical situations; (2) the appropriate entry and training requirements for such persons; (3) the appropriateness of certification procedures for them and the procedures for handling certification; and (4) the appropriateness of some form of licensing and the procedures for licensing. Without presupposing affirmative answers to any question, it still seems true that time is overdue for such a study, and funding sources will be sought to begin that process.

4. Courses

The program of graduate studies in philosophy with concentration in medical ethics already offers a full component of courses, and thus no new ones are contemplated. However, these courses are of variable content, and new course emphases are in the planning. Among them are these:
1. Seminar for graduate students. Based on the experiences of two members of the faculty and five graduate students during clinical residencies, a special seminar will attempt to capitalize on those experiences and yield publishable articles by the students. Using papers initially generated during the students' clinical residencies, the seminar will concentrate upon providing them with a solid grounding in suitable ethical theory and further insights based upon the joint clinical experiences of the class. Through discussion of the papers and revisions subjected to further discussion, a set of first-rate philosophical reflections on practical problems is anticipated.

2. Senior level courses. Too little attention has been paid in the literature to the ethical dimensions of structural features of modern health care delivery, most structural work having been done by social critics and sociologists. The ethical elements of interrelationships between health care professionals and patients-families will be explored with respect to these levels: intra-institutional (e.g., policies), institution-government, institution-community, government vs. government, citizen-profession, etc. The nature of duties, responsibilities, rights, and prerogatives—as these elements interrelate, rather than as any one of them stands as proposed absolute—will be the emphasis of the study, with attention to alternatives for action at each problem level. Specific case studies, many drawn from the clinical experience, will keep the focus from drifting into excess abstraction.

5. Writings

Although no one piece of writing emerged from the clinical residency specifically, the following materials owe some or all of their production to the opportunity afforded by the residency:

a. a record covering personal and research reactions to some five weeks of the residency, used as a source book of problems, cases, and tentative analyses;

b. completion of an article begun before the residency, but completed during the program (a copy is enclosed);

c. elements toward articles on the following subjects: (1) the use of diagnostic surgery on elderly patients with problems not amenable to therapy; (2) the need for medical rather than simple health education in grades K-12; (3) the job role and training of medical ethicists in the clinical setting; (4) structural impediments to physician-patient relationships.

6. Location

One-hundred percent of the fellowship period was spent on the campus of UTCHS, Memphis, Tennessee.
7. **Other contributions**

No direct funds were contributed to the work under the fellowship. However, the Department of Philosophy, University of Tennessee, Knoxville, did release me from all departmental duties for the period. Additionally, Human Values and Ethics, UTCHS, Memphis, waived all fees that might have been connected with the program and supplied essential secretarial and phone services. Finally, the Department of Philosophy, University of Tennessee, Knoxville, has supplied secretarial services involved in follow-up to the residence.

8. **Application**

The work of the fellowship is directly applicable to my regular position as Associate Professor of Philosophy and Director of Graduate Studies in the Department of Philosophy, especially to the concentration in Medical Ethics. This ongoing program involves teaching as well as thesis and dissertation direction at the M.A. and Ph.D. levels. This teaching will provide a continuing basis for the extension of understandings gained during the experience through discussion with others who have undergone similar training. Moreover, research assistance will be rendered to me and by me through interaction with graduate students in the field. My regular release for research is one-third time through the department, with secretarial services provided as needed.

9. **Programs**

As noted above, the Department of Philosophy has in existence a concentration in medical ethics that includes extensive clinical residency experiences at UTCHS under the program in Human Values and Ethics. It is anticipated that the program will expand to include a limited number of postgraduate students already teaching in the field, but without extensive training in medical ethics or a clinical residency. Moreover, additional efforts at more closely coordinating interdisciplinary efforts with departments such as Zoology, Anthropology, and others will occur in this coming year. Coordination with the Human Values and Ethics Program of the medical school in Memphis is developing on a continuing basis: there are under development interlocking roles in admissions and program content with respect to the clinical residency and allied course work between faculty of both schools in order to ensure the highest possible quality of both humanities and clinical experiences for all students. Moreover, additional clinical experiences for graduate students at a local mental hospital and other facilities are under development to continue the benefits gained by students from the UTCHS experience.
My entire fellowship was spent at the National Institutes of Health (NIH) during the period of May 15 to June 15, 1976. More specifically, I interviewed nine members of the National High Blood Pressure Education Program and eleven members of the Office of Cancer Communications. In addition, seven other top administrators were interviewed for background information on the past, present, and future directions of health information and promotion policy.

As indicated in my fellowship proposal, my objectives were:

1. to interview key policy decision makers for their health communication rationale;
2. to review their current health education programs and the communication objectives of each;
3. to analyze the values of the decision makers and their perceptions of the values held by health consumers; and,
4. to make explicit their values and their communication philosophies and the adequacy of both in relating to health consumers.

Objectives one through three were accomplished during the tenure of the fellowship. However, further analysis of the data is needed in order to address adequately the fourth objective. I plan to meet in Bethesda, Maryland, with the individual program directors. At that time we will discuss the findings and tease out their implications.

I plan to write an article that details my conceptual thinking and the specific methodology used in the study. Upon its completion the Institute will receive a copy for publication considerations. Thus, this report will not include the study findings, but only consider possible implications of it.

I found that one way to approach the question What functions do values serve? is to think of values as standards that guide ongoing activities, and of value systems as general plans employed to resolve conflicts and to make decisions. A value system is a learned organization of principles and rules to help one choose between alternatives, resolve conflicts, and make decisions. I assumed that it was possible to obtain data concerning not only a person's own values but also those a person might attribute to others. A person's perception of another's value system represents his image or stereotype of the other. Thus, one of my purposes was to identify the type or types of value systems held by NIH staff members and also their perceptions of the value systems held by health consumers. Are staff members' value systems similar to one another or do they cluster into different types? If more than one type emerges, what values differentiate one type from another type? What values differentiate one type from all other types? What values seem to cut across all the types? These basic questions were applied
to the staff members' perceptions of the ideal health consumer. Answers to these questions will provide the bases for much of my subsequent research activities.

Dr. Wilson, Vice Chancellor for Medical Affairs, raised the question of the relationship between value system types and institutional change. This question has led to a considerable extension of my original research idea. At a recent management workshop, I had the top eighteen administrators of the Vanderbilt Medical Center (VMC) indicate what they perceived to be the actual value system of the VMC. In the second phase, I will assess what they consider to be the relative importance of their own values and what they perceive to be the ideal value system for VMC.

In addition to the administrative group, I plan on gathering data from other relevant groups, such as medical school faculty and students, hospital employees, patients, and the general public. The findings, for example, should be of interest to the Medical Center Administration, Vanderbilt students in Health Policy Seminars, and medical school faculty and students interested in the correspondence between their own values and patient values. At present, a formal program in value studies is not being considered, but one may hope that a heightened value awareness may affect management operations, patient care, employee morale, and future research directions.

Dr. Wilson has provided me with released time and additional secretarial assistance to pursue the above-mentioned research directions. He also supplied secretarial assistance and general supplies during the fellowship. Due to Bicentennial price increases, the actual cost of hotel accommodations and food exceeded the budgeted amount by $200.00. Vanderbilt Medical Center also absorbed this amount.
1. Activity during the tenure of the fellowship: My activities during the tenure of the fellowship may be divided into the following areas: (1) teaching; (2) research; (3) administration; and (4) patient care, with approximately a fourth of my time devoted to each. Teaching included offering two courses, both of which were well-received by medical students. "Philosophic Problems for Physicians" was a sixteen-week course taken by twenty-one students in their third year of medical school. Course description and bibliography are appended. "Interdisciplinary Seminar in Medical-Ethical-Legal Issues" was taught in conjunction with professors from the Divinity School and the Law School. Interdisciplinary teams of students from the three schools researched selected problems in medical ethics to initiate seminar discussion. A course description is appended. Research activities are described below. The administrative effort that has a bearing on the activities of the fellowship concerned development of liaison throughout the medical center and university with those faculty particularly interested in problems of medical humanities. It is our hope to be able to expand the curricular offerings in medical humanities for undergraduate and graduate students as well as medical students. Patient care activities in many ways are the foundation and raison d'etre of medical humanities teaching of medical students and residents in the apprenticeship model, providing many genuine examples of ethical dilemmas in the clinical context.

2. Understanding of the subject as a result of the fellowship: I selected a preliminary research project on "Ambiguities in the Philosophy of Biology" in preparation for my Ph.D. dissertation in Religion. I had hoped to find a device for calling attention to the difference between a mechanistically dichotomized mind-body view of biology and the relevance of a psychosomatically integrated view of the body in clinical medicine. The current sociobiology debate offers such an opportunity for discussing the moral dimensions of our view of biology. A paper, entitled "Is Social Evolution a Moral Inversion?" focuses the epistemological ambiguity in this debate, drawing on Michael Polanyi's postcritical philosophy (see Part II). The next phase of this research will attempt to understand the phenomenon of the moral inversion in terms of some of the newer psychoanalytic theories of narcissism. This work on "The Dynamics of the Moral Inversion" will be presented at the World Congress of Psychiatry in Honolulu on September 2. As a result of this preliminary work I have been able to formulate a dissertation prospectus on "Altruism and the Dynamics of the Moral Inversion."

3. Effect of fellowship on teaching activity: Here I would like to comment on what I call a postcritical approach to teaching medical ethics, which in many ways is strikingly different from the traditional analytical philosophical approach to medical ethics. Following Polanyi's account of
knowing and the process of discovery, I believe it is especially impor-
tant for medical students, highly trained in scientific discipline, to be able to reflect on the decision-making process. We know far more than we can tell, but we can say nothing without relying on unarticulate or tacit judgments. For the physician schooled in an apprenticeship model of learning, many clinical judgments are made antecedent to philosophical analysis. Yet in any attempt to be accountable, that is, to give an account of the ingredients of a decision, it is necessary to articulate as well as possible the commitments that underlie a given decision. The model of critical philosophy would attempt an intellectual clarification of an articulated statement. The effect of such criticism on sometimes taciturn and pragmatic medical students may be a reticence to speak or a defensive stance. Indeed, the underlying commitments of many such decisions are outside conscious awareness and accessible only by a process of self-discovery and self-understanding. This requires a fi-
duciary atmosphere of conviviality, which may be undermined by a criti-
cal stance. Hence it is useful to sanction the disclosure of views that may be quite outrageous. What is lost in terms of a polished ethics of public policy is gained in terms of an ethics of self-
understanding.

4. Production of new courses: Opportunity is being sought to extend the Philosophic Problems for Physicians course to an ethics consultation-
liason (peer-counseling) service. This idea, long a fantasy of my own, emerged spontaneously from the students at the end of the course. The plan would be for students who have completed the third-year course to be available to their colleagues in the second year taking their first clinical rotations. It is envisioned that there would be regular supervisory conferences and ethics grand rounds. It is also envisioned that this would soon be extended beyond medical students to house staff and senior staff.

5. Publications: The following papers were completed: (1) "Medical Ethics, the Art and Science of Medicine," Connecticut Medicine, July, 1976; (2) "Is Social Evolution a Moral Inversion?" (publication pending); (3) "Reflections on the Fiduciary Doctor-Patient Relation-
ship," publication forthcoming in Controversy in Psychiatry, W. B. Saunders. The papers on "Social Evolution" and "Doctor-Patient Relationship" are included in Part II of this volume.

6. Location of fellowship work: Except for conferences and committee work, all of my time was spent at home at Duke.

7. Support: Duke University provided salary support as well as office and secretarial support.

8. Extension of fellowship work: During the coming year I will be working on the Ph.D. dissertation as indicated above. Among other things I will be involved in the teaching of a seminar on humanistic perspectives of a hospital experience for fourth semester undergraduates, who have been selected for medical school admission on the basis of their humanistic qualities. This program will be supported by a grant to Duke University from the Commonwealth Foundation.
9. Program development: Foundation support is currently being sought to develop a program in medical humanities at Duke. This will include support for the medical school offerings outlined above as well as undergraduate seminars, graduate programs, and combined M.D.-Ph.D. programs, in which a number of students have already expressed interest.
1. *Love in the Ruins*, by Walker Percy (Kierkegaard's critique of modernity as it applied to medicine of the recent future).

2. *Zen and the Art of Motorcycle Maintenance*, by Robert Persig (existential reflections on the meaning of "quality," so much a concern for future physicians, as well as notes on how to stay sane in an insane world).

3. *Bodies in Revolt*, by Thomas Hanna (the mind-body problem with a neo-Cartesian twist).


5. *The Study of Man* and selected essays by Michael Polanyi (a philosophy of science that accredits the value commitments of the scientist).

6. Additional selected references.
IND-300 (B) or (C)
Interdisciplinary Seminar in Medical-Legal-Ethical Issues
The seminar will be composed of students in approximately equal number from the Medical, Divinity, and Law Schools, and will explore important medical, legal, and ethical features of current issues (e.g., transplantation, euthanasia, abortion). Faculty and resource persons from all three schools will participate in the seminar. Up to four introductory sessions in the fall semester for all participating students and faculty will be concluded with arrangement of interdisciplinary teams and selected topics. Student teams will meet during the winter and consult at intervals with faculty. All seminar participants will reassemble for a series of weekly meetings, ending in mid-March, to present and discuss the topics researched. Any topics, properly focused, may be considered.
Dr. Dyer (Medical), Professor Shimm (Law), Professor Smith (Divinity); and other faculty members from all three schools
Prerequisites: None
Enrollment: 8 max., minimum to be established in consultation with student enrollment in other schools
Weight: 2
Offered: Credit awarded Term 3 (work covers Terms 2 and 3)

CHS-247(C)
Philosophic Problems for Physicians
This seminar brings the resources of literature, poetry, philosophy, psychology and sociology to bear upon specific ethical and philosophical problems with which the practicing physician deals. Each student leads at least one seminar on a specific subject of his choice. Where appropriate and desirable, selected outside visitors will be invited to contribute to the discussion. The following subjects will be among those offered for consideration: (1) Death and dying from the patient's and physician's point of view; (2) Euthanasia--societal and legal barriers; (3) Abortion, eugenics, and transplantation--ethical implications; (4) Informed consent, the Golden Rule, and the history of auto-experimentation; (5) Ethics of the double-blind controlled therapeutic trial; (6) Behavioral control and psychosurgery in a free society; (7) Quality of indifference as a characteristic of the health care worker; (8) Anxiety and plight of the individual in a technocratic society.
Suggested reading lists for each subject will be provided.
Dr. Dyer
Prerequisites: None
Enrollment: Unlimited
Weight: 2 or 4
Offered: Every year
Terms: Regular Terms 1 and 2
Length (wks): 16
1. Activities

The plan for the fellowship was to participate in a clinical residence program at the University of Tennessee Center for the Health Sciences in Memphis, as developed and coordinated by the Program in Human Values and Ethics. Activities were focused on extensive contact with health care delivery in (a) a general hospital setting; (b) difficult cases in Internal Medicine; (c) acute pediatrics; and (d) a perinatal intensive care unit.

Specifically, the first month was spent in extensive rounding and observation in a Veterans Administration Health Care Center, including the following units: intensive care, ambulatory care (especially Orthopedics and ENT), emergency room, pathology, psychiatric and psychological services, surgery, social services, and cardio-pulmonary resuscitation unit. The format was to visit each unit for one or more entire days, allowing in-depth discussions with the staff and continuity in following the progress of patients in the unit. To provide further continuity, I was introduced to a seriously ill patient, whom I interviewed regularly over a period of several weeks.

During the second month, I spent one week rounding and observing in a perinatal intensive care unit, including discussions with the unit’s social workers; one week observing general pediatrics, including hospital rounds, a well-child clinic, and health care visits to patients' homes by nurse practitioners and nurses aides. The remaining two weeks were spent at a research hospital that concentrates on catastrophic diseases of children. This component included hospital rounds, observing out-patient clinics, research conferences, interviews with the staff psychiatrist, and discussions with the staff.

There were several departures from the prior plan, but they were all relatively minor. Most substantial was the abridgement of the Internal Medicine experience. I had only one or two consultations with this group. The general pediatrics unit was added to the schedule after my arrival in Memphis; and the acute pediatrics was shifted to the direction of Dr. Charles Pratt.

2. Understanding of Subject

My understanding of the subject has been enriched immeasurably by this experience. I had had very little previous contact with the clinical setting. I was already impressed with the importance of exposure to the clinical context in which ethical issues arise, but this experience strengthened this conviction. I plan to seek additional exposure for both my students and myself in the future.

I would not say that either my range of research interests or my outlook on any particular issue has altered drastically as a result
of the clinical residence work. However, my armchair conclusions have been tinctured with a heavy dose of realism. I now recognize even more firmly the impossibility of dogmatic conclusions on these issues and the consequent importance of widespread public discussion of them.

My research interest continues to focus on the elements of personal relationships that figure in the health care setting: the physician-patient relationship, the issues of informed consent and paternalism, the concept of a health care team, and the role model method of medical education.

This experience has convinced me that the only way humanists can hope to communicate effectively with clinicians is by focusing on the particular clinical case. Dr. David C. Thomasma and his associates in the Program in Human Values and Ethics have developed several excellent mechanisms for doing this—monthly Ethical Grand Rounds, an ethical consultation service, a written format for an Ethical Work-Up of a clinical case—and I hope to put some of them to use in Knoxville.

3. Effect on Professional Activity

The experience has effected significant changes in the tenor and organization of my courses. I now focus the courses much more heavily toward clinical cases rather than toward theoretical problems. Citation of my experiences gives my presentations much greater realism than was previously possible. I now include reference to a much wider range of problem areas than I was previously aware of; and I hope that our graduate students will pick up on some of these as areas for research and thus will contribute to my own thinking on these issues.

I am working to develop further clinical contacts for our students and myself. Dr. Charles H. Reynolds of the Department of Religious Studies and I are working on setting up regular Ethical Grand Rounds and clinical rounds oriented to ethical issues through the Department of Family Practice, U.T. Memorial Research Center and Hospital. Dr. Rem B. Edwards of the Department of Philosophy and I are working on setting up a summer-long clinical residence program at Eastern State Psychiatric Hospital.

I will continue to be active in the Tennessee Center for Human Values and Health Sciences, which is an important instrument for promoting both public awareness of the ethical issues in health care and interaction between health care professionals and humanists concerned about ethical issues in health care. The work under the fellowship served to strengthen my commitment to both these goals.

4. New Courses

The program of graduate studies in philosophy with concentration in medical ethics already offers a full complement of courses, and thus no new ones are planned. However, we do plan a change in the focus of a graduate seminar as a result of the experience. Five grad-
uate students in our department participated in the clinical residence with Dr. L. B. Cebik and me and remained in Memphis two additional months. The seven of us plan to meet throughout the winter quarter to focus on the clinical residence experience by means of thorough discussion of papers by each of the students. The outcome we hope for is a set of papers of publishable quality that integrate clinical experience with theoretical materials from ethics and other relevant areas of philosophy.

In addition, I plan to teach for the first time this spring quarter a junior-level course in medical ethics that had been taught previously by Dr. Charles H. Reynolds. In organizing this course, I have drawn heavily on my clinical work in the ways mentioned under Item Three above.

5. **Writings**

No written research was completed, or even substantially advanced, during the period of the fellowship. I found it more profitable to spend as much time as possible in the clinical setting. I did keep an extensive daily journal during the period, but I think of this as a sourcebook for my future research rather than something that might be published itself.

At this writing, I have still only begun to think of drawing on my experiences for specific pieces of research. I have an article on Informed Consent, which has been under development for a year or more, that I plan to work on further during the winter and spring--and I am sure that my clinical experiences will figure heavily in my rethinking this issue. During the fall, I was engaged in further work on an ethics-oriented introduction to philosophy textbook that I have been writing on for a year or more. The clinical work has been useful in this project, since I focus on topics such as suicide, abortion, euthanasia, and other aspects of death. This project is still a long way from completion.

I began an article on the physician-patient relationship this fall, after I returned from Memphis, but it is only in the formative stages. Several other ideas for articles were suggested by the clinical experience, but it will be at least next summer before I can begin to develop them.

6. **Location**

One hundred percent of the fellowship period was spent at the University of Tennessee Center for the Health Sciences at Memphis.

7. **Institutional Support**

No direct funds from any other source were contributed to the work under the fellowship. However, my department did release me from all departmental duties for the period; and it has supplied secretarial services for projects following on the residence. The Program in Human
Values and Ethics, UTCHS, waived all fees which might have been required for the program and supplied me with secretarial and telephone services during the period.

8. Application in Regular Position

There is abundant opportunity to apply the fellowship work in my regular position as Associate Professor of Philosophy and Chairman of the Committee on Graduate Study in Medical Ethics. Our ongoing program of graduate studies in philosophy with concentration in medical ethics requires me to teach courses in this area on a regular basis, as well as to direct graduate theses and to supervise the work of students during their clinical residence experience. There are no immediate prospects for additional grant assistance or released time for this work from my institution, but I will concentrate on medical ethics for a substantial portion of my regular one-third time released for research. Secretarial services are provided through my department.

9. Programs

The Department of Philosophy already operates a program of graduate studies in philosophy with concentration in medical ethics. Under this program, five students went to Memphis in 1976 for four months of clinical residence work under the direction of the Program in Human Values and Ethics, UTCHS. We plan to send five or six more students to Memphis in 1977. The program also includes a year of course work in ethical theory, philosophy of science, and medical ethics in preparation for the clinical residence experience and additional seminars in medical ethics following the experience. As I mentioned above, we are currently working to develop additional clinical exposures for our students, for use both for preparation for the Memphis work and to allow the students returning from Memphis to continue their clinical contacts.
I hope it is appropriate to express my gratitude here for the opportunities which this fellowship provided. Philosophers have precious little opportunity to secure funding in order to carry on research in time blocks, especially on an interdisciplinary basis.

During the tenure of my fellowship I engaged in two major activities. First, I tried to become familiar with some of the literature relating to the concepts of health, essentialism, functions, goals, teleology, and the like. A list of the materials worked through is attached. Second, I worked with Dr. Martin Gluck in his capacity as a practicing clinical child psychologist as he dealt with his clients. This aspect of my research took two major forms. First, after securing written permission from the parents, each interview between Dr. Gluck and the parents and/or the child was recorded. Second, Dr. Gluck and I met to discuss the tapes.

This combination of reading and working on actual cases has proved to be extremely rewarding, at least from my perspective. That is, I can't claim to have found answers to all the major questions, but I have succeeded in getting much clearer on what the critical questions are and how they might be answered. Thus, I have discovered that the question of what is physical health and ill-health is considerably more problematic than I had first thought. I find, for example, that the two most popular positions (the one held roughly by Kass that health is a built-in notion, and the one held roughly by Engelhardt that health is a relative notion) do not adequately represent the facts. Further, there seem to be no prima facie reasons to believe that whatever is the proper analysis of physical health and ill-health will be mirrored by the analysis of psychological health and ill-health.

As an attachment to this report I have included a paper I recently presented to a symposium on mental retardation. This paper contains in outline some of the conclusions I have reached, and in greater detail the reasons I reject the popular positions on health and ill-health earlier referred to. I hope to have a more detailed account of my views in the near future.

I would add, by the way, that since Dr. Gluck's experience with these clients has not come to an end, I am still involved in the procedure described above, insofar as it is possible for me to do so.

The work on this fellowship has already had an effect on my teaching. First, I am currently teaching a readings course with Dr. Fred Grinnell, a cell biologist at the University of Texas Health Science Center, on the topic of teleological explanation. Second, I have begun to incorporate discussion of many of these issues in my undergraduate class on the philosophy of natural science. Finally, I hope to teach the topic in detail in our course, "Philosophy of Medicine."
During the spring term of 1977 I will be on leave from the university in order to do research. My intention is to continue to work on the same set of questions with which I have dealt as a fellow.

Concerning the mechanics of the grant itself, I spent approximately 75 percent of my time at the campus at SMU, and about 25 percent of my time at the University of Texas Health Science Center. During this period the University kindly provided me with supplies and secretarial assistance. All of the funding was used up and, indeed, had to be supplemented in order for me to carry out my research in financial peace.
Materials Worked Through During the Tenure of Fellowship


9. Rudner, Philosophy of Social Science, Chapter 5.


11. Scheffler, I., "Thoughts on Teleology," British Journal for the Philosophy of Science, Vol. IX.


17. Wright, Teleological Explanations, University of California Press.
GEORGE HENDRICK

1. During the tenure of my fellowship I have examined at Swedenborg House in London the large collection of medical and literary works of Dr. J. J. G. Wilkinson, have taken extensive notes, and finished that part of my research. I also did research on my topic at the British Library (formerly called the British Museum Reading Room) and at the library in Hahnemann House, also in London. Upon my return from London, I spent a few days in the Harvard libraries and now await Xeroxes of pertinent materials. Now that I have returned to the University of Illinois, I am arranging my notes and have begun to write sections of my book on Homoeopathy and Literature in Nineteenth-Century America. I will be on leave during the 1976-1977 academic year to complete that study.

2. I have not, as the result of my fellowship, changed the direction of my study, but I do have much new information. I needed to see the materials first-hand; in fact, the papers on Wilkinson at Swedenborg House are much too large to be photographed in their entirety.

3. My fellowship work will be reflected in my course on The Healing Arts and Literature in Nineteenth-Century America, for I have new materials on the relationship of medicine and literature.

4. I have described a new course, The Healing Arts and Literature in Nineteenth-Century America, in my proposal and will not repeat it here. I plan to give that course for the first time when I return to teaching after the completion of my year-long leave.

5. I am now preparing a monograph on Homoeopathy and Literature in Nineteenth Century America. I hope to complete a final draft of this study during the spring of 1977.

6. During the period of my fellowship I spent

10% at other locations in the United States
60% abroad
30% at the University of Illinois.

7. The University of Illinois has been extremely generous in supporting my project. The university bought the library of Dr. S. A. Jones (over $20,000), provided a Research Assistant for two semesters ($3500), provides typing services, and will pay my salary next academic year.

8. As noted above, I will be on leave for the 1976-1977 academic year to complete work on the projects growing out of my discovery of the Jones Collection:

"THE GOAT OF ACTON" VIEWS CONCORD AND THE THOREAUS: Letters of Horace Hosmer to Dr. S. A. Jones. Submitted to a press; the reviewer has strongly recommended publication, and I expect to receive a contract soon.
THE MAKING OF THOREAU'S MODERN REPUTATION: The correspondence of Dr. S. A. Jones, A. W. Hosmer, and Henry Salt (with Fritz Oehlschlaeger). Nearing completion.

HOMOEOPATHY AND LITERATURE IN NINETEENTH-CENTURY AMERICA.

9. I will soon be conferring with the Dean of the Medical School, Urbana campus, about the various courses in the humanities for pre-medical students in particular. The History Department offers an excellent course in the History of Medicine. It is my intention to work with the Medical School and with other departments in the College of Arts and Sciences to present courses on human values in relation the health professions.
1. During the late winter and spring of 1977 I visited several medical schools with humanities programs: the Hershey Medical Center of Pennsylvania State University, the University of Texas Medical Branch, Galveston, the Johns Hopkins School of Health Sciences, and the University of Florida. I looked in on a Conference on Aging sponsored by the University of Texas Medical Branch as an example of interdisciplinary postgraduate education offered by a medical school faculty (including humanists), and I attended a symposium on the contribution of humanities to medical education sponsored by the Biomedical Ethics Committee of Eastern Virginia Medical School.

In Atlanta I sat in on classes in the emergency medicine elective at Grady Hospital taught by John Stone, M.D., poet and associate professor of internal medicine, Emory University. I also chaired the curriculum committee on humanities, social sciences, and community medicine of the School of Medicine at Morehouse College. The committee is planning a humanities course for first- and second-year medical students that will be a topical interdisciplinary survey of issues in medical practice.

I have talked to more experts and fewer medical students than I had originally intended, and I have had much less contact with Emory University Medical School than anticipated, but contact that may lead to more useful cooperation than I had expected. At the suggestion of the Institute, travel became a principal part of my fellowship activity.

2. Yes, my understanding of my subject has developed. I have a fair grasp of the range of humanities teaching in medical education today, a first-rate file of bibliographies and course materials, friendly encouragement, and useful caveats. I am committed to an interdisciplinary humanities course that will serve as a model of what intellectual disciplines have to offer the medical practitioner and that will provide the students an opportunity to observe their teachers, experts in their own fields, responding as intelligent laity in fields outside their own.

3. My fellowship had the effect of establishing the humanities course as a part of the Morehouse curriculum plans. I will teach in the medical school half time and remain half time in the college. How this will affect my research (in eighteenth-century English literature and in satire in literature and the visual arts) has been my one reservation.

4. I will also offer a new college course as a result of my fellowship activity, although this is fairly tangential. I am planning a section of freshman composition (for biology majors among others) with readings in the literature of cell biology: Lewis Thomas, James Watson, etc.

5. My writing plans in this field are presently confined to grant proposals and course outlines.
6. Proportion of the fellowship period spent
   at my own campus 60%
   at other institutions in the U.S. 40%

7. My department in the college contributed office space and supplies. The School of Medicine contributed funds for released time; the money was received from the Southern Education Foundation for that purpose. Thomas E. Norris, Ph.D., shared his institutional travel grant from the National Endowment for the Humanities through the Institute.

8. My work on the medical school curriculum committee will continue and will be supported by secretarial assistance and travel funds from the School of Medicine. I will also continue to serve on the school-wide curriculum survey committee. Further released time for the academic year 1977-1978, before the first class enters in 1978, will depend on the disposition of grant applications.

9. Preparing a humanities program rather than occasional courses was the purpose of the fellowship; and that purpose has been achieved.
LAURENCE A. LARSON

1. Activity during the tenure of the fellowship:

I attended a workshop on Medical Ethics in a Clinical Setting at Dartmouth College from 11 July through 18 July 1976. The Workshop provided clinical experience to those who already had some theoretical exposure to medical ethics. The workshop activities utilized the facilities at the Dartmouth-Hitchcock Medical Center in Hanover, New Hampshire, and the Veteran's Administration Hospital at nearby White River Junction, Vermont. The clinical experiences involved talking with professional medical persons and, most important, with patients or observing them in the following situations:

a. care of the terminally ill
b. care and examination of the dead body
c. adult intensive care
d. inpatient alcoholism unit
e. neonatal nursery

In addition to the clinical experience there was opportunity to visit, discuss, hear lectures, etc., on a variety of subjects. Some of these were:

a. Electroencephalograph demonstration
b. Discussion of brain death
c. The experience of dying
d. Discussion of a hospital chaplaincy
e. Nursing home care
f. Ethical dilemmas in nursing practice
g. Paternalistic behavior
h. Comparison between a large teaching-research hospital and a small community hospital
i. Psychiatric illness
j. The use of clinical experience in teaching medical ethics

The workshop at the Dartmouth-Hitchcock Medical Center was, in fact, all I had originally planned to do on the fellowship, but I was able to attend two other bioethical related events. These were: (1) A symposium on Bioethics and the Classroom sponsored by the Ohio College Biology Teachers' Conference held at the University of Toledo on 23 October 1976 and (2) a conference on Death and Dying sponsored by The Episcopal Church--The Diocese of Southern Ohio, and held 10-12 December 1976 at the Fawcett Center for Tomorrow in Columbus, Ohio.

2. Understanding of the subject as a result of the fellowship:

I teach a course in bioethics and up until the time spent on the fellowship my resources in developing and teaching the bioethics course came mostly from reading. The fellowship grant gave me an
opportunity actually to be exposed to some of the clinical experiences that lead to the bioethical dilemmas I discuss in the classroom. I feel it added a dimension of credibility to my classroom presentations.

3. Effect of fellowship on teaching activity:

The effect here is difficult to measure. The time that I spent at the Dartmouth-Hitchcock Medical Center was extremely valuable with respect to my teaching activity. I talked with most of the participants, who represented a variety of disciplines but had a common interest in bioethics. Some of the disciplines represented were religion, philosophy, gerontology, ethics, pastoral care, psychiatry, medical legal adviser, futuristics, zoology, and my own botany. It was of value to me to be able to discuss our common interests with people from different backgrounds. Also, I realized, after talking with and listening to the staff persons of the three hospitals we visited, the need for training and awareness in bioethics at all levels.

4. Production of new courses:

As a result of the fellowship experiences I have initiated a series of discussions among the faculty at Ohio University. There is interest within this group to create an Institute of Bioethics. One of the functions of the Institute would be to bring together all those persons who have an interest in bioethics and to develop a curriculum. We already have about twelve courses taught in as many departments representing four colleges. For example, there are three bioethics courses now taught—one each in the departments of botany, zoology, and philosophy. Examples of other related courses are:

- The Economy of Health Care—Economics Department
- The Ethics of Energy Utilization—Industrial and Systems Engineering
- Aging in the Welfare State—Department of Social Work

These courses and others could be organized into a minor program. The Dean of the Graduate College is very much interested in this project and has expressed interest in providing the administrative base for the Institute.

5. Publication of material resulting from the fellowship:

At this time there are no plans for the publication of any material. However, if the Institute of Bioethics becomes a viable instrument, it may be of interest to others to know how a group of diverse faculty were able to organize such a program. If this were written up and accepted for publication, the support of the Institute on Human Values in Medicine of the Society for Health and Human Values through the National Endowment for the Humanities Grant #EH10973-74-365 would be acknowledged.
6. **Fellowship Expenses:**
   
   a. at your own campus?  0%
   b. at other institutions or locations in U.S.A.  100%
   c. at other institutions or locations abroad?  0%

   Total 100%

7. **Ohio University financial contribution:**

   $158.00 toward travel expenses for the Dartmouth-Hitchcock Medical Center workshop.

8. **Extension of fellowship work:**

   This is explained in items 3 and 4 above. It may be of interest to know that any activity I perform related to the fellowship and the general area of bioethics is at this time in addition to my regular duties assigned to me as professor of botany in the Department of Botany. However, as a member of the department I am able to use department and university facilities to further my interest in the area of bioethics. The indirect costs are probably considerable. For example, there is a proportion of my salary, secretary salaries, fringe benefits, materials such as paper, postage, phone, university classrooms, etc. For this privilege I am grateful.

9. **Program Development:**

   There is a real possibility that a Bioethics program will be developed at Ohio University. I think the interest in an Institute of Bioethics is a good example. Also, I have already submitted a preliminary proposal to the NSF for funds to be able to present a series of lectures and workshops in several areas of Human Values. Tentative topics are:

   - Genetic Engineering
   - Survival in a World of Technology
   - Health Care Delivery
   - Behavioral Modification
   - Alternatives in the Dying Process
   - Human Experimentation and Consent

   While it is impossible to say with certainty what spin-off may result from such a program, I do know from past experience with similar programs that interest in both the Athens community and the University community is high for these kinds of programs. Once the Institute of Bioethics becomes established so as to provide a firm administrative base from which to work, health-related organizations will be contacted so their staff will be aware of what course is available to them through the university as well as our being made aware of what resources they may have to offer.
us in developing further programs. Informal discussions have already taken place with:

- College of Osteopathic Medicine
- Day Care Living Center (for the aged and retired)
- School of Nursing
- Department of Social Work
- Department of Mental Health-Genetics Unit
The fellowship I received was to cover the time from July 1, 1976 to September 30, 1976. Some of my work relevant to the fellowship occurred after that time, and is, in fact, still going on. My report will cover activities up to the present time (January 1977).

1. In my proposal I agreed to spend one-half to one day a week in the Department of Obstetrics and Gynecology and the Department of Endocrinology attending their case conferences, having weekly discussions with their students, seeing some patients, and looking over their teaching program. My purpose in this was twofold: to see what kinds of value questions arose in this particular context of medicine, and to introduce students and residents to questions of philosophical import in medicine.

I also mentioned that the Department of Psychiatry and Human Behavior and the Department of Obstetrics and Gynecology were planning to open a clinic for the patients with problems of sexual dysfunction. Since I intended to be part of the clinic and to be involved in setting it up, I planned to see what kinds of value questions might arise. Since the first planning meeting was held in December and was concerned exclusively with the mechanics of beginning the clinic, nothing relevant arose.

Endocrinology Department

Because of the strong support given me by Dr. Abraham Rakoff, head of the Department, I was able to hold a one-to-two hour seminar every week during my tenure. Attending this seminar were medical students on rotation through the service, residents assigned to that service, and a counselor on the staff. I spent the first session describing the differences between fact and value statements and how these relate to the kinds of decisions we make. I introduced them to some of the literature in philosophy that discussed some value questions, and offered some examples of value issues from my own practice. Over the next ten weeks, they brought in examples of cases that they felt raised issues similar to the ones we discussed in the seminar; also, cases they were uncertain about regarding how or why they had made the decisions they had.

The specific issues I raised had to do with the nature of the decisions they made, for example: Were their decisions made on the basis of facts or values? Were their concerns related to the ethics of their profession? Were their concerns related to personal ethical standards? I encouraged them to examine the nature of the doctor-patient relationship, models of such relations, how they saw their role vis-a-vis their patients, whether they saw themselves as expert-authorities, expert-collaborators, expert-persuaders, etc.—we made up a fair number of related categories. I introduced them to Illich's Medical Nemesis and the idea of iatrogenesis. The participants brought in cases every week that raised interesting and relevant issues. A
number were discussed that involved the physician's decision to help or not help patients to become pregnant. The following is a fair paradigm: A seventeen-year-old, unmarried, black woman comes to the clinic wanting to become pregnant. The physicians admit being uncomfortable with the case for the following reasons: She is not married; she wants to get pregnant because all her friends are; she wants to get pregnant to get on welfare; she does not appear bright, might be a poor mother, may even be retarded: they wonder what kind of life the baby would have if the mother were retarded and there was no father. The only medical issue mentioned concerned the chemical and surgical procedures of treating infertility since these might be dangerous to the patient.

Most physicians agreed they would do a basal temperature chart on such patients to determine whether they were ovulating, but they would refuse to do any medical procedures to enhance the likelihood of fertility unless a boyfriend agreed to be tested so that his sperm count could be determined to be adequate.

A more sophisticated example was discussed. A middle-class white woman who looked somewhat unstable wanted to have a child by her boyfriend. She did not plan to tell him that she was trying to become pregnant; she did not intend to marry him and planned to move to Africa after she had the baby. Again the physician refused to help her become pregnant under these circumstances. We discussed possible cases that might present even more problems: artificial insemination for women who did not plan to marry, radical feminists or lesbians, for example. In such cases, what view would the doctors hold, and on what grounds?

A case was discussed in which the husband was found to be infertile. The wife, feeling he would not be able to handle that fact about himself, deliberately became pregnant by someone else. Both she and her physician knew this. The husband assumed it was his child.

Questions about what to tell patients were often raised. Gender problems arose. For example: patients raised as male or female because they had the appropriate secondary sexual characteristics or some semblance thereof, were found to be of the opposite sex when checked for infertility. They were usually told they could not have children and were given no other information.

The seminar was lively and raised interesting questions for all of us. The residents, who were making many of these decisions, felt that they were stimulated by the discussions and realized that they had developed certain stereotyped ways of handling difficult decisions quickly and with a minimum of personal discomfort. It was a useful experience for all.

Obstetrics and Gynecology

Dr. James Lee, Chairman of the Department, allowed me to sit in on the residents' conference that was held weekly. Residents often presented cases, and physicians from other departments regularly spoke
about their special areas. I observed much more than I participated, since most of the material was unfamiliar to me at the beginning. The cases presented raised unusual or difficult medical problems for the residents. Emphasis and discussion centered almost exclusively on the medical procedures that were followed, whether all the possible lab tests had been run, etc. Seldom, if ever, did anyone raise the question of patients' feelings or even patients' rights. Toward the end of my tenure, I sometimes asked such questions and found that many of the residents had been uneasy about similar questions but didn't discuss their discomfort in such a group. Toward the end, I gave a talk on the patient as a whole person entitled to take responsibility for himself, and the importance of giving patients more responsibility, not less. This was in the context of a discussion on pain, its meaning in our culture, and the problem for the physician of alleviating pain. A number of residents called me in as a consultant on cases they were seeing while I was there. I think they wanted to talk about many of the issues that came up at the conferences but the group was too large for sharing such concerns.

I found some of the speakers from other departments very interesting. Physicians from Pediatrics talked about problems of fetuses with difficult births, how to facilitate births with minimum damage to the fetuses, how to monitor what was going on, etc. Speakers from Anesthesiology discussed the hazards of drugs with respect to delivery and child birth, and the importance of making correct decisions quickly. As an outsider, I was impressed with the number of potential problems obstetricians regularly faced, how pressed they were for time, how unclear many of their cases were, how many decisions had to be made on very little evidence, and how many mistakes could easily be made. I was particularly struck by the remark of a leading anesthesiologist who mentioned the high number of lawsuits against obstetricians: "What do you say to a family when you take a healthy pregnant woman into the delivery room and bring out two corpses, the mother and the baby?"

Dr. Lee asked me to give a lecture on "death and dying" to fourth-year medical students on rotation through his service. This proved to be a good opportunity to discuss many of the concepts I'd heard debated at conferences and talks on medical-ethical issues—for instance, the "right to die," "active and passive euthanasia," "death with dignity," "natural death," and "living will." Students were very receptive to this topic and asked for references for their own research.

Conferences

I attended the 4th Annual Symposium, "Endocrinology of the Female: Diagnosis and Treatment," November 10, 11, 13, at Jefferson Medical College. In September, I attended "Mental Illness and its Policy Implications for Law and Health Care," sponsored by the University of Texas Medical Branch, Galveston, and Rice University, Houston, in both Galveston and Houston and participated in an afternoon of small group discussion, in Galveston.

In October, I spent the weekend at a conference on "Philosophy, Law and Medicine," sponsored by Western Michigan University and Kalamazoo College, in Kalamazoo.
Also in October, I attended a conference, "Ethics, Science and Psychology," at Long Island University.

Other Activities

1. I have met with several residents and medical students from other departments at Jefferson who are eager to promote humanism in medical education. I helped the student group with their arrangements for Dr. Edmund Pellegrino to speak on "Humanism and Medicine" in the Department of Psychiatry and Human Behavior Wednesday Noon Conference and the University Hour, in January, 1977.

2. This was the first time I have had to do some concentrated reading in the area of medical-philosophical problems, and I feel as if I have really just started. As a result of attending the conferences, reading, and encouraging students to think about some of the issues I was becoming more familiar with, I think I could now offer a course in biomedical ethics, that I could raise some of the problems in a way that would be more directly relevant to the medical profession. I also understand more clearly the issues discussed at the conferences. It is very difficult to work in a medical setting, caught up in the everyday demands of the job, and shift into thinking about philosophical problems. I knew this was a problem for physicians, at conferences I had attended before, as it was for me. Having now obtained some concentrated material, I believe I can digest the debates as I move from conference to conference. I believe it still poses a problem for physicians who attend such conferences--trying to see as quickly as possible the point of what is going on. The kind of work I did helped a few people think in new ways for a while. It was helpful at the time, but I feel that the more often we can pursue the relevant issues in small groups where discussion can be brought to bear on physicians' immediate work, the greater the likelihood that medicine can be positively affected by the humanities.

3. I have just begun small group teaching for freshmen in the course "Man and Society." Several other faculty members and I will continue with fifteen students through their freshman and sophomore years, meeting with them for an hour and half each week. There, I will have the opportunity to introduce both topics. For example, this week I am going to ask their opinion on a case discussed by Veatch in his book Death, Dying and the Biological Revolution in which a dispute arose among physicians about a patient's being considered legally dead so his kidneys could be given to a young girl on the nephrology service. Besides my work at Jefferson, I run a small group for psychologists who are working for licensure in Pennsylvania. Usually we discuss cases they are handling, but often I bring up other issues. Recently, I have been discussing problems with pain, a number of puzzling questions regarding pain, and how different people and different cultures interpret pain. I have introduced them to some of the philosophical literature on pain and have opened the way for more discussions on conceptual issues.
4. I am in the process of exploring a possible symposium on value issues in medicine, sponsored jointly by the Department of Psychiatry and Human Behavior and other departments at Jefferson and the Institute on Human Values in Medicine. I have permission from the Chairman of Psychiatry to proceed. I have met twice with Dr. McElhinney, and once with faculty from Family Medicine. I hope to interest several departments in planning the program in the next several months, for the fall or winter of 1977.

5. I would like to submit an article on ethical issues of Obstetrics and Gynecology or Endocrinology, using some of the above information, but I will have to see about my time commitments in the spring.

6. About 90 percent of my time was spent at my own institution. The rest of the time was spent at conferences.

7. I was given some time off for travel. I had secretarial help and supplies from Jefferson.

8. As I mentioned, I am still involved in some activities that began with my fellowship—planning a symposium, offering course material on human values. I feel that I will have a great deal of support for things that I want to do from the chairman of my department. My problem is that my own time commitments are extensive and I have little time to develop further activities.

9. I don't plan to try to initiate a teaching program in human values, although, if the symposium works out, I could see our planning a yearly conference. I certainly will help students and other faculty to promote interest in the area.
"Let us deal justly," suggests Edgar to Lear, yet those who would cavalierly urge us to do just the same ought to be chastened by the fact that, at this point in the play, Edgar still feigned the fool. Not that the notion is utterly unattainable or platitudinous. Still, while justice may genuinely be, as Rawls regards, "the first virtue of social institutions,"\(^1\) the extent to which the idealized demands of justice can be reconciled with both competing values and intrinsic institutional constraints often remains problematic - frequently as problematic as settling upon the "demands" themselves. I originally proposed to explore both the possible formal demands of social justice theory and the delicate process of arriving at acceptable accommodations to necessary or existing societal limitations by focusing upon the subject of legislatively-mandated national health care.

My Fellowship began with a summer of directed reading and research under the aegis of several members of the Kennedy Interfaculty Program in Medical Ethics at Harvard. A preliminary review of the literature quickly revealed that, despite the occasional prophecy of moral degeneration or economic disaster, some kind of national health care was inevitable, a rough consensus existed on its desirability, and much of the remaining controversy was about mechanics of the program; i.e., choices over kinds of coverage, how much and how funded. While the importance of these issues should not be minimized, their predominance in the national health care debate made the subject a less than perfect vehicle to pursue the larger (or certainly more general) philosophic and pragmatic political questions in which I was interested. Therefore decided to shift focus and examine America's collective obligations (if any) toward a palpably hungry and hurting world.

As a result largely of previous work in the realm of philosophy and public affairs (both at Yale and as an intern at the Institute of Society, Ethics, and the Life Sciences in New York), I was designated a Scholar of the House.\(^2\) This appointment was made before I spent my summer at Harvard. After returning to Yale, I soon found that my new joint Institute Fellowship and Scholar of the House project divided into roughly four parts:

I. ISSUES

What is. Painted with a broad brush, this first part was intended to provide no more than an impressionistic picture, an overview of under-development. Facts and figures, reports and recommendations from a wide range of sources were consulted, while the "existential contact" so crucial to a genuine appreciation of and greater perspective on the problem was provided by field work in India and Bangladesh (travel and living costs contributed by Yale).
II. IMPERATIVES

Why ought. By far the bulk of my time was spent exploring various philosophic grounds for aid to developing societies. Obviously pragmatic policy questions and the proper form such aid should take were considered as well. Religious reasons, retributive justice, and self-interest were all found to be - like the poor themselves - somewhat wanting, while a compelling case grew out of a careful examination of both justice theory and the natural and human rights traditions. Ultimately, though, the most convincing arguments were those which rested upon a notion of empathy or identification (for individuals), and upon an adherence to previously espoused principle (for American society as a whole). A major effort was made to arrive at a compelling secular ethic, what I called "agape without God." Of necessity, two meta-ethical issues were also raised: the first concerned with the move from is to ought, the second with the passage from ought to action.

III. POSSIBILITIES

What can. Since, as Kant appreciated, ought implies able, an outlet for ethical energy had to be described. Hence, and however briefly, the practical possibilities were explored.

IV. PROSPECTS

What will. In this final part I played prognosticator, in painful recognition of the fact that the rift between the possible and the probable is as real as it is wide. The question here was obvious: Based upon present trends and a reading of the past, does capacity mandate commitment?

My year as a Fellow culminated with the writing of a 400-page paper on American foreign policy and the ethics of world poverty, health, and hunger, a work perhaps more notable for the unbridled breadth of its ambition than the significance of its findings.

As the foregoing suggests, I have no plans to publish it (although it is available in the Yale archives). Still, the entire year was designed less to break ground than to cover it, and as an educational experience it was without peer. While this particular effort will not be distributed, it should also be noted that I regard it as having laid the groundwork for a great many articles and papers to come.

While my conclusions and recommendations were too detailed to summarize, Camus comes closest in spirit, if not specifics:

Perhaps we cannot prevent this from being a world in which children are tortured. But we can reduce the number of tortured children.
While we might not do everything, mightn't we try to do just that? Ultimately it was this question which my work as a Fellow asks.... It is a question I will be asking again.

FOOTNOTES


2. Each year twelve senior Yale undergraduates are freed from all exams, courses, and other curricular requirements and allowed to pursue a project of their own design with the help of a group of personally-selected faculty advisors. Each student is monitored closely by a senior faculty committee, the Scholar of the House Program itself becoming his or her own major.
1. I spent the period of my fellowship completing a manuscript based on a seminar that I had organized in late 1975 treating some questions in medical ethics using Talmudic sources. I have received guidance from the participants in the seminar, Medical Humanities Professor Stanley Reiser, Talmud scholar and mathematician Shlomo Sternberg, and Primary Care physician Steven Levisohn, in its preparation.

I did essentially what I had planned to do, except that the questions I dealt with were modified from those I had proposed as my understanding of the subject developed. Instead of considering primarily the question of which lives to save when not all can be saved, I addressed the broader issues (encompassing this question) of the conditions under which an individual can put himself at risk for his own benefit, those under which he can do so for another's benefit, the scope of action a third party has in deciding the fate of others, and considerations pertinent to the treatment of the gravely ill patient.

2. My view of ethical questions in medicine generally, and in particular of those I have considered, has grown from untutored intuition to at least an appreciation of the vastness of the field and the compelling need for investigation into it. As a result of the work I have done during my fellowship period, I have resolved to make the investigation of the human questions in medicine my first priority along with developing and maintaining competence as a physician. In fact, it has become clear to me, particularly through my contacts with Dr. Stoeckle and Dr. Levisohn, of Massachusetts General Hospital Primary Care Unit, in the course of my fellowship work, that the overlap between the two goals is substantial. I have finally seen what I had suspected before embarking on this project: that given the central importance of the human dimension in the doctor-patient relationship, enhancement of the quality of patient care stems very directly from concern over human issues. In a word, I see indefinite possibilities for the humanities and health professions to enrich each other and intend to structure my career around their exploration.

3. Since I am a medical student and not currently teaching, please see item 4.

4. I am now making plans to offer a course at Harvard College, with the advice of Professors Reiser and Sternberg and Drs. Stoeckle and Levisohn, based on work done during the tenure of my fellowship. I will take this occasion to study and present these topics in more depth, to investigate new topics, and most important to try to give Harvard undergraduates a perspective that places humanistic concerns on a par with grounding in medical science as an essential ingredient of effective health care delivery. I am hoping that my background in both scientific and humanistic research (including publication in the former) will lend credibility as well as substance to my presentation.
The seminar forming the basis of my work will be continuing; Dr. Levisohn and Professors Sternberg and Reiser have developed an enthusiasm for this approach to medical ethics, and we plan to begin meeting again to refine my manuscript as well as to explore new areas next month. Based on expressions of interest from the Harvard Medical Community, we expect considerable participation when we resume meeting.

5. I intend to have a manuscript ready to submit in the next couple of months. The first draft is currently being read by Professors Reiser and Sternberg and Dr. Levisohn.

6. I spent 100 percent of my time at my own campus.

7. Harvard was not able to fund me.

8. I will receive whatever secretarial and financial assistance I may need in developing and offering a course at Harvard College as well as in the final preparation of my manuscript. No expense will be involved, initially at least, in opening our seminar to the Harvard community. Should any be incurred, it will be covered. I am being granted academic credit, which gives me considerably more flexibility than I would have otherwise.

9. Harvard already has such a program under Dr. Stanley Reiser and his associates. I am hoping that what comes out of my work will contribute to the program in the measure that I have received guidance and support from Dr. Reiser.
1. During the tenure of my fellowship I continued my preparation for a Ph.D. degree in ethics at Harvard University Graduate School of Arts and Sciences. It was a particularly good year because I completed my qualifying exams and prepared my dissertation prospectus. Both of these represented important moves forward in my studies!

Also, I continued to try to integrate my learning in philosophy and theology with my background and experience as an allied health professional. This involved presenting several papers at professional meetings and conducting workshops occasionally.

This is entirely consistent with what I had planned to do when I applied.

2. My understanding of the subject of medical ethics has developed considerably during the last year. This has been due to continuing exploration into and exposure to the complexities of several key topics. For instance, one area of examination was medical ethics: I chose questions in the areas of euthanasia and the physician-patient relationship, to name two.

Having seen some of the issues more clearly also enables me to imagine how I must approach some of them so as to help students see their complexities; the humanities aspects of the health professions seem more indispensable than ever.

3. The fellowship work has not caused me to plan any specific changes in the scope, organization, or presentation of my discipline in my research or writing. It has simply further stimulated my interest in and commitment to my goal of integrating humanities perspectives into the allied health curricula.

4. Not applicable: not teaching at present.

5. I did not complete an article, book, or monograph as part of the fellowship year.

6. Except for the occasional meeting, I spent 100 percent of the fellowship period on my own campus.

7. No support from Harvard G.S.A.S.

8. Not applicable. Or, perhaps, entirely applicable in the sense that my work this year will be of paramount importance in allowing me to return to the allied health professions prepared to teach ethics and other humanities concerns to students.

9. Not applicable.
I. General Description

The tenure of the fellowship went through several phases. The progress of the experiential study at the Children's Hospital of Buffalo, New York, can best be described by first giving the general outlines of the activities and the time framework of each. My experiential study involved participation in the summer program of Clinical Pastoral Education already established at the hospital under the supervision of Rev. Rudy Roder.

This program had several dimensions: (1) students were assigned clinical areas of the hospital with the responsibilities of active involvement in the health care team; (2) a number of seminars were held with medical and paramedical personnel; (3) there were peer group sessions for dialogue and interaction; (4) and there were supervisory sessions with Rev. Roder. I participated in all of these to a varying degree. The time and scope of participation were determined by circumstances at the hospital, that is, in terms of schedules of physicians and the exigencies of medical care, and by the limit of my participation to the average of fifteen hours per week and my priorities in the study. Because of the emphasis on the experiential in the proposal, more time was devoted to clinical experience. When there was a conflict of schedules between clinical experience and peer group sessions, the choice was made in favor of clinical experience. A great deal of experience was gained in making clinical rounds with the medical staff. This necessitated being available for the rounds and foregoing other activities at those times. However, there was some formal participation in peer group sessions, and also informal interaction with the five interns in Clinical Pastoral Education (henceforth, CPE). Sharing thoughts and feelings relating to our clinical experiences was very helpful in rounding out my own experiences and in coping with personal emotional responses to the critically ill children and their families.

Looking back on the whole experience, I discern that much more was derived in these encounters in terms of readjusting and deepening my thoughts and feelings than can be adequately expressed in writing.

Clinical experience embraced several aspects: clinical rounds with the medical staff and subsequent discussions; visiting with parents and patients; attendance of staff meetings, discussing condition and care of patients; research into medical records. Complementary to the clinical were the seminars with medical and paramedical personnel, the great majority of which I attended.

In terms of distribution of time per week, approximately ten hours were given to clinical experience and five to seminars, peer group sessions, and supervisory sessions. The supervisory meetings with Rev. Roder were in addition to the frequent group sessions.
with him during the first two weeks and peer group sessions occasion­ally attended during the program. With his many years of clinical experience as chaplain, he helped me confront my reactions to the clinical situation and put the features of medical care in perspective.

II. Areas of Concentration

My study concentrated on pediatrics. Personal interest and contact with medical personnel with specialization and with parents brought me to focus on certain cases and units. Rounds were made with Dr. David Klein, Chief of Neurosurgery, Dr. James Allen, Associate Chief of Surgery, Dr. Luis Mosovich, Clinical Coordinator of Intensive Care Unit (ICU), Dr. James Budney, resident neurosurgeon, Dr. Ben Hart, resident in intensive care nursery (ICN). The cases were neurosurgical, involving tumors and congenital defects; surgical, involving various cardiac defects and intestinal disorders; medical, involving chronic diseases and severe infections. These were encountered in rounds with medical staff in intensive care units and on different floors. Rounds on the eighth floor (a medical floor) brought me in contact with young children with various conditions. Rounds in the intensive care nursery saw a number of infants with conditions resulting from congenital and birth trauma defects.

Visits with parents and patients focused my attention on problems relating to neurosurgery and open-heart surgery and especially on the issues of communicating and counseling and of coping with the reality of a seriously ill child. Because of some fluency in Italian, I had the opportunity to talk at length with parents who came from Italy to have open-heart surgery for their child. These discussions revealed the problems of communication due to cultural differences.

In each instance, there was an opportunity to learn of the medical history, condition, and prognosis through rounds with attending physician and team members, discussion with physicians, staff meetings, and medical records. The psychological and social dimensions of care came up from time to time in the course of rounds. But these were explored more thoroughly in the Hospital Counseling Services in-patient rounds and Social Services rounds for the intensive care nursery. At the Hospital Counseling sessions, social worker counselors discussed patients referred to the department under the direction of Judith Sullivan, ACSW. At some sessions, a child psychiatrist also participated. Social Services rounds held once a week for the intensive care nursery also offered an opportunity to understand the complexity of medical care in view of psychological, economic, and social factors. These meetings were attended by resident doctors, interns, nurses, Convalescent Care Coordinator, Nancy Youngblood, R.N., and Parent Advocate, Cheryl Rabe-Lipton, M.S.
III. Weekly Schedule: Events and Topics

To give an overall view of the progress of the experiential study, a weekly account of activities seems a convenient method. For the entire fellowship period, time was distributed between The Children's Hospital and Canisius College in these proportions: 75 percent at the Hospital and 25 percent at the campus.

First week: June 7 - 12

This week was generally devoted to orientation to the hospital community.

**SPE Group Sessions:**

Rudy Roder gave us a preview of the two-week schedule and conducted tours of the hospital, followed by an explanation of the organization of the hospital and interrelations of departments.

Sessions with Rev. Roder were devoted to various theories and techniques of counseling and group interaction, the grief process.

Peer group reflected on experiences of first days.

**Seminars with Staff:**

Cheryl Rabe-Lipton, M.S., Parent Advocate for Intensive Care Nursery: issues of intensive care and counseling parents.

Richard Batt, Associate Director of the Hospital: dimensions and problems of health care at a medical center.

Charlotte Wolpin, Director of Volunteers: function of volunteers in relating to children's problems of adjustment and care of the family.

Behavioral Sciences and Child Psychiatry seminar on Child Placement.

Private meeting with Dr. David Klein, Chief of Neurosurgery, to discuss objectives of personal program.

**Clinical:**

Rounds with Dr. Klein, followed by discussion.

Second week: June 14 - 17

Private Meeting with Dr. Allen, Associate Chief of Surgery, to discuss personal program.
Clinical:

Rounds with Dr. Allen, followed by visits with patients met during rounds.

Rounds with Dr. Klein, in-patient rounds with Hospital Counseling Service.

Seminars:

Pauline Keefe, R.N., Director of Nursing: history of hospital and nursing staff.

Judith Sullivan, Director of Hospital Counseling Service: function and relation of service to the medical staff.


Peer Group:

Discussions of experiences.

Week ended with controlled videotape interviews in which all members of the CPE acted as counselors in a simulated situation.

Third Week: June 21 - 24

Seminars:

Behavioral Sciences with Dr. Charles Bachmann, on the hospice.

Charles Brodnicki, Director of Behavioral Sciences, on adolescent care and multifamily therapy.

Dr. Kuhn, Chief of Radiology, on diagnostic procedures employed by department.

Clinical:

Visits with parents of children with cardiac defects, awaiting diagnosis for open-heart surgery and with parents after open-heart surgery; also with patient after brain surgery.

Rounds with Dr. Mosovich with medical team in ICU and on eighth floor.

In-patient rounds with Hospital Counseling Service.

Peer Group:

Discussion concerning the significance of pain, the problem of children suffering and dying and attempts to cope with these realities.
Fourth Week: June 28 - July 1

**Clinical:**

- Observation of chest surgery. Discussion with Dr. Allen in ICU.
- Preoperative rounds with Dr. Allen. In-patient rounds with Hospital Counseling Services.

**Seminars:**

- Dr. Allen on the development of pediatrics and present state of care, and relating to children at different ages.

**Peer Group:**

- Discussion of issues of self-growth and awareness as they relate to religious practice and clinical experience.

Fifth Week: July 5 - 9

**Clinical:**

- Visit with adolescent patient awaiting open-heart surgery and with patient.
  - Rounds with Dr. Mosovich and team on eighth floor on two occasions.
  - Visit with parents of child with complications after open-heart surgery.

**Peer Group:**

- Discussion of issues raised by personal meaning of death. Discussion of issues raised by counseling parents and patients in different situations, e.g., patients awaiting catheterization and open-heart surgery and patient awaiting an abortion.

**Supervisory Session:** with Rev. Roder on progress of study.

**Seminar:** with Dr. Vlad, Chief of Cardiology, on cardiac defects, corrective surgery, complications, and emotional social factors.

Sixth Week: July 12 - 16

**Seminars:**

- Behavioral Sciences with Dr. Vicki Bessigini on adolescent depression: causes and therapies.
  - Dr. Dennis, clinical geneticist, on testing, diagnosis, and treatment of genetic diseases.
Clinical:

Visits with parents of open-heart patient.

Rounds with Dr. Mosovich and team on eighth floor and ICU on two occasions.

Rounds with Dr. Mosovich in ICU, followed by discussion on patient care.

In-patient rounds with Hospital Counseling Service.

Visit with patient after open-heart surgery.

Seventh Week: July 19 - 23

Peer Group:

Discussion with Walter Boepler, regional head of Clinical Pastoral Education about personal program.

Group discussion with Walter Boepler on changes and direction of CPE.

Interpersonal Relation Group session - shared personal reactions and background to clinical experience.

Group discussion of case study presented by member of CPE: Systematic Lupus Erythematus.

Clinical:

Rounds with Dr. Mosovich in ICU.

Rounds with Dr. Mosovich on eighth floor on two occasions.

Eighth Week: July 26 - 29

Seminars:

Behavioral Sciences with Mr. Barone, on hypnosis.

CPE seminar on the dying child.

Peer Group:

Discussion of chaplain's functions and coping in a clinical setting.

Supervisory Session: with Rev. Roder on progress of program.

Clinical:

Rounds with Dr. Mosovich in ICU and in eighth floor on two occasions.
Visit with parents and child to be discharged after open-heart surgery.

Visit with parent of child with inoperable brain tumor.

Discussion with intern on counseling parents in such cases.

Ninth Week: August 2 - 6

Seminars:

Behavioral Sciences, on play therapy.

Dr. Warren, Director of Children's Rehabilitation Center, on relating to children with minimal brain dysfunction and to parents in the course of rehabilitation.

Clinical:

Rounds with Dr. Mosovich and discussion on experimental therapy.

Rounds with Dr. Klein and Dr. Budney; discussion afterward with Dr. Budney.

Social Services rounds for intensive-care nursery.

Rounds with Dr. Hart and team in ICN.

Supervisory Session: with Rev. Roder on focus of research: communication and informed consent.

Tenth Week: August 9 - 13

Seminars:

Discussion with Cheryl Rabe-Lipton on counseling parents and problems of communicating relating to ICN.

Clinical:

Rounds in ICN with Dr. Hart and team.

Genetic laboratory for observation and discussion of testing and diagnosis of chromosomal defects.

In-patient rounds with Hospital Counseling Service.

Social Services rounds for ICN.
Peer Group:

- Movie on various counseling techniques (Roger's, Perl's, and Ellis') and discussion.
- Discussion of issues as experienced.
- Case conference on cystic fibrosis: discussion of counseling techniques.

Eleventh Week: August 16 - 17

Clinical:

- Discussion in ICN with Dr. Hart on parent-doctor relationship.
- ICU with Dr. Klein and Dr. Budney and meeting with family of dead teen-age patient.

Seminar:

- Dr. Klein on doctor-patient-family relationships and issues of informed consent.

Supervisory Session: with Rev. Roder on next course of study.

The rundown of activities for each week does not mention the informal discussions with the CPE interns, which dealt with the problems of counseling and the conditions of various patients. Their insights and information helped to round out my experience.

IV. Growth of Understanding (in view of objectives)

In the grant proposal, several objectives were stated: to enhance understanding of the dimensions and relevant data of clinical cases; to discuss and evaluate value issues; to deepen awareness of the perspectives involved in the team approach in care; to reflect on personal values in light of experience. These objectives were fulfilled by the combination of the varied activities mentioned above. Some were more directly related than others to specific objectives, but in practice all had some bearing. Clinical rounds in ICU as well as on the floors, coupled with visits with parents and patients, brought direct confrontation with the realities of sickness and death in the young. The experience could not but lead to personal reflection on attitudes (my own included) toward death and dying and their influence on communicating and relating with patients and family. Peer group and supervisory sessions were helpful in dealing with personal emotions and in coping with the realities of life at a medical center.

Seminars, clinical rounds, Hospital Counseling Services rounds and Social Service rounds, along with research into medical records and discussions with members of the health care team, contributed to a deeper understanding and appreciation of the follow-
ing points:

a. The multidimensions of clinical cases and the relevant data.

b. The process of differential diagnosis and team approach to it.

c. The functions of various departments in the process of diagnosis and care and need for smooth interaction.

d. The issues of counseling patient and family at various stages of diagnosis and therapy.

e. The problems of informed consent at different stages of care.

f. The capacity to comprehend and cope with the information and situation.

g. The emotional factors influencing physicians as well as patient and family.

h. The sophistication of medical technology and the dilemmas posed by its use in critical situations.

i. The extent to which we do not know causes of certain diseases and merely treat symptoms.

j. The healing powers of the human organism.

k. The need for followup care for whole family in cases of chronically and critically ill members after they are discharged.

l. The economics of health care at a medical center.

m. The concerns of physicians in regard to malpractice.

In staff sessions, the psychological, social, economic issues and demands of total patient care became highlighted. These gave me a glimpse of team interaction and of varying approaches to communicating and counseling. The various perspectives seem related to personal values, priorities, and focus of concern.

The peer group and supervisory sessions provided insights and a framework with which to evaluate the counseling of patients and family in a clinical situation. They fostered sensitivity to counseling as a process within which counselors must be attuned to changing moods, attitudes, and emotions of parties involved (including oneself).
V. Impact on Professional Activity and Teaching

The overall experience has brought home the need to explore the dimensions of interpersonal communication and the issues of informed consent in the context of health care. There seems a need to delineate clearly between the issues of informed consent relating to medical care in general and the issues of informed consent relating to experimental medicine. I hope to research the whole question of informed consent as it relates to health-care situations that do not involve experimentation and to ones that do involve experimental medicine. Research into similarities and differences between different medical situations with and without experimental medicine seems an important study for a better understanding of the responsibilities of physicians in informing and counseling.

Another area of research is the economics and politics of medicine: economic and political factors affecting medical staff and administration as well as patient and family. These factors impinge upon the health care scene and need to be analyzed in behalf of possible reforms. There is little doubt that health care is in a financial crisis.

In the fall semester, students are directed to examine the above topics in Bio-Moral Problems. This course focuses on the advances made in biological and medical research and technology and their social, economic, cultural, and moral implications. Dr. Joan Lorch, Assistant Professor of biology, is collaborating with me in developing the course and in the teaching of certain topics. A greater appreciation for an interdisciplinary approach has come from the realization that in matters of informing, counseling, and consenting, the layman often does not fully realize the complexities of the clinical situation. There should be more dialogue with health care professionals so that those writing and speaking on such topics are relating to the real world. With this in mind, students will be directed to contact health care professionals in their research. Whenever possible, the schedule will be adjusted to provide opportunities of dialogue with them.

VI. Application of Fellowship

As stated above, the immediate application of the experiential study is the course on Bio-Moral Problems, employing an interdisciplinary approach. Canisius College is contributing to the program by providing the opportunity to teach the course as one of my three scheduled courses. In terms of financial support, this translates into a reduction of class load by twenty students, which amounts to about one fifth of my salary per semester.

The college has also approved a sabbatical leave during the
spring semester of 1978 to pursue the experiential study begun under the fellowship.

VII. Program in Value Education

Over the past year, I have been project director for the development of a program of Value Education that centers on the study of human values and their role in decision-making and behavior. This program has a twofold appeal and purpose. It expands and enriches the present humanities program by bringing together disciplines from the humanities and sciences to explore the nature and function of values and their impact on decision-making, behavior, and relationships in all areas of major concern in a liberal arts education. It also speaks to the professional career objectives of students by examining value issues raised by problem-solving in specific fields in a way that promotes a more comprehensive understanding of the issues and the field of professional interest. The interdisciplinary approach to value questions enriches both faculty and student appreciation of the multidimensional character of human life and enhances their awareness of the interrelation of various dimensions.

Five interdisciplinary course are at present planned: (1) Values and Contemporary Affairs, a broad introductory course to value issues in different fields; (2) Bio-Moral Problems; (3) Business and Values; (4) International Affairs and Values; (5) Education and Values. The development of the program has already begun with the offering of Bio-Moral Problems and Values and Contemporary Affairs. The latter was supported by grant, allowing the participation of faculty from five departments.

At present, the college is requesting an award from foundations to support the planning and introduction of courses (3) through (5) over a year period beginning July 1977.

Grants would provide the support allowing participants released time to devote themselves to the project. Work as project director follows naturally upon experiences of the Bio-Moral course and the fellowship. Development of such a program of value-oriented courses could be the first phase in the introduction of additional courses relating to various aspects of health care. A second possibility is the establishment of institutes to deal specifically with the value concerns of the health care professionals and the community at large.
1. I was able to get many patients to discuss their knowledge and/or use of alternative systems of response to illness—e.g., nonscientific or indigenous healers and folk remedies.

I approached only those patients whose physical condition was satisfactory and who seemed able to tolerate an interview. Some patients told me that they could not answer any questions because they either did not believe in these factors at all or they knew nothing about these beliefs. The majority of patients did share what knowledge or experiences they had had, either personally or vicariously.

I really had little deviation from my original intent except that staff became more interested in what I was doing than I would have originally suspected. They asked numerous questions and were curious to know what kind of responses I received from the patients.

This reinforced my belief that because little, if any, focus is ever placed on a person's use of a healing system of a nonscientific nature, the average health worker has no sensitivity for or awareness of the importance of these beliefs for many people. Some inclusion of the medical professions' historical roots in a nonscientific system and their development into a highly specialized, scientific, and respected system would benefit the health worker. We often overlook or forget these humble origins, shrouded in mystery and superstition.

2. As a result of my study, I have a broader understanding of how and when nonscientific healing systems may be used. I believe that many people use parts of folk healing, often in conjunction with traditional scientific medicine.

This study was only a very small part of one of the many cultural factors that operate within the clients' belief systems.

I see unlimited possibilities for the humanities and the health professions to develop new programs that would help health workers to have more insight into clients' cultural needs and to consider more than technical areas when planning health care. I have discussed some proposals with the Dean that would involve the Health Center and the humanities. If these are implemented, I will send the specifics on to the Institute.

3. I have been asked to speak at professional nurses' meetings. They expressed an interest in a discussion of my findings and what this could mean to them in their work.

For further investigation I have considered projects for students to do in different areas: i.e., ethnic communities, rural and semi-rural communities. The data collected could be analyzed for similarities and differences in beliefs and expectations about health and illness and could be shared in seminars. Students would have a more
personal view of the client and better appreciate transcultural factors. Most student nurses work in the acute care facilities and emphasis is on skills of a more technical nature. Projects that provide even limited field experience could enrich their perceptions of the client as a person. The focus would be on the basic cultural concepts that health workers need to know to introduce them to the humanistic dimensions that were not a major part of their nursing preparation.

The gaps in knowledge can be partially bridged through in-service and continuing education workshops. I have discussed this with the Director of Continuing Education Nursing Programs for the University of Pittsburgh and these programs can be arranged.

4. In the new curriculum for the School of Nursing, we will have a course devoted to sociocultural forces and ethnomedicine. The findings from this study will be one part of the course.

I also believe that a core course should be developed for all students in the health professions. While my ideas for course content are not confined only to the findings in this study, the study reinforced my beliefs that health care providers must be taught more about the patients' belief systems and that this can best be implemented in an interdisciplinary seminar.

During this project an idea occurred to me that little systematic work has been done to evaluate the patient's perceptions and understandings of the meaning of the doctors' instructions. Feedback is seldom given to the doctor about any misconceptions that the client has or what cultural forces are operational to enhance or impede patient compliance.

I am going to do a pilot study on my own time and if it seems to have possibilities, I will apply for a sabbatical.

I had time to think more about these dimensions when I was doing the project, and will keep the Institute informed of future studies which I do.

5. At this point, it is too soon to formulate plans for any publications, but I am going to submit abstracts of my research and recommendations to professional nursing journals for review. I do want to consider some form of publication.

6. I spent 100 percent of the fellowship period on my own campus.

7. I had released time to do the study and my salary was partially paid. I did not ask for any supplies or secretarial assistance because I was able to use part of my stipend for this. I received much support and encouragement from the Dean to do this study.

8. I began full-time teaching on September 7, 1976, so I will be unable to do much additional research at this time. Due to heavy teaching commitments and limited funds to hire more faculty, no pro-
vision for released time can be anticipated. However, the Dean is supportive of my research interests. She can provide any secretarial assistance that I might need if I do any follow-up studies. In the future, if possible, she is willing to give me released time to do more follow-up work.

9. I am the School of Nursing representative to the Task Force on Human Values for the Health Center. Dr. William Cooper has asked us to use our individual expertise to get some ongoing programs planned to incorporate human values in medicine and the other health-related schools. I definitely intend to be as actively involved with this as I can. I am very interested in this and have been for several years. It was with this in mind that I had a doctoral program specifically designed in higher education and cultural anthropology to maximize my nursing and health background and experience.

**CONCLUDING STATEMENT**

Both nursing students and graduates need to have some theoretical constructs that focus on cultural variations and health practices. They also need follow-up experiences that allow them to observe different ethnic groups, share these findings, and discuss ways that nursing care can be planned to allow for cultural differences.

Health agencies have a responsibility to provide time to create an environment that permits more dialogue with clients. Too often this kind of activity is not seen as important and the nurse is told not to waste time by not "doing a task." When investigators do studies to determine nursing tasks and time involved to do them, they seldom focus on the assessment and health-teaching activities of the nurse. Because these interactions vary considerably in length of time necessary to meet client needs, one cannot put a time schedule on them, but they cannot be overlooked.

I will teach a course in the new curriculum that will integrate transcultural nursing concepts. One component will deal with alternative healing systems.

I have submitted a proposal to the Director of Continuing Education to plan and implement a series of workshops to help the graduate nurse who does not have a background in social sciences. This will be on my own time. I believe there is an urgent need for this and I am very eager to do it.

As I get even more involved in transcultural nursing, I hope to develop new ideas and experiences that will help both nurses and the consumers of health services.
My strategy for the Fellowship reading was to start with several general histories of world medicine and then to focus in somewhat more detail on American medical history, at all times keeping flexibility to pursue possible new areas of interest. At the outset, I was greatly helped by a conference with Prof. Leonard Wilson of the History of Medicine Department on the Minneapolis campus. Professor Wilson provided me with a wealth of specially prepared bibliographies, particularly in American medical history. I arranged my time roughly as planned, with 20 percent of the study being done at the Owen H. Wangensteen Historical Library in Minneapolis, and most of the remainder being spent at my own "institution"—largely reading at home. My notes indicate that I read twenty-one books, surveyed twenty years' issues of the Bulletin of History of Medicine and the Journal of the History of Medicine, and took complete notes on some seventeen professional articles in these journals.

The result of the month's study surprised me, but is easily summarized: I'm hooked. The field of study is fascinating, filled with exciting areas of potential research, and offering many points of intersection with my teaching both in the School of Medicine and in the College of Letters and Science. Although at present I feel especially obligated toward more study of American medicine and the rural practitioner, I look forward to much more study of ancient-to-Renaissance medical histories. A more specific result of the Fellowship opportunities was the final revision of an article on which I have been working for several years on the subject of feminine hygiene and the emancipation of twentieth-century women. Among the rare books at the Wangensteen Library I read some otherwise unavailable treatises on menstruation, but even more, the reading in the field of contemporary historiography of medicine provided me with a more effective rationale for the article. In another specific area my reading is still incomplete, but a paper will be certain to emerge during the coming year on the topic of popular histories of medicine. Tentatively, I envision a literary study of best sellers, but I sense that something deeper is there, closer to a reflection of popular values, images and stereotypes about doctors, about medical practice, and about biomedical science.

The effect of the Fellowship study on my medical school course, "Rural Life Styles," will be considerable, but at present only occasionally specific, e.g., the Parke-Davis collection of paintings is being exhibited here and we will hold class in the gallery. Probably my greatest insight has been to learn how recently rural general practice dominated the profession, and how recently—even currently—cults, quacks, and provincials have dominated rural practice. My study has already begun to do what I had hoped for: It has made available to me connectors between the rural value systems and my students' modern medical training. The history of medicine may not be important to these young physicians, but the historical perspective must be, for in their awareness of the closeness of a prescientific past I think they
will find an intensified urgency of mission, a respect for the community of history, and a reasonable sense of human fallibility, both in the doctor and in his patients.

This course is now in its fourth year, and has been revised continually, so it will not be possible for me to demonstrate direct effects of my Fellowship study on the course. I tend to be opportunistic in the curriculum; e.g., this fall the Guthrie Theatre is mounting a new production of *Enemy of the People*, and the class is attending *en masse*—but I feel certain that everything I teach will be affected by a more authoritative ability on my part to relate cultural phenomena to medical practice. Thus, underlying the medicine of Ibsen's play is hydropathy—incidental though it may be to the ethical and community issues of the play. Working from this example, however, I would say that at present I am satisfied that I will not convert the course to a history of rural medical practice—the medical history obscures the human values, no matter how much motivation the students may derive from professional history.

I received no other financial aids during the Fellowship period, and aside from the fact that I have a hundred or so pages of Xeroxing yet to do, the funds were spent in general according to budget, and my next visit to the History of Medicine Library will be at my own expense. I am most grateful to NEH and to the Institute for the Fellowship. It bought time and forced an obligation to a study that I felt was long overdue.
In order for humanists to understand what contributions they can make to medical education they need exposure to the medical setting. And this exposure needs to be sustained, not merely attending a one-hour teaching conference once a week. That is, it needs to include significant contact with patients, medical students, house staff, and senior staff physicians as well as a host of allied health professionals. To bring a humanist from his ivory tower into the medical center to teach the students their ethics is to invite disaster.

The fellowship itself was designed to be a twofold enterprise with an educational component and a research component. The objective of the educational component was simply to provide me with practical experience in a medical center context, which in turn would promote a better understanding of and appreciation for the routine stress of medical center life. This objective was completely accomplished. The objective of the research component was to develop an instrument to evaluate the quality of humanistic health care. This objective was only partially accomplished.

The educational component of the fellowship consisted of making rounds, attending morning reports, attending teaching conferences, and generally gaining valuable experience through exposure to the daily routine and stress of part of the teaching hospitals associated with Eastern Virginia Medical School, particularly Norfolk General Hospital, and to a lesser extent the Veterans Administration Hospital and DePaul Hospital (a private Catholic institution). During the fellowship period I worked with Dr. Robert T. Manning, Chairman of the Department of Internal Medicine. However, I found that to a certain extent I encountered a greater variety of "front line" experiences by tagging along with the Chief Resident, Dr. Ignacio Ripoll. So I spent considerable time with him. I found that side comments or parenthetical comments by the staff, which appeared to be thought not significant, were in fact frequently the most revealing and intriguing. They were usually interesting, sometimes frightening, and often discouraging. But they always provided intriguing glimpses into the dynamics of health care delivery.

Some of the interesting comments included things such as the following: An attending physician commented, "A depressed patient does not need one drop of psychotherapy, just medication. Psychiatrists have introduced notions of illness where there is none." A clerkship student commented, "I would like a cup of coffee, but I don't know whether to go into the doctor's lounge or not because I don't know what my status is as a medical student." On one occasion an attending physician gave the historical derivation of the nursery rhyme, "Ring around the roses, pocket full of poses, all fall down," and its relationship to the plague during the Crusades.
Some of the frightening comments included things such as the following: One afternoon when I accompanied a junior resident as he did a bone marrow procedure, I asked how often bone marrows were done. He replied, "Well, right now the majority of patients get bone marrows done because we have a new senior resident who just finished a hematology rotation, and he is interested in bone marrows, but as soon as he leaves we will go back to doing them only occasionally." It was frightening to consider that procedures which are by no means painless or without risk are done when not related to the needs of the patient. Similarly an attending physician who was exhorting the staff to be careful and compulsive noted, "Studies show that 30 to 40 percent of all hospital patients will have a drug error either in dosage, interval, drug incompatibility, etc." Incredible!

Some of the discouraging comments included things such as the following: During a grand rounds discussion of diabetic ketoacidosis one morning, an attending physician commented, "Changing of the guard (shift) kills more patients with diabetic ketoacidosis than anything else." Another morning, shortly after 10 a.m., a resident was paged to come to the emergency room to examine a woman who had come in at 12:30 a.m. and had waited all night--9-1/2 hours--to be examined. Similarly, at morning report one day, a resident was reporting on a patient who had come to the ward from the emergency room with no chest x-ray, when an astonished attending physician replied, "I just can't believe that. Everybody who comes in the ER gets a chest x-ray whether they need it or not." It's discouraging, to say the least, if, when you are sick, you get something you don't need, have to wait all night for it, and may die simply because the shift changes. Surely this must tell us something about the health care delivery system.

But that is not all. Perhaps the most interesting, frightening, and discouraging comment all combined came when a resident told of an instance to which he was a party. It seems that there was a diabetic alcoholic patient who rather predictably would come in during the wee hours of the morning on the weekend, intoxicated and having not taken his medication. The residents would wearily combat the crisis and after several days discharge the patient and wait for the next episode. Well, after very many repeats of the cycle the residents decided that there must be a better way. So the residents each chipped in ten dollars, bought a one-way bus ticket to San Francisco, told the patient about this wonderful VA hospital there, placed the patient on the bus, and have never heard from him since. Draw your own conclusions!

Now I am assuming that my experience is not significantly atypical from what one would find in any large teaching hospital in this country. Thus, I am not commenting on the institutions where I happened to be spending my fellowship time, but rather on the nature of the health care delivery system.

The experience gained in the educational component of the fellowship will be extremely useful to me as I return to my teaching duties. For example, I will be able to respond to questions with more confidence and
accuracy after having been present to experience the determination of
brain death for a patient, cardio-pulmonary resuscitation of a patient,
the stress on the staff in an intensive care unit, the stark difference
between clinic wards and private patient facilities, etc.

The research component of the fellowship consisted of attempting to
identify, and develop an effective instrument for measuring, the character-
ostiics of humanistic health care. This was soon found to be no small task,
for humanistic health care was being interpreted broadly to incorporate
the very nature of what it is to be a human being, including the character-
ostiics of compassion, dignity, autonomy, etc. Indeed, the objective of
the research component was only partially accomplished as evidenced by
Appendix I. Nevertheless, a rough draft of an instrument assessing the
level of humanistic health care provided by an institution was attempted.
It resulted from reflections upon conversations with patients, different
levels of hospital staff, and the fellowship experiences in general. I
was mainly looking for which aspects of the health care delivery as received
or given seemed to be dehumanizing and which aspects seemed to be more
humanistic. I immediately realized that considerable conceptual work
needed to be done, for if you ask five different people to define "humanistic"
you get five different answers. This conceptual work was begun and is
continuing even after the fellowship period has ended. It is anticipated
that it will eventually culminate in a paper dealing with the theoretical,
conceptual foundation of humanistic health care delivery and humanistic
medical education.

The preliminary rough draft of an instrument for assessing the level
of humanistic health care may seem rather simplistic and related to exceedingly
basic issues. But it resulted from my observation that a lot of patients
did not know important basic information about their hospitalization--such
basic things as who was their doctor, why were they in the hospital, what
was wrong with them, and what was being done for them. It seems, perhaps,
that better patient education programs would be one component in more
humanistic health care.

The significance of the research component of the fellowship is profound,
and, indeed, its potential is hard to overestimate. When an instrument
is developed for measuring humanistic health care, many questions, both
theoretical and practical, could be answered. Some of the difficult,
recurring, theoretical questions concerning an adequate, accurate defini-
tion of humanistic health care and the distinguishing characteristics
of it would first have to be answered. Equally important from a practical
standpoint would be the capability of determining what settings most
adequately foster humanistic health care. In this respect, the instrument
would lay the foundations for numerous additional studies. For example,
it would be interesting and worthwhile to compare the quality of humanis-
tic health care between private and public hospitals, large teaching
hospitals and small country hospitals, Catholic and Protestant institutions,
military and civilian hospitals, as well as comparing similar institutions
on a sectional basis of the country, such as the industrial Northeast and
the rural South. When my preliminary instrument is refined and developed
to a satisfactory degree, it will be communicated in the literature.
Increasingly attention is being given to the humanistic aspects of health care. However, virtually all of it is of a highly theoretical nature. Very little in the way of applied, practical determination of the characteristics of humanistic health care has been done. I hope to make a contribution to this area as my work continues. A good beginning has been made and a continuing link has been established, for Dr. Manning has asked me to continue my association with the Department of Internal Medicine to whatever extent my schedule will permit. Also, the Department of Family Medicine has asked me to participate in its program and lead a monthly medical ethics discussion group for residents. At the same time, Old Dominion University has asked me to develop a graduate seminar in bioethics there. Meanwhile, at Eastern Virginia Medical School I am becoming more deeply involved in the Human Values in Medicine program through greater involvement in the Human Dimensions in Medical Education project, the Behavioral Science Course, the elective program, and the greatly expanded activities of the Biomedical Ethics Committee.

In short, the fellowship has both provided me with the needed practical medical center experience to integrate with my past theoretical work in medical ethics and facilitated my greater involvement in a wide range of significant medical school activities. This alone has made it a highly successful and worthwhile endeavor even if nothing more ever comes from it. But I am confident that it will.
Appendix I
Assessment of Humanistic Health Care
Patient Questionnaire

Please supply the following information in order to help us determine ways of providing better health care. Reference to the staff includes all hospital employees (doctors, nurses, technicians, aides, etc.).

A. Fill in the blank with the most appropriate word or number. If you wish to make additional comments write in the space between the questions or on the back of the page.
   1. always  
   2. often  
   3. seldom  
   4. never  
   5. not applicable

1. I ________ feel that I can influence what is being done to me.

2. I ________ feel that the staff is compassionate and sensitive to my needs as an individual.

3. There is ________ enough information provided to me.

4. I ________ negotiate with the staff the things I can do for myself.

5. Communication between me and the staff is ________ open and honest.

6. The staff ________ respects my needs for privacy.

7. The staff ________ takes enough time to explain everything adequately to me and my family.

8. I have ________ been able to maintain a sense of dignity during the various activities of my hospitalization.
9. I _______ feel that I am treated like an individual person rather than like an item on an assembly line.

10. My hospital chart is ________ available for me to read.

B. Please answer the following questions as best you can.

1. Why are you in the hospital?

2. Who is your doctor?

3. What are several things you liked best about this hospital?

4. What are several things you liked least about this hospital?
Appendix II

Evaluation

It should not be uncritically assumed that humanistic care equals quality care and vice versa. It may be that humanistic care is one aspect of quality care. But compassion is not enough; competence is also required.

In Appendix I an attempt to look at and assess the major components of humanistic health care was made in terms of the parameters of compassion, dignity, autonomy, privacy, and informed consent. It may well be that the keys to humanistic health care are education and consent. However, other parameters must be looked at also. For instance, it is conceivable that humanistic health care will prove to be economically unfeasible because of increases in time commitments, number of personnel, inefficiencies, etc. However, if that turns out to be the case, then we should reject it for legitimate reasons that are well documented rather than for unsubstantiated fears of what it might cause. My personal bias is that we can have humanistic care and quality care go hand in hand and that in fact perhaps we cannot have total quality care without humanistic care.

Nevertheless, other parameters of quality care need to be assessed carefully. Such parameters might include, among others, average length of stay, recidivism rates, personnel turnover rates, average cost of hospitalization, incidence of drug reactions, and staff morale. For given institutions comparisons would need to be made between these quality care parameters and the earlier elaborated humanistic care parameters. My hypothesis is that environments which foster humanistic care will be found to provide as good or better quality care.

85
BELA SOMFAI

My research program at the Medical College of Georgia started in September, 1975. Consequently, it is not always possible to separate particular aspects as pertinent to the duration of my fellowship. It is with this caution that I proceed to answer the questions.

During the months of April and May I continued to attend medical rounds in Internal Medicine, completed a bibliography and course outline for a two-semester course in medical ethics, arranged two articles for publication from my doctoral dissertation (a copy was forwarded to the Institute earlier), and, following the advice of two professors, I began readings on the phenomenon of pain.

This latter part of my program proved to be more complicated than originally envisioned, and thus it will have to be carried beyond the end of my tenure at Georgia before it will provide an adequate basis for a better and more comprehensive assessment of the problem of pain as relevant for decisions involving euthanasia. It was originally in the context of ethical questions that I approached the issue.

There were several developments of my thought during this period of time. Exposure to methods of teaching in the clinical setting gave me a better idea and appreciation of case-oriented educational method. I found that this approach could be very helpful in ministerial education too, even beyond the context of the so called "clinical training."

In the area of medical ethics proper I have collected sufficient material for a two-semester course offered for nonmedical graduate students in philosophy and theology. I could also handle comfortably a similar course for medical students. In my research I have given considerable time and thought to the question of artificial life-support, and came to the conclusion that the so-called "traditional Roman Catholic position" is beset with some inconsistencies.*

The possibility of having first-hand experience on how medical decisions are made enriched my thinking on medical ethics. It became clear that the so-called "classical" functional model of man that guides physicians in their decisions is inadequate. Although I learned to appreciate and admire the anxious care for accuracy of assessments and for efficiency of procedures, I became convinced that the quality of medical care could be greatly improved if a more comprehensive vision of man became the guide for the service offered to patients. It would be therefore important to leave more room in medical curricula for ethics, humanities in general, and religious studies.

I have included below a brief outline of the two-semester course I intend to offer in the coming years.

* See Part II (Ed.).
I have been asked to write a book on medical ethics in Hungarian. Although it was not completed during my fellowship, it will draw to a great extent on the research of the last year. In other areas of medical ethics, I intend to do further research on the euthanasia question. This problem, in my opinion, follows the footsteps of the abortion debate, and will create the next conflict in political, social, and religious interests.

I have spent the whole period of my fellowship at the Medical College of Georgia. Regis College provided $4000 for living, research, and travel expenses. As indicated in my request, it was not quite enough to carry my project to the end of May. I used the stipend of my fellowship on my April-May expenses and covered part of my deficit from the earlier months.

I hope to continue my work on the medical-ethics boards of two hospitals in Toronto, broadening further my contacts with issues of ethics in medicine. Within the Faculty of the Toronto School of Theology I hope to initiate a discussion group, reaching also to the faculty of the Medical School at the University of Toronto. At the present I see no further financial assistance coming from Regis College, though it is possible that eventually we can get financial assistance from the Canada council for a center of medical ethics.

A program for medical students is already available through the undergraduate department of Philosophy at the University of Toronto. I see no possibility of competing with that service, but I hope that through some of my students I will be able to influence the ethical training of nurses in the nursing school of George Brown Community College.

First Semester - ETHICAL PROBLEMS OF LIFE AND DEATH:

A theological evaluation of the value of human life, and its application to ethical issues connected with birth and death. Biogenetics, abortion, birth control, euthanasia, the theological and pastoral problems of suffering, dying, and death. Lectures, seminar discussions; one research paper and final examination.

Second Semester - ETHICAL PROBLEMS OF MEDICAL SERVICE:

PART II

THE PAPERS
The placebo effect, until a few decades ago largely ignored, has recently been studied extensively but has not been subjected to philosophical scrutiny. Three philosophical issues are treated in this dissertation: (1) the meaning and breadth of the term "placebo effect"; (2) implications of the placebo effect for the mind-body relation; and (3) ethical problems regarding clinical use of placebos.

The medical literature on the placebo effect depicts a very powerful phenomenon that holds the power to change a wide range of symptoms and pathological conditions and that can be invoked by a wide variety of agents. Its total incidence among a group of subjects is roughly predictable from study to study, but attempts to identify a "placebo reactor" personality type have been elusive; it seems that situational variables such as setting or physician behavior are more important than individual personality differences in determining whether a placebo response will occur. Theories put forth to account for the placebo effect include mentalistic (expectation) theories and behavioristic (conditioning) theories, as well as some attempts to account for the placebo effect in cultural or symbolic terms. Medical authors have tried to define "placebo," but never in formal and rigorous fashion; hence this problem must be dealt with first.

The placebo effect might be considered as an anomaly (in Thomas Kuhn's use of the term) from the standpoint of the currently dominant paradigm of medical science; anomalies can either be dismissed as nuisance variables or else can be used to challenge the comprehensiveness of the paradigm. Thus, the placebo effect must be analyzed against the background of this paradigm.

Consideration of illustrative case examples reveals that we wish to apply the term "placebo effect" in a context broader than that indicated by the use of inert treatment modalities; we want to speak also of a placebo effect accompanying the administration of a pharmaceutically active drug. But we also want to restrict the use of the term, excluding both situations where an accepted pathophysiological or pharmacologic theory will explain the results more readily, and situations that do not take place within a "healing context" (which is a culturally relative construct)—otherwise all cases of self-fulfilling prophecy or autosuggestion might be labeled as "placebo effects." We also want to consider the subject's belief state, in that it would be paradoxical to say that one had taken a placebo if, e.g., someone slipped a sugar pill into one's coffee without one's knowledge.
These considerations suggest the following formal definition: The placebo effect occurs for person $X$ if and only if:

1) $X$ has a condition or symptom ($C$)
2) $X$ believes that he is within a healing context
3) $X$ is administered intervention ($I$) within that context, where $I$ is either the total active intervention or some component of that intervention
4) $C$ is changed
5) the change in $C$ is attributable to $I$, but not to any known specific therapeutic effect of $I$ or to any known pharmacologic or physiologic property of $I$.

This definition contains two important epistemic elements. The first refers to the belief state of the individual; the second refers to the belief state of medical science, insofar as which pharmacologic and physiologic properites are currently explainable.

One may next ask which views of the mind-body relation seem most illuminating when applied to the placebo effect. Promising mind-body theories include behaviorism (classical conditioning theory), causal interactionism, and identity theory. But behavioristic accounts appear to be inadequate for fully describing belief states, which play an important role in our definition. The other two theories give adequate accounts of the placebo effect, but raise other problems--intersectionism in the areas of psychophysical causality and the other-minds problem; and identity theory in the area of the adequate characterization of the contingent identity relation.

A more sophisticated mind-body theory, which also accounts adequately for the placebo effect and which avoids these philosophical problems, is eliminative materialism. This theory gains its power by attempting a radical reconstruction of our present mentalistic view of the world, instead of trying to explain that view in commonly accepted terms. But this radical reconstruction can be achieved only at the cost of abandoning our present "form of life" and network of interpersonal attitudes--including the attitudes that underlie our moral thinking. Thus a plausible mind-body theory that does not require this radical shift would be preferable to eliminative materialism.

All the mind-body theories discussed so far presuppose the Cartesian dualist tradition. But Strawson has suggested an alternative to this approach by taking "person," rather than "mind" and "body," to be the primitive concept. One way of fleshing out the "person" concept is suggested by Anthony Kenny and Marjorie Grene, whose views I have combined and labeled the "capacity theory" of the person. By this theory, one of the capacities that a body might possess is the capacity to acquire the ability to use symbols in such a way that one's own activity confers meaning upon the symbols; bodies that possess this capacity are persons. Since to use symbols in this way is to be a dweller within culture and a user of language, a person is by nature at once a biological organism and a cultural-linguistic being. Thus a phenomenon in
which cultural context influences the state of the body, such as the
placebo effect, ceases to be an anomaly and becomes understandable. The
"capacity theory" also has a number of interesting philosophical implica-
tions for other mind-body puzzles, including self-consciousness, the
possibility of disembodied minds, and possible construals of psychophysical
causality. It raises questions regarding reductionism in its explanations
of mental phenomena, but these questions do not seem to be insurmountable.

The ethical issues surrounding therapeutic use of placebos have been
debated by physicians for more than a century. Defense of placebo use
usually emphasizes the efficacy of placebos and the supposed absence of
side effects. Objections to placebo use generally take the form of util-
itarian or deontological arguments against deception. The debate, however,
has seldom placed sufficient weight on possible alternatives to placebo
use; in this regard it is significant that the formal definition of "placebo
effect" makes no mention of "placebo." This implies that a pharmacologically
inert substance is not needed to elicit the placebo effect. Nondeceptive
means of eliciting the placebo effect, such as emotional support and
increasing the patient's sense of control over symptoms, need to be explored
farther.

These philosophical inquiries suggest that the best model of the placebo
effect for guiding further empirical research is the "meaning model" of
Adler and Hammett. This model focuses on the meaning of the illness expe-
rience for the patient, where meaning is a function both of a culturally
acceptable explanation for the illness and of social support by a care-
giving group. This model suggests research on cross-cultural features
of the placebo effect; symbolic features of illness from the patient's
perspective; other impacts of "meaning" on health such as life-change
correlated with disease; and similarities between the placebo effect
and psychotherapy. The model suggests in particular that the mere act
of diagnostic labeling should frequently be considered a therapeutic
intervention in and of itself.

This discussion of the placebo effect has touched upon conceptual,
mind-body, and normative issues, with the aim of placing these three
issue areas in juxtaposition so that they will prove to be mutually
illuminating. The goal has been to seek a "reflective equilibrium"
(John Rawls' term) rather than a deduction of results from basic prin-
ciples or assumptions. An area that could be explored farther from this
viewpoint is how the concept of "person" arising from the capacity theory
of mind compares with the notion of a person as a bearer of rights and
interests in ethical discourse. This investigation, then, may serve in
a small way to indicate important features of the new subdiscipline of
philosophy of medicine. Given the way medicine overlaps the empirical,
ethical, and metaphysical realms, philosophical consideration of important
medical issues can seldom be restricted to one of these areas to the exclu-
sion of the others.

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93
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Dying is not an event, it is a phenomenon to be understood existentially.

Heidegger

Death is big business for philosophy these days. I know of no era in which more people have written more words on the subject—and with so little effect. For all the words, people keep dying in much the same old ways they always have. War, pestilence, famine, and simple old age take their toll, so that—in the end—we break even. Excluding the present generation of the living, there has been for every historical person one death. Theologically debated exceptions I will not cover here.

If these initial remarks ring of callousness, flippancy, cynicism, so be it. They illustrate a point (perhaps the point) I wish to make on the subject of death: Death is not just an event, the end of events, a change of state or status, an attitude toward eternity or nullity; it is also an attitude toward life. As such it has implications for how we live, how we treat those about us in a myriad of circumstances, how we perceive the world in which we live. In what follows, I shall try to show how this works or might work by explicating some thoughts out of Heidegger and Sartre. Then, I shall suggest some ramifications for care of the noncritically ill. My only excuse is a penchant for looking over the overlooked: first, death as an attitude toward life is and has been the least mentioned aspect of the subject; and second, the noncritically ill have yet to have philosophic eyes turned upon them.

Although I could take the last statement as a primitive of this paper, an indirect case for it may prove instructive. What sorts of questions have philosophers and their partners in verbal mayhem been asking of death? First, what is death? In its rawest metaphysical form, the question seeks out a descriptive formulation of death, and raises quibbles over the descriptions. See, for example, Wittgenstein's denial that death is an end, in the Tractatus. Second, what is beyond death? Presupposing, as this question does, that it makes sense to speak of "beyond death" (even to asserting as an answer "Nothing!"), the normal range of Western replies has spread over three regions: (1) personal immortality, (2) special immortality, and (3) annihilation. If I mention Plato, Aristotle, and Epicurus in matched pairing with these categories, I do no more than hint at a long line of philosophers who have blindly followed their respective leads.

Third, we have asked how we should approach death. Foremost among our attempts has been the effort to overcome the fear of death, and here we encounter subtle differences of tone. Contrast Epicurus with Nietzsche:
So death, the most terrifying of all ills, is nothing to us, since so long as we exist death is not with us, but when death comes, then we do not exist.\(^5\)

From love of life one should desire a different death: free, conscious, without accident, without ambush.\(^6\)

Fourth, we have asked for the meaning of death—as if death should and does have a significance apart from our attitudes toward it. “Throughout man's history,” writes Feifel, “the idea of death has posed the eternal mystery which is the core of our religious and philosophical systems of thought.”\(^7\) Yet, only a few lines earlier he had written that the "critical question is . . . how each one of us relates to the knowledge that death is certain."\(^8\) The end result is a volume split between philosophical ruminations and behavioral observations. From the outside, we get the social and psychological structure of death activities, meaningful, but not a clarification of the mystery of death's meaning.\(^9\)

If we cannot find the meaning of death, perhaps we can at least find the meaning of dying. Kubler-Ross categorized the five stages of death, conceptualizing the transitions of Ivan Ilyich into stair-steps. The result: we avoid the question of death by watching people die.

Finally (for our survey must have limits), we deny death, and as odd as it may seem, thereby do we come closer to opening a new door to death. Kierkegaard hinted that the door was near: “Death is by no means the last thing of all, hence it is only a little event within that, which is all . . . .” At the same time, "Humanly speaking, there is hope only so long as there is life."\(^10\) From this point we find two trails. One concentrates on the substance of the idea and ends with Camus' plea to ignore the Christian sides of Kierkegaard's dialectic, and to live where "there is not further place for hope."\(^11\) The second trail leads to where we would explore in this paper, to the reassessment of the role of death in living—not just near the end when the arteries harden, the heart jumps, and coldness creeps inexorably from the extremities to the trunk, but throughout the middle of our lives.

This little survey of death questions has not touched on a number of matters that philosophers from time to time interrogate. Euthanasia—active and passive—funerals and grief, death penalties, genocide, suicide: all are fascinating, and perhaps that is their chief distracting fault. We invite them to blind us to the place of death in living. But then it is the nature of most of us to take ourselves so seriously that we cannot bear to look at more than our fringes. Heidegger was not afraid to look deeper.

II

Heidegger and his interpreters have long debated whether Being and Time promotes and encourages a change in our lives so as to embody authenticity of Dasein, or whether Dasein and its contrasting
modes of "fallenness" and "everydayness" represent mere descriptive categories. Rhetoric alone—in the contrasting pejorative content of the "authentic" and the "fallen"—would find for the ethical prosecution. Nonetheless, it is often instructive to read Being and Time in a descriptive mood; to do otherwise is to miss some of Heidegger's more valuable insights. (It is, for better or worse, often the case that a philosopher's most valuable observations occur outside the boundaries of his cherished positions and arguments.) "Freedom toward death—a freedom which . . . is factual, certain of itself, and anxious" has been treated and criticized on one of two grounds:12 (a) it is an ethico-metaphysical notion more or less adequate for a coherent system of thought positioning man in the universe, or (b) it is a product of a psyche having certain fears about death.13 What is lost in these sorts of judgments is any sense of subtlety in attempts to interpret freedom toward death in its interrelationships with other attitudes or modes of looking toward death.

Death, for Heidegger, is a part of living. It is a function of the most authentically human sort of living, or Dasein, but, as well, it is a function of other modes of living. What sort or mode of living one has taken on either determines or is determined by (depending upon one's purpose in determining) one's response toward death. Whether one does metaphysics or psychology sets the order of investigation. If one does neither, the problem disappears. Death does not.

Yet death is not an end and certainly not simply the end. It is not a stopping, a fulfilledness, a finishedness, or a disappearing. "By none of these modes of ending can death be suitably characterized as the 'end' of Dasein."14 To the extent that the living individual is by nature forward projecting, a teleologically oriented existent, then death must be put into a framework compatible with that nature. For the living individual, death is a present thought and reality; yet it does not present itself now as an accomplished fact. Hence, all present reality of death has the character of a "not yet." Unlike commonplace ends we either reach or strive for—ends such as the termination of winter or the earning of our first million—death is (a) not lived beyond and (b) is ever present. Hence, Heidegger notes that instead of taking death to be a goal or an event, we should view it as a "Being-towards-the-end of this entity. Death is a way to be, which Dasein takes over as soon as it is."15

What is clearest in Heidegger's formulation of death for the living is that the view developed must be consistent with the nature of living itself. In a respectable but often overlooked heritage from Aristotle through Leibniz to Hegel, Heidegger views the existing individual as teleologically oriented. Only such an orientation makes sense of certain facets of the way in which we look at, approach, and operate upon the world we encounter. We find ourselves "there" within a world. In part, that world is tough, resistive to our efforts to grapple with it. It is merely there or factual. Yet, we try to understand it, work with it, and take attitudes toward it. All of these—without priority of one over the other—form the basis of our knowledge. The living individual "is constituted by disclosedness—that is, by an understanding with a state of mind."16 The coordinateness of knowing,
doing, and making in this view lends greater stress than in most writers not just to the temporal dimensions of a forward-looking view of life, but as well to the active involvement of the individual in living forward. Living is an unfinished business in which there is "constantly still something to be settled," a possibility, an anxiety over its indefiniteness. And to the extent that death is a natural and necessary part of living, it must share these characteristics.\textsuperscript{17}

Thus, it is no surprise (or should not be one) that Heidegger characterizes "Authentic Being-toward-death" as an "own most nonrelational possibility." Unlike things that are "ready-to-hand" or "present-at-hand" to which we are related in producing, preparing, or readjusting, death belongs to, is a possibility of (and not for), the living individual.\textsuperscript{18} Wherein does that possibility lie? That is, in what sense is death a possibility? "As something possible, [death] is to show as little as possible of its possibility."\textsuperscript{19} At this point Heidegger rejects the notion of attempting to actualize the possibility of death (suicide) since that would destroy our ground of being, our nature as forward-projecting individuals. Too, he rejects the idea of "expecting" or "waiting for" death, since expectation involves an understanding of what we expect in terms of "whether and when and how it will be actually present-at-hand."\textsuperscript{20} Death may only be "anticipated."

Anticipation of death is expressed and explicated by Heidegger in terms of death's characteristics for the authentically living individual. It is undeniably one's own ("ownmost"), nonrelationally an aspect of oneself (not a possession), not to be evaded in immortality ("outstripped") about which finite mortality discloses nothing, certain--not by "evidence," but by the nature of ourselves--and yet indefinite as to the time, place, and circumstances of its occurrence. Anticipation of death "utterly individualizes" the living individual, who finds himself "face to face with the 'thought' of the possible impossibility of [his] existence."\textsuperscript{21} Thus, "being-towards-death is essentially anxiety," "the state-of-mind which can hold open the utter and constant threat to itself arising from [one's] ownmost individualized being."\textsuperscript{22}

III

The consequences of this much of Heidegger's view are both considerable and limited. Let us sample. First, authentic living is also anxious living. Rather than being a characteristic of a pathology, anxiety in the sense noted herein becomes the mark of a desirable mode of living. Second, the understanding of death here given is both cognitive and emotive, a joint product and function of knowledge and attitude. It is a fit content for the expression "living with death," if the death with which we live is our own and not the death of others. Third, the characterization applies only to "authentic" living, not to ordinary, normal, or any other form of living. There is no guarantee that authenticity is either statistically typical of our population or temporally typical within the life span of any individual.
This last point suffices to justify an exploration of "nonauthentic" modes of understanding death or of living with death as one aspect of our existence. What Heidegger takes as primitive is that the living individual, by virtue of being a living individual, does live with his own death and is anxious over it. Here, anxiety is not to be equated with fear anymore than living with one's own death means self-consciously facing up to our finitude. Having been thrown into life, we are equally thrown toward death. That many "do not know about death" does not contradict the universality of being-toward-death, but only indicates the mode of that being, as in the effort to flee in the face of death. If this point can be made with respect to individuals, it is perhaps equally true temporally: even if death appears of no concern to an individual at a given time, it is a part of his way of life at every instant.

For we do not (ordinarily) live authentically at every instant (if at any instant). If in moments of lucid self-reflection we rise to heights of authenticity, the bulk of our lives—as when we write down our referential footnotes, brush our teeth, buy an automobile, or luxuriate on sheets of lovemaking—is taken up in what Heidegger calls "falling." More expressly, it is constituted by taking the attitude, appropriate toward others, toward ourselves. "But the Self of everydayness is the 'they.'" The "they" of everydayness is the "public," the unidentified and unidentifiable impersonal voice found in "idle talk," the accepted wisdom and presuppositions of an age, a culture, a place.

"Everyday Being-towards-death is a constant fleeing in the face of death. Being-towards-the-end has the mode of evasion in the face of it—giving new explanations for it, understanding it inauthentically, and concealing it." Implicit in the evasion are three distinguishing marks. There is the "temptation" to cover up death as one's own possibility by immersion into the generality with which I began this paper: everyone dies. Under this cliché, death becomes an actuality, fit for study by any number of disciplines. My death—as a potential to be lived at every moment—becomes concealed by the public event of representative deaths.

Such a view does not necessarily breed a hardness in humans toward death. We console the dying with talk of escaping death. In fact, we console ourselves with this "constant tranquilization about death." This second mark of our evasion signals the effort to remain carefree in the face of death. "Indeed the dying of Others is seen often enough as a social inconvenience, if not a downright tactlessness, against which the public is to be guarded." The public "they" would not even have us think about death. "It is already a matter of public acceptance that 'thinking about death' is a cowardly fear, a sign of insecurity on the part of the living individual. As we cultivate a superior indifference toward death, we alienate ourselves from a natural and significant portion of our potential. This alienation is the third mark of our evasion.

None of these marks is unambiguously given in public talk and
wisdom over death. Nor are these marks exhaustive of the evasions. Indeed, it is possible to evade death by meeting it head on in our convictions about it. We may be certain that death is coming, that is an "undeniable 'fact of experience,'" and still be evading death as a certainty of our own lives. Moreover, since Heidegger wrote in 1927, death has become a well-worded, if not wordy, subject. One has to wonder how many of the words represent merely an inverted evasion technique bred of our self-consciousness of our former silence. Are we merely talking death back to sleep?

IV

In all of post-Heideggerian philosophy there is perhaps only one set of relevant arguments in criticism of "Being-toward-death": those of Sartre. If I am to sustain this position, we shall have to look further into the structure of Heidegger's case, as well as into some small correlative matters.

Unlike those critics of Heidegger who attack "Being-toward-death" as ethically or metaphysically inadequate or as a product of mere fear, Sartre attempts to come to grips with the relationship of death to living individuals. And he concluded "in opposition to Heidegger that death, far from being my peculiar possibility, is a contingent fact which as such on principle escapes me and belongs to my facticity." In other words, death for Sartre lies outside the living individual, the "ontological structure of the for-itself." It functions not as an integral aspect of living, but as a "permanent limit of my projects." It is not an obstacle to those projects, but instead a "destiny of those projects elsewhere." The "elsewhere" noted here is the Other, the remainder of mankind.

Sartre's counterconception of death rests upon death's absurdity. Otherwise put, "Death is never that which gives life its meanings; it is, on the contrary, that which on principle removes all meaning from life." Moreover, it represents a triumph of the point of view of "the Other" over "the point of view which I am toward myself." Viewed thusly, death ensures that the perspectives which other persons take toward me are privileged with respect to determining what I am. "To be dead is to be a prey for the living." While living, the attitudes and perspectives of others toward me can be held in abeyance by my freedom to choose ends and to make of myself what I am. Death, on the other hand, "alienates us wholly in our own life to the advantage of the Other."

Nonetheless, death marks no limit to our freedom for Sartre. "Since death is always beyond my subjectivity insofar as it lies outside me as part of my facticity, there is no place for it in my subjectivity," in myself as a freely acting human. It may cut off my projects, and the possibility of my projects, but it does not limit them.

The critique of Heidegger that flows from this position, though
somewhat scattershot,39 focuses upon "waiting" and the "Other" for its force. Sartre argues that death cannot be "waited for," since this concept belongs only to a "determined event which equally determined processes are in the act of realizing." "To expect death is not to wait for death," for expectation includes the "unforeseen, unexpected impediment" that may have to be accounted for without losing its indeterminate nature. Hence, there can be no project "toward my death," since "death cannot be my peculiar possibility; it cannot even be one of my possibilities."40

Heidegger, of course, had already rejected the notion of "waiting for" as applicable to death on exactly the same grounds as Sartre. "Waiting for" applies to that which one can conceptualize in its actualization. Heidegger's term for one's relationship to death is "anticipation," which implies holding death always as a possibility. "Death, as possibility, gives" the living individual "nothing to be 'actualized,'" nothing which the living individual, "as actual, could itself be."41 Thus, where Sartre speaks rightly, he does not speak contra-Heidegger.

Sartre's appeal to the Other contrasts his view, that death gives power over us to others, to Heidegger's position that his own formulation of death frees the authentically existing individual from the "they" of the public. The difference between the two positions lies in the conception of "death" which is employed. For Sartre, there is only the "dead life," the post event-of-death life which the remaining members of mankind may stand over as guardians or alter by any means from reconstruction to forgetting. "The dead life does not thereby cease to change, and yet it is all done."42 In short, Sartre is concerned with "my existence after death" (although nothing of an afterworld outside this world is implied).43 Heidegger is precisely not concerned with existence after death, but rather with death as "something that stands before us--something impending."44 Only in this form—or within these conceptual limits—does death present itself as an aspect of our lived existence. Indeed, to the extent that Sartre concerns himself with a conceptualization of death that "alienates us wholly in our life to the advantage of the Other,"45 he is to Heidegger's way of thinking "fleeing in the face of death" to a "superior' indifference."46

It would do no harm for the present to let the issues remain moot. Heidegger's defense of his own views is but a reflection of the total structure of his argument, a consequence of the form his case takes. The characterizations of authentic modes of living might well be reversed in rhetoric, although it would still follow that a self-consciousness of death as an anticipated but unrealized end of existence would attach itself to the individual existence postulated by Heidegger.

What remains of the structure is a certain assumption (for metaphysics) on presumption (for ethics): whatever the mode of living—authentic or not—the living individual carries with him an anticipation of death. And he carries it not just in case death approaches imminently, but in every activity of life. In point of logic, such a position must exist in every system within which there is a dialectical
interplay of being and nonbeing or nothingness, if life or living is associated with the former and death or dying with the latter. What emerges thereupon is a remark consistent with both Sartre and Heidegger: "No internally coherent policy or commitment whatsoever is rationally precluded by man's understanding that he must die." In short, "the significance of death is purely formal, has no doctrinal content at all."47

Anticipation of this position goes back at least to Seneca, whose thoughts on death can be divided into formal and doctrinal parts. Formally, we have this: "Who does not have the will to die, does not have the will to live, for life has been given to us only under the condition of death."48 That Seneca hoped for eternity and thought humans innately evil makes little difference to the formal point. Similarly, one can distinguish formal and doctrinal elements in the early psychoanalysts, especially in Freud's opposition of "the sexual or life instincts" on the one hand with "the ego or death instincts on the other."49 That Freud's theorizing should have a strong mechanistic element (instincts are defined as urges inherent in organic life and the search for them related to work on unicellular life) belongs to the doctrinal dimensions and inclinations of his thought. And, oddly enough, though Freud in 1920 characterized Jung's theories as "monistic," Jung himself wrote by 1934: "From the middle of life onward, only he remains vitally alive who is ready to die with life."51 Seneca reappears, at least for the over-forty crowd.

The confluence of ideas on the dialectical relationship of living and dying--antique in origin, flourishing again between 1920 and 1934--disintegrated in the 1940's with Sartre's attack on Heidegger. What remained amounted to reorientations toward the central assumptions so as to obscure the main point. Yet, when pressed, Heidegger yields a too little appreciated case for the coordination of living and dying within the attitudinal framework of the living individual. Moreover, he bequeaths us a collection of concepts sufficiently large to allow for subtlety in the range of possibilities for understanding various ways in which the dialectic can be worked out by individuals as they face situations of a significant order.

Precisely because Heidegger's account has utility in this regard, it surpasses Sartre's. Whether dealing with authentic existence or with fallenness, Heidegger provides clues that can be developed into insights into human mentalities as they are concerned with death. Sartre--and other writers within the same general tradition--leave us little with respect to the analysis of the multiplicity of ordinary individuals who do not meet the ideal terms of authenticity. While these ideals, assuming they meet the test of criticism, supply existential goals not to be underestimated in their significance, they leave us emptyhanded in our efforts to understand better the everyday. In his analysis of fleeing death, Heidegger provides possibilities in just this arena. It is to these possibilities and their ramifications I next turn. If I depart from a strictly Heideggerian standpoint, it is in the interests of (a) finding a method by which to exploit these
possibilities and (b) suggesting applications to a general area of medical ethics as the concluding focus of this paper.

Recuperative care for patients suffering nonfatal illnesses or undergoing routine surgery provides for all necessary biomedical and physical ingredients. Yet, even within the same institution, recovery rates vary. Normal empirical procedures demand a search for intervening variables. Inevitably, the variables sought are biomedical and physical. It would be considered abnormal and unreasonable to look elsewhere for elements that intervene in the recovery from ordinary illnesses and procedures.

Yet, the material developed so far in this paper suggests that there are areas outside the purely biomedical and physical within which to find new opportunities for rendering care. It is a truism that attitude affects recovery rate. Accepted wisdom notes that a positive confident attitude speeds recovery. A sense of goal or cherished duty on the part of the patient leads him to leave his bed and resume normal activities more quickly than a depressed, pessimistic, directionless counterpart. Such generalities as these cover the entire range of recuperative ground from headaches to pneumonia. Perhaps O. Henry captured it best in the words of Johnsy's doctor in "The Last Leaf":

I will do all that science, so far as it may filter through my efforts, can accomplish. But whenever my patient begins to count the carriages in her funeral procession I subtract 50 percent from the curative power of medicines. If you will get her to ask one question about the new winter styles in cloak sleeves, I will promise you a one-in-five chance for her, instead of a one in ten.

Accepted wisdom does not go far enough. If Heidegger is right to any degree whatsoever, the attitudinal aspects of recovery, even in cases where fatality is not in question, run far deeper into the value systems, outlooks, and philosophic perspectives of patients than anyone has thought to examine. The situation is especially unexplored for noncritical cases. For terminal illness, dangerous surgery, and experimental procedures, a vast body of both authoritative and suggestive literature now exists to guide new ideas in dealing with patients. Kubler-Ross's work both in dealing with dying patients and in the analysis of the phases of their changing mentalities is one sort of landmark. Team treatment of cancer patients with patient-family and medical team groups conducted by the East Tennessee Cancer Research Center is breaking ground in another direction. In these and other novel care methods, the full patient again is coming in for care, even to depths of philosophic perspective the patient had not been previously aware he had.

Again, if Heidegger is even partly correct, important new thinking about recovery care for noncritical cases could now be going on. For such patients too have more than a passing stake in life and death,
and possibly in ways that might affect the means and types of care rendered. To establish this as possible, I shall offer a few hypothetical cases. If any one of them is plausible, the next step will belong to those equipped to translate logical possibilities into empirical data. Perhaps enough models of care systems already exist to translate such data and the philosophic tenets underlying it into concrete action.

It follows from the concept of "Being-toward-death" that not merely attitude in the sense of personality and demeanor informs one's handling of death's possibility. Integral to it is also a conception of death and the role it plays within one's life pattern. Few, if any, can or would consistently hold death as an open possibility without face or form or function. Instead, the fleeing in the face of death that Heidegger so briefly and inexhaustively describes can be expected to take on many physiognomies. Just as Nietzsche's "bad conscience" of Western man bedecked itself in positive goals and values, so too we may expect ordinary humans living with or beside death to wear masks that smile as well as frown.

Nor could I claim, given the earlier position that rhetorical approval is to be avoided, that such masks are unnatural or bad. Three facts mitigate against such a view. First, although one may admit that "authenticity," "good conscience," and like are conceptual possibilities, it is a far move from that point to instantiating them among living individuals. Even Kierkegaard confessed he could not sustain his religiousness (nor, he suspected, could anyone) at every instant; the stairsteps between stages on life's way were well worn from stepping and leaping both up and down. Second, we grow up wearing a mask. Call it culturization, socialization, or what you will, but the process of achieving authenticity and good conscience always involves removal of a mask. Whether this entails the experience of Camus' creeping Absurdity, Sartre's sudden nausea, or Nietzsche's leonic nihilism, the unmasking procedure is integral to the subjectively new individual. I am not sure we ever have a right to demand this painful process of anyone; more relevantly, I am sure we cannot expect to encounter many who have been through it.

Third, even if we could be sure there are others who live "authentically" and in "good conscience," we could not recognize them upon passing, whether in the light of noonday or in the dark of night. There is a principle, as old as Dostoyevsky's police investigator, that goes: "This damnable psychology can be taken two ways!" Otherwise expressed, that point is this: philosophic analysis of human mentalities must always allow the possibility that for a given set of behavior, there are at least two diametrically opposing rationales that will explain it. And--they may sometimes operate simultaneously. It is for this reason that the practical task of understanding a fellow human being--whether our purpose be therapy, friendship, or some other--must ever remain an art whose key element is sensitivity.

The task herein is to suggest mentalities, and that requires a method. Heidegger has noted that one in a state of fallenness with respect to death flees death. But he has not told us how and where
such a one runs. How is one to guess? The answer, I think, comes from Nietzsche and the conception of "bad conscience." Traditionally treated as a doctrine of historico-philosophical significance, bad conscience has another potentiality that has been too little understood, even by those perceptive writers who have used it. The potential is as a method for the analysis of possible human mentalities as they live in situations. Began Nietzsche, "All instincts that are not allowed free play turn inward. This is what I call the man's interiorization." Thus are instincts transformed into a "secret violation of the self." Thus arises also the eternal tension of man with himself, for the instincts and their outward force remain while inwardness and defeat of the instincts become the goal. We are split from both our present selves and our past. Indeed, in an example of applying the principle of reversal to an advanced state of affairs with civilized man, Nietzsche traces the origins of the gods. Out of fear of the "ancestor and his power," the gods are created; later, guilt ennobles them. In short, we embrace, enshrine, and ennable that which we fear most. (It is little wonder, on this account, that the proclaimed worth of the individual has steadily increased in eras of the West when his active sociopolitical place grows less.)

What we have, then, is a clue--Heidegger and the fallen modes of living with death--and a method--Nietzsche's principle of reversal. From such sources as these something useful perhaps can emerge for the place of death in the lives of the living. It must be remembered, however, that while clues and principles can produce mentality types, only sensitivity holds potential for the understanding of living individuals.

VI

Let me sketch several possible types for whom sensitivity may be essential in recuperative care from noncritical illness.

If the inability to hold death as an open possibility yields fear and flight from death as its first fruits, then flight from fear becomes a second season's produce. This flight leads straight back to death, as something to be embraced and desired. It is only resisted so long as one has other, more pressing duties. When those duties are done, death's call rings ever louder. Not even a "heaven" is needed as a utopian goal or release from pain. Indeed, a "heaven" would only confuse matters, for essentially, one's existence is earthbound, and death is simply a personal termination.

Yet life goes on in the family. One has transferred skill, wisdom, and being to one's heirs. By middle age no more is left to do. More important, no more is left to be. What one is (or was) survives in the heirs, is in the heirs. One is empty, and death is welcome. Such a view coincides with species survival views of death, but is not a reasoned position. It is the framework of living for an existing individual. As foreign to youth, especially urban youth, as such a situation may be, its setting in rural families rooted to a timeless working of the land suggests there need be no discord between human mentality and sociophysical surroundings.
Disease or surgery at middle age, however noncritical, works as a trigger. It signals that the time has come. Colloquially, the children are grown, settled, and have produced the first grandchildren. They are "out on their own" or can "take over the place." No more is needed; all has been done. Death at this point is timely and appropriate, not so much desired as welcomed. Yet physically, death is not to be. The assault upon the body was not severe enough to bring an end. But the end is expected. What this implies for recovery depends a large part on the soundness of the body and the efficacy of treatment. Yet there is a war going on between body and soul. To the extent that death is more expected than hoped for or desired, the warfare may be the more drastic. Should physical recovery be complete enough, one goes home to what is no longer home. The trigger has discharged one's drives, one's need to have drives. No more is required. One sits in a corner, rocking away time, pursuing the idle, awaiting a death that is already late. Heart attacks, it seems to me, make perhaps the most dramatic of triggers.

A second type may be yet more common. We live a childhood em­bedded with conflicting pictures of death. The horrors of the grave drive us to flight, more in panic than fear. Yet simultaneously we are drawn toward a field of bliss and a loving Father in heaven. We flee not so much from death as from a certain kind of death, the one that is promised as the wages of sin. Our sins must be fully atoned here on earth if the terrible side of the unknown is to be escaped. At the same time, our world has lost most of the credible means of atonement. Scapegoats, authoritative forgiveness, and other means of cleansing ourselves are no longer effective; we must cleanse ourselves—and we cannot. We can forgive everyone but ourselves.

Affliction of the body becomes, in a relatively comfortable world, the only sign of atonement. For left to ourselves and our own devices, we must picture the cleansing process as painful, as a searing away of the evil. That evil be of the flesh only adds fuel to the fire. The fires of purgatory and the fires of pain become one. Placed into the medical situation, such a one as this can be a significant problem. If treatment is too quickly effective, an individual feels cheated. Atonement has not been fully achieved. If treatment is too comfortable, one is doubly cheated. It is supposed to hurt and to hurt for a long time. One may return again and again for follow-up treatment or with "new" afflictions. Yet, if treatment is just right—just long enough and painful enough—the patient may return again and again after commission or memorial realization of each new sin.

Such a one can make of the physician a god, and of his staff flights of healing angels. But these troops of heaven are not ex­pected only to be agents of mercy; they must first be avengers. One must earn mercy in the fires of pain. It is no accident that medicine has inherited this religious role. The role belongs to the heritage of medicine, when the shaman was healer of mind, body, and soul. Upon his work depended one's personal immortality. And he was, for love of his people, often ruthless in inflicting pain. The demise of other means of self-atonement brings medicine again to the fore, though per-
haps only in degree for a dependence that has never been completely absent.

If these sorts of mentalities toward death seem overly dramatic, there are others derivable from Heidegger's insights and Nietzsche's methods that seem far more calm and normal. The patient seems cheerful, yet it is not the exterior with which one here deals, for equal exterior may hide opposing interiors. The distracted, listless, middle-aged family man may simply be energyless. The dependent recurrent patient may indeed suffer new and wholly physiological ills. And the cool surface of the cheerful may hide a boiling cauldron of mental life. Again, I am not doing psychology here; rather I am following the course of an idea, even if it must touch human potential.

Why is this man smiling? Perhaps it is because he is not himself. Whatever he is has been displaced by his flight from death. If death is dreaded sufficiently for what it is, a hopelessly unknown "I know not what," our defense may be either to make of it a beautiful fulfillment of all we desire, or to make of it nothing. Either course takes away the dread, makes it meaningless. Yet, two considerations follow. First, concrete pictures of death and its beauty are difficult to sustain in a technical, pluralistic, sceptical world. Hardly anyone has the individual hardness to get away with believing in Valhalla. No one shares our belief, our picture. No one reinforces it. Far easier is it to sum up all the pictures we receive and perceive into a nullity. The temptation then is to see death as simple annihilation. Second, dread is not so easily put aside. It does not disappear with a simple change of our conceptualizations.

Instead, we overcome dread by embracing the thing dreaded. In simple matters—as in scary antics of physical prowess—we do so in the name of adventure. In war, we lunge headlong into battle. Illness and treatment, however, are far more subtle. They are dangerous to an unknown degree. They carry annihilation with them. To embrace them, we must prepare, and preparation means setting aside all else. We place ourselves in the hands of those who treat us. In short, we give up our will. We alienate ourselves from ourselves in the sense of being whatever is required. We are already annihilated. Cheerfulness is the face of nullity. If we die, that is all right, since we are already dead. If we live, that too is all right, for in having put ourselves aside, there is nothing by way of problem, trouble, or concern to disturb our thoughts. Whether the recuperation is long or short, we tranquilly meet it a moment at a time. There can be no disturbances where there are no concerned or caring thoughts.

The interface of such a mentality to physical recovery is uncertain, more uncertain perhaps than the general uncertainty that marks this whole arena of thought and knowledge. To whatever extent freeing our organic systems of psychic interference may aid recovery, perhaps this man has cause to smile. To whatever extent a positive desire for health may be necessary to full recovery, the smile may mask a tragedy. In either case, we must remember that displaced dread unlike displaced water, does not flow somewhere else. It lurks in and through one, surrounding the individual's cheerfulness in a dark
frame. In what way and when it will emerge, this partial portrayal cannot say.

The casting of types could be extended both in detail and number. Besides the spatial limits of this paper, the uncertainty of the starting point gives reason to curtail the task. To the extent that Heidegger's insights into the significance of death for the living have any merit, they force us to think through the many masks death wears in noncritical as well as critical medical situations. Each has the marks of temptation, tranquilization, and alienation, and perhaps there are others worth discovering. In any event, it is also worth remembering that each of these and of many other types one could generate are normal human beings. If I have restricted myself to examples corresponding to each of the traditional views of death—personal immortality, special immortality, and annihilation—66—the reason has been only to test the breadth of the conception.

To specify in detail the implications of these conceptions for the care of the noncritically ill would be largely beyond the scope of this work. Certain suggestions as to sensitivity and risk have been noted along the way. I hope that they may one day find translation into the definite courses of action for those who are charged with such care. One suspects they are already unselfconsciously a part of the caring of many. Thus, I shall take it as sufficient if this work shows that death is indeed present in the mentalities of the living when faced with the need for medical care.
NOTES


2. I am indebted to Ms. Bonnie Voigtlander for the formulation of these categories and for extensive discussions on Heidegger's and Sartre's views out of which this paper emerged. As the British would add, she is not responsible for the errors remaining.

3. See, e.g., Plato, Phaedo, 70a-107b; Aristotle, De Anima, 415a; and Epicurus, Letter to Menoeceus.

4. With Plato we may pair Descartes and Kant, with Aristotle goes Spinoza and (perhaps) Feuerbach, and to Epicurus we may wed Hume. These will do for starters.


14. Heidegger, Being and Time, p. 289. In this and all subsequent citations, italics have been removed.

15. Ibid.
16. Ibid., p. 304.
17. Ibid., p. 279.
18. Ibid., pp. 304-305.
19. Ibid., p. 306.
20. Ibid., pp. 305-306.
22. Ibid., p. 310.
23. Ibid., pp. 294-95.
24. Ibid., p. 295.
25. Ibid., p. 296.
26. Ibid.
27. Ibid., p. 298.
28. See Ibid., pp. 290-293.
29. Ibid., pp. 297-98.
30. Ibid., p. 298.
31. Ibid.
32. Ibid., pp. 300-301.
34. Ibid.
35. Ibid., p. 547.
36. Ibid., p. 539.
37. Ibid., pp. 540-544.
38. Ibid., p. 545.
39. There are arguments that are simply unjust readings of Being and Time, as in the charge that Heidegger treats death like a resolved chord of a melody. Others, more subtle or ambiguous, rely upon a replacement of Heidegger's metaphysics with Sartre's; see Being and Nothingness, p. 535, on subjectivity for an example of this.


42. Sartre, Being and Nothingness, pp. 540-543.

43. Ibid., p. 544.

44. Heidegger, Being and Time, p. 294.

45. Sartre, Being and Nothingness, p. 543.

46. Heidegger, Being and Time, p. 298. This study is all too brief for adequacy. For more fulsome treatments, see Kierkegaard, Heidegger, and the Concept of Death (Stanford: Lelan J. Stanford University Press, 1969), or Regis Jolivet, Le Probleme de la Mort chez M. Heidegger et J. P. Sartre (Paris: Editions de Fontenelle, 1950). See also Bernard P. Danenahuer's most suggestive paper, "On Birth and Death" (to appear in The Personalist) in which a certain order of symmetry is revealed between the two. An analogous but differing symmetry also occurs in Sartre. If we grant (actually we take for granted) the influence of birth on the living, we must also grant the influence of death. Then the entire problem is to specify that influence. Thus, the point of this paper.


50. Ibid., pp. 67, 80-83.


52. In this decade of doing only what is necessary, I shall accept responsibility for the unbridled idealism in the notion of seeking opportunities for rendering care.


55. Flyer: "What Is the East Tennessee Cancer Research Center?" produced by ETCRC.


59. As noted to me by Ms. Voigtlander, much of this paragraph reflects the theme of Ernest Becker in *The Denial of Death*.


61. This includes Sartre himself in *St. Genet*, the interesting study--however accurate in the eyes of its subject--of playwright Jean Genet.


65. This account is too brief for adequacy, but will perhaps do in order to get to the mentality typology. One can note that Nietzsche's remarks, while having a literal side with respect to ennoblement, also have an ironic, if not sarcastic, tone insofar as those qualities with which the gods are ennobled are just the qualities that make the gods wholly unhuman and perhaps inhuman. And then we follow or strive to follow their model, their commands to be like them, their image. Were the task below to criticize the attitudes toward death held by the mentality types, similar things might also be said. Since the aim is to understand sympathetically, that aspect can be ignored, as can Nietzsche's biting critique. The principle of reversal remains operative.

66. See above, page 2.
PROBLEM

In the health field there is much discussion about the nature of the professional-client relationship. One way we distinguish a health professional from a client or consumer is on the basis of the professional's above-average knowledge and/or abilities concerning health problems. The client or consumer role in the relationship is not well defined. Consumers are a very diverse group, making it almost impossible to select one who could represent the interests of all consumers. A person's role in this relationship cannot be distinguished by whether he is young or old, male or female, dark- or light-skinned, rich or poor. There is no single "type" of consumer.

One thing we do know, however, is that professionals and consumers alike have life experiences shared with a combination of reference groups, whose beliefs, attitudes, values, and customs significantly influence their behavior. We assume that health professionals are responsible for improving the health status of the general population and for promoting good health as an important societal value. It is also fair to say that we assume that the client or consumer feels his own health is important and that he will seek out information and/or care when needed. These assumptions or perceptions tend to break down when we consider health as an absolute value of utmost importance for either the professional or consumer. Obviously, it is not the absolute presence or absence of health that is important, but its relative ordering in respect to other values. Furthermore, if each person's values represent his "conception of the desirable" the question arises: desirable for whom? for himself? for others?

The purpose of this paper is to explore the perceptions of health professionals regarding the relative importance of their own values and their perceptions of the values of an "ideal" health consumer. The significance of this investigation lies in what we might learn about how these perceptions affect the performance of health professionals in relating to one another and to the majority of health consumers.

Problems of values similar to this one have been studied in all fields of the social sciences (Allport, Vernon, and Lindzey, 1960; Kluckhohn and Strodtbeck, 1961; Maslow, 1964; Williams, 1968; Smith, 1969; Rokeach, 1973). Most of these investigators agree that a person's values serve as the criteria or standards by which he makes evaluations of himself and others. One way to approach the question What functions do values serve? is to think of values as standards that guide ongoing activities, and of value systems as general plans employed to resolve conflicts and to make decisions.

Rokeach (1973) indicates that a person has an enduring organization of values concerning preferable modes of conduct or end-states of existence, wherein each value is ordered in priority of importance relative to other values. Through fairly extensive research, he found...
that a person has what he terms an instrumental value system and a
terminal value system. Figure I contains a modified version of
Rokeach's value survey and lists the values used in the current in-
vestigation.

Figure I

<table>
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<tr>
<th>Instrumental</th>
<th>Terminal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambitious</td>
<td>A comfortable life</td>
</tr>
<tr>
<td>Broadminded</td>
<td>An exciting life</td>
</tr>
<tr>
<td>Capable</td>
<td>A sense of accomplishment</td>
</tr>
<tr>
<td>Clean</td>
<td>A world at peace</td>
</tr>
<tr>
<td>Courageous</td>
<td>Equality</td>
</tr>
<tr>
<td>Forgiving</td>
<td>Family Security</td>
</tr>
<tr>
<td>Helpful</td>
<td>Freedom</td>
</tr>
<tr>
<td>Cheerful</td>
<td>Happiness</td>
</tr>
<tr>
<td>Honest</td>
<td>Health</td>
</tr>
<tr>
<td>Healthy</td>
<td>Inner harmony</td>
</tr>
<tr>
<td>Imaginative</td>
<td>Mature love</td>
</tr>
<tr>
<td>Independent</td>
<td>National security</td>
</tr>
<tr>
<td>Intellectual</td>
<td>Pleasure</td>
</tr>
<tr>
<td>Logical</td>
<td>Salvation</td>
</tr>
<tr>
<td>Loving</td>
<td>Self-respect</td>
</tr>
<tr>
<td>Obedient</td>
<td>Social recognition</td>
</tr>
<tr>
<td>Polite</td>
<td>True friendship</td>
</tr>
<tr>
<td>Responsible</td>
<td>Wisdom</td>
</tr>
</tbody>
</table>

Instrumental values may have either a moral or competence orienta-
tion. Moral values refer only to certain kinds of instrumental
values, to those which have an interpersonal focus that, when violated,
arouse pangs of conscience. Other instrumental values, those which
may be called competence or self-actualization values, have a personal
rather than an interpersonal focus. In the same way, terminal values
may be self-centered or society-centered, intrapersonal or interpersonal
in nature. The connection between the two kinds of instrumental values,
and the two kinds of terminal values, are explored in the investiga-
tion reported below.

From May 15 to June 15, 1976, the investigator observed and talked
with nine members (Subjects 01-09) of the National High Blood Pressure
Education Program and twelve members (Subjects 10-21) of the Office of
Cancer Communications of the National Institutes of Health, Bethesda,
Maryland. These health professionals are responsible, each in their
own way, for the formulation and implementation of health policy re-
garding the dissemination of health information to other health pro-
fessionals and the general public.

Each of the twenty-one health professionals was asked to "arrange
the values in order of importance to YOU, as guiding principles in YOUR
life." When they finished ranking the two kinds of values, they were
asked to "rank the same two kinds of values the way you think an IDEAL
consumer of health information would rank them." Thus, each subject completed four separate value sorts: Instrumental-self; Terminal-self; Instrumental-ideal; and, Terminal-ideal. The analysis of these sorts was guided by four basic questions:

How many independent common patterns of sorting the values (types) will emerge for the twenty-one health professionals?

What is the belief pattern (a hierarchy of value acceptance) for each of the types?

What values differentiate one type from all other types?

On what values is there agreement across types?

METHOD

Data from the sorts were submitted for analysis by means of the QUANAL program, which provides a single-execution method for handling all phases of Stephenson's Q-Analysis (1953). Specific analyses of the Q-data included the following steps:

Step 1 -- Subjects were asked to sort slips of paper, which had values printed on them, into a specific number of ranked piles according to a modified normal distribution. The sorting was done on the basis of most important to least important. Each subject completed four sorts: Instrumental-self; Terminal-self; Instrumental-ideal; and, Terminal-ideal.

Step 2 -- A matrix of intercorrelations was formed by correlating every person's sort of the values with every other person's sort of the values.

Step 3 -- The matrix of intercorrelations was submitted to factor analysis so that persons were variables and values were observations. A principal axis solution was obtained. This was submitted to a varimax rotation, which produced orthogonal factors. On this basis, a factor represents a grouping of persons around a common pattern of sorting the values. Hence a factor represents a type of person.

Step 4 -- Each pattern of sorting the values associated with each factor or type of person was estimated. This was done by weighting each value response of each of the persons most highly associated with a given factor by the degree to which they were loaded on that factor. The higher a person's loading on the factor, the greater was the weight. These weighted responses were summed across each value separately. This produced a value array of weighted responses for each factor in the rotated factor analysis solution selected. The arrays of weighted responses were then converted to z-scores.

Step 5 -- The arrays of value z-scores for each factor (factor arrays) were ordered from most accepted to most rejected for each fac-
tor. This provides a hierarchy of value acceptance for each factor or type of persons.

Step 6 -- The arrays of value z-scores (factor arrays) for each factor were compared by subtraction for each pair of factors. This produced arrays of differences scored for each pair of factors and provided the basis for differentiating one factor or type of persons from another.

FINDINGS

More than one distinct type emerged for each of the four value sorts. A hierarchy of value acceptance, ordered in terms of the z-scores, provided a means for interpreting each type. The values at the extremes were particularly useful in the interpretations. Each type was also differentiated from all other types by analyzing those values which were higher (or lower) in the array for one type than they were in the arrays of the other types. Mostly values with a z-score differential greater than 1.00 were used. Finally, those values for which there were agreement for all types were used in the interpretations. If the z-scores for all types were nearly equal, this defined agreement. An agreement value was one in which the difference between the largest z-score given that value by one of the types and the smallest z-score was less than 1.00.

Only subjects with pure, significant loadings were interpreted as "belonging" to a type (see Table I). Subjects that had no significant loadings, or relatively equal loadings on more than one type, were "dropped out" of the interpretations.

Instrumental-self

The health professionals were instructed to "arrange these values in order of importance to YOU as guiding principles in YOUR life." Four types emerged from their consideration of the nineteen modes of conduct.

Type I. Eight persons--2, 5, 11, 12, 16, 18, 19, and 21--constituted this type. The four top-rated values indicated an intrapersonal rather than an interpersonal focus. A concern for competence dominated their orientation. Their most accepted and most rejected values were:

<table>
<thead>
<tr>
<th>Values</th>
<th>z-scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>capable</td>
<td>1.62</td>
</tr>
<tr>
<td>responsible</td>
<td>1.39</td>
</tr>
<tr>
<td>imaginative</td>
<td>1.28</td>
</tr>
<tr>
<td>intellectual</td>
<td>1.00</td>
</tr>
<tr>
<td>clean</td>
<td>-1.52</td>
</tr>
<tr>
<td>obedient</td>
<td>-2.23</td>
</tr>
</tbody>
</table>

More than Types II, III, and IV, Type I considered important being imaginative (1.28). Less than all others, Type I considered important being loving (-0.75). Furthermore, Type I persons rejected being help-
ful (-0.67) and healthy (-0.38). It seemed that neither the welfare of others nor their own personal well-being was related to their being capable and responsible.

Type II. This type consisted of only three persons--8, 15, and 20. Type II persons also emphasized an intrapersonal focus. Their most accepted and most rejected values were:

<table>
<thead>
<tr>
<th>Values</th>
<th>z-scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>independent</td>
<td>1.95</td>
</tr>
<tr>
<td>honest</td>
<td>1.04</td>
</tr>
<tr>
<td>logical</td>
<td>1.03</td>
</tr>
<tr>
<td>capable</td>
<td>1.02</td>
</tr>
<tr>
<td>courageous</td>
<td>-1.08</td>
</tr>
<tr>
<td>healthy</td>
<td>-1.09</td>
</tr>
<tr>
<td>obedient</td>
<td>-1.26</td>
</tr>
<tr>
<td>clean</td>
<td>-2.23</td>
</tr>
</tbody>
</table>

More than Types I, III, and IV, Type II considered important being independent (1.95) and helpful (0.90). Less than the others, Type II considered important being healthy (-1.09), courageous (-1.08), and broadminded (-0.48). Unlike Type I persons, their concern for being capable was related to being independent and logical rather than to being intellectual and imaginative. A major distinguishing factor was Type II's rejection of being healthy. When being courageous, obedient, and clean were clustered with being healthy, a much clearer picture of what they meant by the rejection became apparent.

Type III. The three persons--4, 6, and 9--in this type were all from the National High Blood Pressure Education Program. Their most accepted and most rejected values were:

<table>
<thead>
<tr>
<th>Values</th>
<th>z-scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>broadminded</td>
<td>1.95</td>
</tr>
<tr>
<td>loving</td>
<td>1.82</td>
</tr>
<tr>
<td>obedient</td>
<td>-1.85</td>
</tr>
<tr>
<td>clean</td>
<td>-2.15</td>
</tr>
</tbody>
</table>

More than Types I, II, and IV, Type III considered important being broadminded (1.95) and loving (1.82). Less than the others, Type III considered important being independent (0.00) and helpful (-0.80). The primary characteristic that distinguished them from the other types, however, was their indifference toward being capable (0.58), intellectual (0.49), responsible (0.47), logical (0.25), imaginative (0.08), and healthy (-0.12).

Type IV. The four persons--3, 7, 10, and 14--in this type were the only ones who felt that being healthy was important. Their most accepted and most rejected values were:
More than Types I, II, and III, Type IV considered important being healthy (1.63). Less than the others, Type IV considered important being intellectual (-0.55). Of the four types, this was the only one to combine health and competence. These values seemed to provide the necessary condition for their being helpful (0.72) and responsible (0.55). Their rejection of the moral values tended to lessen the potential for any conflict with their intrapersonal orientation.

Discussion of Types I, II, III, and IV. Eighteen persons had significant loadings on one of the four types. Persons 1, 13, and 17 were dropped from the interpretations because of significant loadings on more than one type. The values that all types agreed upon were:

<table>
<thead>
<tr>
<th>Values</th>
<th>z-scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>responsible</td>
<td>0.80</td>
</tr>
<tr>
<td>logical</td>
<td>0.59</td>
</tr>
<tr>
<td>self-controlled</td>
<td>0.22</td>
</tr>
<tr>
<td>ambitious</td>
<td>-0.04</td>
</tr>
<tr>
<td>forgiving</td>
<td>-0.32</td>
</tr>
<tr>
<td>polite</td>
<td>-0.75</td>
</tr>
<tr>
<td>obedient</td>
<td>-1.66</td>
</tr>
<tr>
<td>clean</td>
<td>-2.08</td>
</tr>
</tbody>
</table>

It is clear that the types agreed more on the values rejected than on the values accepted. The lack of agreement among the health professionals basically accounted for the distinct patterns of belief. Most of the differences involved slight variations within an intrapersonal, competence-based orientation. The most interesting finding was that being healthy was unimportant to Type II, highly important to Type IV, and treated with indifference by Types I and III.

Terminal-self

The health professionals were given the same instructions as before, but this time to be applied to the nineteen terminal values. Three types emerged from their consideration of the nineteen end-states of existence.

Type I. Six persons--7, 8, 10, 11, 18, and 21--were identified with this type. Again, the four top-rated values indicated a strong intrapersonal focus. The pattern seemed consistent since most of the
rejected values were of an interpersonal, society-centered nature. Their most accepted and most rejected values were:

<table>
<thead>
<tr>
<th>Values</th>
<th>z-scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>wisdom</td>
<td>1.68</td>
</tr>
<tr>
<td>freedom</td>
<td>1.08</td>
</tr>
<tr>
<td>mature love</td>
<td>0.83</td>
</tr>
<tr>
<td>an exciting life</td>
<td>0.75</td>
</tr>
<tr>
<td>equality</td>
<td>-0.72</td>
</tr>
<tr>
<td>a world at peace</td>
<td>-1.19</td>
</tr>
<tr>
<td>national security</td>
<td>-1.54</td>
</tr>
<tr>
<td>salvation</td>
<td>-2.64</td>
</tr>
</tbody>
</table>

More than Types II and III, Type I considered important an exciting life (0.75) and pleasure (0.14). Less than the others, Type I considered important salvation (-2.64). Type I persons showed a slight indifference to both health (0.42) and family security (0.43). Overall, hedonism might be a term used to characterize this pattern of belief.

Type II. This type consisted of five persons—1, 3, 5, 6, and 15. As before, there was a rejection of society-centered values and an acceptance of self-centered ones. Their most accepted and most rejected values were:

<table>
<thead>
<tr>
<th>Values</th>
<th>z-scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>self-respect</td>
<td>1.88</td>
</tr>
<tr>
<td>a sense of accomplishment</td>
<td>1.58</td>
</tr>
<tr>
<td>inner harmony</td>
<td>1.44</td>
</tr>
<tr>
<td>wisdom</td>
<td>1.06</td>
</tr>
<tr>
<td>a world of beauty</td>
<td>-0.68</td>
</tr>
<tr>
<td>equality</td>
<td>-0.70</td>
</tr>
<tr>
<td>a comfortable life</td>
<td>-0.86</td>
</tr>
<tr>
<td>a world at peace</td>
<td>-1.66</td>
</tr>
<tr>
<td>national security</td>
<td>-2.07</td>
</tr>
</tbody>
</table>

More than Types I and III, Type II considered important inner harmony (1.44) and salvation (0.22). Less than the others, Type II persons considered important national security (-2.07), a world at peace (-1.66), and freedom (-0.27). They also treated health (0.34) and family security (0.34) with some indifference. This type seemed to be characterized by a private, almost spiritual quality.

Type III. Six persons—2, 4, 13, 14, 16, and 18—were identified with this type. Unlike Type I, Type III persons rejected all forms of hedonism and spiritualism. Their most accepted and most rejected values were:

<table>
<thead>
<tr>
<th>Values</th>
<th>z-scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>freedom</td>
<td>2.04</td>
</tr>
<tr>
<td>wisdom</td>
<td>1.74</td>
</tr>
<tr>
<td>self-respect</td>
<td>1.21</td>
</tr>
</tbody>
</table>
More than Types I and II, Type III considered important freedom (2.04), equality (0.36), a world at peace (0.12), national security (-0.20), and wisdom (1.74). Less than the others Type III considered unimportant an exciting life (-1.13). Pleasure (-1.40), and a sense of accomplishment (0.19). Of the three types, Type III persons had the strongest society-centered focus. However, they regarded health (0.37) and family security (0.28) with the same indifference as the other types.

Discussion of Types I, II, and III. Seventeen persons had significant loadings on one of the three types. Persons 9, 12, 19, and 20 were dropped from the interpretations because of significant loadings on more than one type. The values that all types agreed upon were:

<table>
<thead>
<tr>
<th>Values</th>
<th>Average z-scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>mature love</td>
<td>0.55</td>
</tr>
<tr>
<td>health</td>
<td>0.38</td>
</tr>
<tr>
<td>family security</td>
<td>0.36</td>
</tr>
<tr>
<td>true friendship</td>
<td>0.27</td>
</tr>
<tr>
<td>a world of beauty</td>
<td>-0.39</td>
</tr>
<tr>
<td>social recognition</td>
<td>-0.64</td>
</tr>
<tr>
<td>a comfortable life</td>
<td>-0.51</td>
</tr>
</tbody>
</table>

The cluster of health, family security, and mature love indicated a consistent primary group orientation. However, the most accepted values by all three types focused on primarily intrapersonal concerns. The differences among the types proved to be the most interesting finding. Type I manifested hedonic values, while Type III rejected these values outright. Type III favored extended society-centered values, while Type II rejected these for more spiritual concerns. When we compared persons on the Instrument Types with those on the Terminal Types, we found that those persons who preferred the same mode of conduct do not necessarily select the same end-state (see Table II). Intrapersonal modes of conduct and self-centered end-states of existence tended to constitute the overall values of the health professionals.

**Instrumental-ideal**

The health professionals were instructed to "rank the same values the way you think an IDEAL consumer of health information would rank them." Only two types emerged from their consideration of the nineteen modes of conduct.
Type I. Ten persons--1, 3, 4, 9, 12, 13, 14, 16, 17, and 19--constituted this type. A concern for competence dominated this focus. Their most accepted and most rejected values were:

<table>
<thead>
<tr>
<th>Values</th>
<th>z-score</th>
</tr>
</thead>
<tbody>
<tr>
<td>healthy</td>
<td>2.24</td>
</tr>
<tr>
<td>responsible</td>
<td>1.29</td>
</tr>
<tr>
<td>independent</td>
<td>0.83</td>
</tr>
<tr>
<td>capable</td>
<td>0.71</td>
</tr>
<tr>
<td>obedient</td>
<td>-1.01</td>
</tr>
<tr>
<td>forgiving</td>
<td>-1.11</td>
</tr>
<tr>
<td>polite</td>
<td>-1.12</td>
</tr>
<tr>
<td>cheerful</td>
<td>-1.18</td>
</tr>
<tr>
<td>imaginative</td>
<td>-1.24</td>
</tr>
<tr>
<td>loving</td>
<td>-1.27</td>
</tr>
</tbody>
</table>

More than Type II, Type I considered important being independent (0.83), capable (0.71), courageous (0.60), and intellectual (0.52). Less than Type II, Type I considered important being obedient (-1.00), clean (-0.66), and self-controlled (0.22). Obviously, Type I represented the health professionals' perception of the ideal self-actualizing, self-caring person. However, unlike most of the health professionals' self-perceptions, being healthy was regarded as the most important value.

Type II. This type consisted of seven persons--5, 6, 7, 10, 11, 19, and 21. Again, the health professionals showed high regard for being healthy. A close examination, however, revealed a very different configuration of values for Type II persons. Their most accepted and most rejected values were:

<table>
<thead>
<tr>
<th>Values</th>
<th>z-scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>healthy</td>
<td>1.88</td>
</tr>
<tr>
<td>obedient</td>
<td>1.71</td>
</tr>
<tr>
<td>responsible</td>
<td>1.59</td>
</tr>
<tr>
<td>self-controlled</td>
<td>1.37</td>
</tr>
<tr>
<td>courageous</td>
<td>-0.98</td>
</tr>
<tr>
<td>independent</td>
<td>-1.23</td>
</tr>
<tr>
<td>ambitious</td>
<td>-1.27</td>
</tr>
<tr>
<td>imaginative</td>
<td>-1.46</td>
</tr>
</tbody>
</table>

More than Type I, Type II considered important being clean (0.40). Less than Type I, Type II considered important being intellectual (-0.48) and capable (-0.29). Type II represented the health professionals' perception of the ideal passive, dependent person or patient.

Discussion of Types I and II. Seventeen persons had significant loadings on one of the two types. Persons 2, 8, 15, and 20 were dropped from the interpretations because of low or mixed loadings on more than one type. The values that both types agreed upon were:
Values | Average
-------|--------
healthy | 2.05
logical | 0.54
broadminded | 0.33
forgiving | -0.72
polite | -0.96
ambitious | -1.08
imaginative | -1.35

All the health professionals perceived the ideal health consumer as placing great importance on being healthy. When we compared the health professionals' self-perceptions with their perceptions of the ideal health consumer, we found that almost 80 percent of the health professionals flunked the test. In addition, Type II, with its emphasis on being obedient and clean, was selected by 41 percent of the health professionals, yet they overwhelmingly rejected those very same values for themselves. Health professionals were either unwilling to accept their ideal for themselves or they preferred to live by a double standard.

Terminal-ideal

The health professionals were given the same instructions as before, but this time to be applied to the nineteen terminal values. Three types emerged from their consideration of the end-states of existence.

Type I. Eleven persons--1, 2, 3, 4, 9, 12, 13, 14, 16, 19, and 20--were identified with this type. The four top-rated values indicated a strong intrapersonal focus. Their most accepted and most rejected values were:

Values | z-scores
-------|--------
health | 2.09
wisdom | 1.22
self-respect | 0.98
inner harmony | 0.98
a world of beauty | -1.19
national security | -1.67
salvation | -1.80

More than Types II and III, Type I considered important wisdom (1.22), inner harmony (0.98), and freedom (0.82). Less than the others, Type I considered important salvation (-1.80). Obviously, for Type I persons, health will be maintained by relying on their intrapersonal capabilities rather than on any form of societal and spiritual help.

Type II. This type consisted of four persons--5, 6, 7, and 15. Type II persons shared an intrapersonal orientation with Type I, except they also indicated a need for some social and spiritual support. Their most accepted and most rejected values were:
Values | z-scores
--- | ---
health | 2.09
self-respect | 1.89
salvation | 1.47
family security | 0.96
a world of beauty | -1.24
social recognition | -1.39
national security | -1.45

More than Types I and III, Type II considered important salvation (1.45). Less than the others, Type II considered important social recognition (-1.39). In many ways, the values emphasized by Type II persons were very similar to those values stressed by the Type II for the health professionals.

Type III. Five persons--8, 10, 11, 18, and 20--constituted this type. At first glance, Type III persons appeared to be similar to Type II persons. For instance, their most accepted and most rejected values were:

Values | z-scores
--- | ---
health | 1.85
self-respect | 1.64
family security | 1.55
true friendship | -1.00
equality | -1.23
a world at peace | -2.08

However, a major difference emerged from an analysis of the other values. More than Types I and II, Type III considered important social recognition (0.65), pleasure (0.55), a comfortable life (0.78), and an exciting life (0.02). Less than the others, Type III considered important a world at peace (-2.08), true friendship (-1.00), and wisdom (-0.45). Both Types II and III regarded health, self-respect, and family security with utmost importance, however. Type III persons preferred earthly rewards in place of the spiritual ones.

Discussion of Types I, II, and III. Twenty persons had significant loadings on one of the three types. Person 17 was dropped from the interpretations because of low loadings on all types. The values that all types agreed upon were:

Values | Average z-scores
--- | ---
health | 2.01
self-respect | 1.50
family security | 1.10
happiness | 0.46
a sense of accomplishment | 0.10
mature love | -0.05
an exciting life | -0.47
equality | -0.74
national security | -1.29
The cluster of health, self-respect, and family security demonstrated a
definite primary group orientation similar to the one indicated by the
health professionals' self-perceptions. Also, the health professionals
separated the ideal types on exactly the same values that separated their
own three types. In both cases, the distinguishing factors were personal
competence, spiritual rewards, and earthly desires. When we compared
persons on the Instrumental-ideal Types with those on the Terminal-ideal
Types, we found that Type I persons on the former were the same as Type
I persons on the latter, and Type II persons on the former tended to be
either Type II or Type III on the latter (see Table III). For example,
the health professionals who indicated that the passive, dependent per­
sons were the ideal (Type II) also rejected personal competence in favor
of spiritual (Type II) or earthly desires (Type III) as the ideal end-
states for these same persons. In addition to each health professional's
individual sort of the Terminal-ideal, the National High Blood Pressure
Education Program staff and the Office of Cancer Communications staff
were each asked to agree upon one sort of the values as a group. When
allowed to discuss the values among themselves, both groups arrived at
extremely similar patterns, that is, both groups had significant load­
ings (0.85 and 0.86 respectively) on Type I as the ideal end-state.
Needless to say, Type I persons were the most persuasive in both groups.

IMPLICATIONS

The findings have some interesting policy implications. The
formulation of health policy targeted at specific consumer types, based
on their shared values rather than demographic similarities, might prove
to be an extremely heuristic approach. The consumer types, however,
should be developed from actual consumer responses rather than from the
perceptions of health professionals. One could add greater specificity
by describing the demographic characteristics for each type. In ac­
tuality, four or five common patterns of belief would probably account
for the majority of health consumers. Health professionals could formu­
late strategies for reaching people based on appeals that are known to
be important to them. The findings indicate that health professionals
perceive that being healthy as a mode of conduct and health as an end-
state should be the most important values for a health consumer. If
this were true, it would be logical to use an appeal to health as the
basis for new campaigns or programs. As the findings show, however, most
health professionals would not be the least bit enticed by such an appeal.
For health professionals, strategies that use appeals to promote cap­
ableness, independence, responsibility, and logic would have a good
chance at influencing their attitudes and/or behavior.

Clusters of closely related values provided a way of understanding
the sometimes complex meanings that people give to health. For instance,
Type III health professionals rejected being healthy, but they also
rejected being courageous, obedient, and clean. On the other hand,
Type I health professionals highly accepted being healthy, but they
also accepted being capable and independent. The point being that in
both instances one must deal with the entire cluster of values in order
to understand the motivations at work.
Another important implication is just how one's values affect the process of policy formulation and implementation. The findings show that several distinct patterns of belief exist within each of the health policy groups. What problems arise because of conflicts between persons with different patterns of belief? For instance, health professionals split on whether the ideal consumer should be self-caring or passive, dependent. Does the formulation of policy take a middle-of-the-road thrust in order to avoid possible intragroup conflicts? Also, if these conflicts sustain themselves, will the cooperation necessary for the implementation of policy be drastically impeded by a lack of communication? The real question is whether values should be considered along with knowledge and ability as basic criteria for determining the qualifications of health professionals since their value systems are employed to resolve conflicts and to make decisions. Obviously, there are many questions and few answers. Hopefully, this line of research will provide some insights for continued policy analysis.

FOOTNOTES

1. Fellowship support provided by the Institute on Human Values in Medicine of the Society for Health and Human Values through National Endowment for the Humanities Grant #EH-10973-74-365.

2. Pure loadings occur when a subject has a significant loading on only one type. Significance may be computed from the formula \( \sqrt{\frac{1}{n}} \), where \( n \) = number of values. As a rule of thumb here, .40 is used as the minimal significance criterion.
REFERENCES


# TABLE I
Rotated Factor Matrix: Loadings on Factors
(All Decimal Points Omitted)

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127
**TABLE II**

**SUBJECTS LOADING ON TYPES BY SELF SORTS**

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**TABLE III**

**SUBJECTS LOADING ON TYPES BY IDEAL SORTS**

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INTRODUCTION: OVERVIEW

The notion of informed consent, increasingly coming to stand at the center of our thinking about ethical problems in human experimentation, is particularly pivotal to problems in psychiatric research and practice. The problem of obtaining informed consent from a psychiatric patient is, in form at least, similar to that of obtaining informed consent from other persons whose capacity to consent is limited. Children, prisoners, the senile, the comatose, and participants in research involving deception, all lack the inner freedom to give a truly informed consent. Because much contemporary research is highly complex and human motivations are so varied, it might be questioned whether even more or less rational and sane people are really capable of giving a truly informed consent.

Before considering the problem of obtaining informed consent from a psychiatric patient, it will be necessary first to consider the way informed consent focuses ethical questions in research with human subjects in general. At one time in the recent past, ethical standards in research were governed by the consciences of the investigators, which usually, but not always, served as an adequate safeguard for experimental subjects. Increasingly, this country is "moving away from informal standards of professional ethics, from broad and general principles developed over centuries and toward a civilly enforced body of law and administrative regulations, which will control research projects and the use of human subjects in such projects." (Curran, 1973). Daniel X. Freedman (1974) has interpreted this change as one based on a deep current mistrust of all "assumed relationships" -- the breakdown of Gemeinschaft (a community of feeling that results from likeness and shared life experience) into Gesellschaft (a more rational, more mechanistic way of life, with greater structure and with more written and explicit rules and regulations). Broad ethical principles no longer serve as shared values, and there is an attempt to make moral principles explicit as behavioral guidelines.

The substance of consent is very carefully specified by DHEW guidelines: It must be informed, voluntary, and competent and must include the following elements: (a) a fair explanation of the procedures; (b) a description of discomforts and risks; (c) a description of expected benefits; (d) disclosure of alternate procedures; (e) an offer to answer any inquiries; and (f) an instruction that the person is free to withdraw consent and discontinue participation in the project or activity. The content of every informed consent form is carefully scrutinized by a
local Institutional Review Board (IRB). The manner in which the informed consent is transacted, the interaction between the doctor and the patient, the investigator and the subject, cannot be individually reviewed and inevitably these intangibles rely on some measure of good faith between human beings.

Informed consent is required in experiments involving human subjects. It is worth remembering that these experiments are performed by human beings with (or on) human beings. Circular as this may sound, it serves to emphasize that there is an interpersonal relationship and that there is an element of mutuality. Informed consent does not occur in isolation or in abstraction. Furthermore, as fellow human beings, the experimenter and his subject exist as epistemological peers; the experimenter knows no more about his subject than he knows about himself. The humanness stressed is from the perspective of a person who experiences himself as someone, not something.

Romano (1976) has commented on this personal aspect of obtaining informed consent in his studies of the families of schizophrenics:

What has been most impressive to me is the old-fashioned altruism of the families who have participated in our studies, however one chooses to define altruism. Even though a full explanation of the project was given at the time the subjects filled out appropriate consent forms, more than 2/3 appeared to retain little of what they had heard or read... Often we hear: "We're really not sure what this is all about, but we and the children have enjoyed doing it. We wanted to take part in it to express our appreciation for having been helped in the past, and perhaps one day, while the information you are getting may not be useful to us, it may be to someone else."

He further adds a note that gives some indication of the affect underlying the controversy as to whether or not and how informed consent can be obtained from a psychiatric patient:

I wish sincerely that some of our militant philosophers, theologians, and ethicists, whose instant omniscience in matters of privacy and informed consent appears to be matched only by their overweening arrogance, could hear some of these remarks, and learn from them of the need of the patient to give something of himself and to recognize that among one's fundamental rights is the right to know, and one hopes to know more, about the disturbance which affects his life.

These remarks call attention to the locus of an ethical controversy in the feelings it generates. "Where is the affect?" is a useful question to ask when dealing with an ethical controversy. Romano's comments reveal the frustrations of a highly ethical investigator at some of the convictions (held every bit as sincerely) by certain
philosophers, theologians, and ethicists. His remarks may reflect in part different worlds of discourse, but they also highlight a very genuine perplexity and disclose the kind of tension -- if not outright suspicion and distrust -- prevalent in a society questioning its fundamental values about who people are and what they may and should do. The broad ethical principles, which once inspired human conduct, are no longer seen as adequate to protect against ethical violations. The shared values, confidence, and trust of a community can no longer be called upon to provide sanction for right conduct. Yet the proliferating guidelines may give a false sense of security, an illusion that an ethical problem has been solved once it has been codified, thereby camouflaging the hard ethical thinking that must be done in each individual case.

In fact, ethical codes do not simplify anything. These documents perform a kind of bilevel function. They serve on the one hand as minimal barriers beyond which we cannot transgress without sanction. On the other hand they serve an inspirational or consciousness-raising function to sensitize us to dimensions of conduct we might otherwise overlook. These two functions occur more or less simultaneously even though their goals are different. Much of the confusion about how informed consent should be used stems from failure to recognize the dual function it must serve.

**TOWARD A DEFINITION OF INFORMED CONSENT**

An attempt at definition of informed consent must explore the way the phrase is used, as well as its implications, in hopes of discerning underlying values and conflicts. The term is already heavily laden with the variety of ethical issues it must mediate. Therefore it is important to keep its functions clearly distinguished. The following chart has been designed to aid in that task:

**FUNCTIONS OF INFORMED CONSENT**

<table>
<thead>
<tr>
<th>Upward perspective</th>
<th>Downward perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>moral inspiration</td>
<td>regulation of abuse</td>
</tr>
<tr>
<td>fiduciary relationship (based on trust)</td>
<td>adversary relationship (based on control)</td>
</tr>
<tr>
<td>teleological ethics (end-based, goal-based)</td>
<td>deontological ethics (rule-based)</td>
</tr>
<tr>
<td>emphasis on consent</td>
<td>emphasis on information</td>
</tr>
<tr>
<td>focus on process</td>
<td>focus on content</td>
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The upward perspective on informed consent is that of the individual clinician or investigator seeking to ensure that his behavior is of the highest moral standards. It employs the informed consent as a good-faith demonstration of the mutual trust between the physician/investigator and the patient/subject. There is no maximal limit in mutual responsibility of the patient and physician in their collaboration. But there are minimal limits. The downward perspective on informed consent is that of a regulating agency seeking to ensure that the behavior of the investigator does not fall below certain minimum standards of ethical conduct. Here the informed consent functions as protection against possible bad faith on the part of the investigator. No trust is assumed, and in the downward perspective informed consent serves to bring clarity of intent through adversary procedure such as peer review, Institutional Review Board, or actual judicial review. There may be no actual relationship with the patient/subject, whose interests are accounted for in abstraction, as a member of a group, or in reference to the upward perspective of the one-to-one relationship.

The relationship of the doctor and patient is spoken of as a fiduciary relationship, a relationship based on mutual trust. For the physician the minimal limits of the downward perspective are not ethically sufficient; the physician must be open to the greater trust placed in him by the patient. The investigator, however, may not be subject to such claims, and even if as a person the investigator maintains the highest ethical standards, his commitment to the outcome of the investigation places him in the appearance at least of conflict of interest. Many investigators are themselves physicians and therefore have divided loyalties. Although they may in fact be persons of sufficient integrity to keep their motives straight, minimalist standards help in this sorting out. Adversary procedure may be helpful in clarifying conflicting ideas. Adversary relationships between people, however, are antithetical to the fiduciary relationships on which good medical practice must be based.

This formulation parallels the distinction between teleological, or end-based, ethics and deontological, or rule-based, ethics (Frankena, 1963). Another way of looking at the distinction is to choose between emphasis on the consent in "informed consent" and on the information. "Consent" in the dictionary definition derives from the Latin com-(with) + sentire (to feel), hence to feel together. It means "agree," "assent," or "give permission" and indicates involvement of the will or feelings and compliance with what is requested or desired. Consent by itself is not enough for our ethical requirements and must be "informed," meaning that the patient/subject must understand what he or she is consenting to. What constitutes adequate information is at the root of our controversy.

Implicit in the definition of consent is a community of feeling, a shared trust. With recognition of this mutuality, Otto Guttentag in his excellent article, "Ethical Problems in Human Experimentation" (1968), offers a useful definition of informed consent: "Informed consent may be
defined as the experimenter's willing obligation to inform the experimental subject, to the best of the experimenter's knowledge, about the personal risk that the experimental subject faces in the proposed experiment, the significance of the experiment for the advancement of knowledge and human welfare, and last but not least, the stakes involved for the experimenter himself. In short, informed consent implies that the experimenter has made the most honest effort he can to say everything that will enhance the experimental subject's freedom, so that the subject can make the most adequate choice of which he is capable in agreeing or refusing to become a volunteer.

IS THERE A FUNDAMENTAL ETHICAL PRINCIPLE GOVERNING INFORMED CONSENT?

Following this very personal view of ethics, Guttentag offers the notion of "partnership" as the basic ethical principle in experiments involving human subjects: "With reference to the relationship between experimenter and experimental subject, it is the concept of partnership between the two, resulting from the fact of their being fellow human beings, that reflects our basic belief and cannot be subordinated to any other." By partnership he does not imply a legal contract or business association, but rather "sincerity without reserve," a relationship of mutual trust and confidence, or openness between experimenter and subject, and a complete reliance that discards any guardedness. A criterion of this partnership, Guttentag insists, is the personal effort involved in its enactment, "the amount of 'loving care' or devotion given to disclosing to the experimental subject and to 'mankind' the content and limits of any actual partnership. It is the antipode to negligence."

Reliance on the notion of "partnership" may serve to maintain an upward perspective on ethics as we review the procedures of informed consent. Recourse to such words and phrases as "trust," "sincerity," and "loving care" may well seem vague, if not downright anachronistic, to those seeking operational guidelines, but to the experimenter as human being this should not be so.

An alternative contender for the title of "fundamental ethical principle" needs to be considered here because it will help focus an aspect of the underlying controversy. In a major position paper entitled "Three Theories of Informed Consent: Philosophical Foundations and Policy Implications," Robert Veatch (1976) argues that "the most plausible foundation for informed consent is the principle of autonomy." This principle holds that individuals are the possessors of individual rights including the right to self-determination.

The respect for the rights of individuals would seem to be an aspect of the fiduciary relationship, which Guttentag refers to as "partnership." But Veatch insists that this is not what he has in mind. He refers to three different theories of informed consent,
which he sees as mutually exclusive. The fiduciary tradition of Hippocratic medicine Veatch refers to as the "Patient Benefit Theory of Informed Consent." He rejects this because its purpose is to protect patients from harm, which could be done by banning nontherapeutic research. Also, the reason patients are to be protected from harm is because they possess the right to self-determination. The second principle, utilitarianism, the greatest good for the greatest number, he rejects because it permits too much. The third principle, which Veatch favors to the exclusion of the first two, is the principle of autonomy, the right of the individual to self-determination.

The principle of autonomy has the heuristic merit of bolstering against possible violations of trust. It has the liability of degenerating to an abstraction, of being applied to persons in isolation, or of being applied to groups without due regard for the idiosyncrasies of individuals. Fundamentally, the principle of autonomy makes sense not as an abstraction but as an extension of the fiduciary principle. Autonomy becomes meaningful not in isolation but only when it is respected by another person.

In developmental psychology, autonomy is seen as a developmental task subsequent to the formation of basic trust (Erikson, 1959). The omission of trust in Veatch's discussion is understandable enough since trust is assumed as prerequisite for the successful mastery of all subsequent development. But many psychiatric patients have not developed even a sense of basic trust. Furthermore, trust or mistrust is an important element in all human affairs involving more than one person. Unless we are to assume that a person is to decide to consent or not consent in the privacy of his own imagination, we must consider the nature of the relationship which obtains between doctor and patient, experimenter and subject. One of the great virtues of the Hippocratic tradition in medical ethics is that it has kept the fiduciary commitments of the physician in focus over the centuries.

In his discussion of the Hippocratic tradition, Veatch stresses the obligation of the physician to do no harm to the patient. He also notes the "naturalistic footing" on which medicine was placed and the demystification (and dedivinization) of illness. Modern medicine is of course vastly different from Hippocratic medicine, but Veatch is correct in his contention that its ethical norms are ones with which the modern physician is comfortable. The dominating ethical norm that the physician's duty is to do according to his ability and judgment that which will benefit the patient is a standard which has endured for centuries. Although the Oath of Hippocrates is deontological in style and many of its admonitions are no longer applicable, what remains significant is the telos or goal that benefit to the patient be always kept in mind -- never to be ignored. Whereas self-determination as a telos is a desirable goal, it is not in fact a measurable or quantitative entity which would admit to a rule-based ethic.
Although the fiduciary spirit of Hippocratic medicine informs the ethics of contemporary medicine and its demythologized naturalism gives rise to modern medical science, we must not overlook residual forms of archaic divinity in contemporary practice. Aesculapius, the "divine physician," was the prototype, the ideal of the physicians of his age whom people could contemplate or evoke in the myths and in the cult of a god or hero. (See Kerenyi, 1959) Even today the familiar staff and coiled snake symbolize the archetypal image of the physician's existence and experience. It is interesting to note that the prototype physician was seen as a divinity, and it is not surprising to find in ancient Greece an archetype divinized in the popular imagination. However, what is surprising is the way in which the physician is still divinized in today's hard-nosed world. A tension is thus created between the expectations that the physician behave as a god, i.e., have the power of a god to control life and death, and the ever-increasing realization that his mortal powers are limited.

The fiduciary tradition in medical ethics is at least as old as the Oath of Hippocrates and the cults of Aesculapius, and it has endured not as a code but as a symbol of the ideals most deeply cherished by the medical profession. While not encompassing in terms of behavioral guidelines, it has yet to be replaced by anything more morally inspiring.

DIFFICULTIES IN APPLYING THE FUNDAMENTAL PRINCIPLE TO PSYCHIATRIC PATIENTS

The transaction of an informed consent has two requirements that may be difficult to meet with psychiatric patients. The "consent" requires a mutual trust, and the "information," requires a certain amount of rational understanding. Both of these requirements may be problematic with psychiatric patients, whose pathology may involve inability to form trusting relationships or to think rationally. Psychiatric patients are not uniquely problematic in this regard, however. Many people not designated as "psychiatric patients" have difficulty forming trusting relationships, and few people think rationally at all times and in all areas of their lives, with never a lapse into irrationality, impulsivity, or spontaneous passion. Thus, we need to avoid any tendency to think of psychiatric patients as somehow categorically different from our fellow human beings and ourselves, even though Kraepelin is said to have found those suffering from dementia praecox as alien to him as the birds in his garden.2

We are a rationalistic society, yet there is no logical cogency in the truth of a personal relationship. And if for "psychiatric patient" we include "neurotics" as well as "psychotics," their ambivalences undermine the principles of rationality on which we would like to conduct the affairs of cognitive and ethical discourse, and which would be necessary if a consent could ever be considered "truly" informed.
The difficulties we have in considering informed consent with psychiatric patients disclose underlying conflicts in the values held by our society. The premium we place on "rationality" and "intelligence" conflicts sharply with the ambiguities so characteristic of human emotional life and interpersonal relationships. Unless we remain sensitive to the rich complexities of human existence, our attempts to regulate ethics may ironically protect our cherished notions of rationality more than the experimental subjects who can never quite conform to our ideals. Paternalistic attempts at protecting such subjects may be motivated more out of guilt or fear of our own irrationality than a willing interaction or partnership. Prohibitive regulations may exclude a psychiatric patient rather than mandate the difficult task of making human contact.3

In common practice the transaction of informed consent is seen as an instantaneous event, which occurs once before the start of the experiment or procedure and is conditioned temporally only by the statement that the patient/subject is free to withdraw at any time. The establishment of a trusting relationship is never a static event, but rather requires a certain "temporal thickness" (Merleau-Ponty, 1962). The unrealistic thinking of a psychotic may not be a global phenomenon, but may be limited to certain periods of time or to certain aspects of a patient's mental life. It is seldom an all-or-none, either-or phenomenon.

In psychotherapeutic work with psychiatric patients, the establishment of a trusting alliance is one of the first tasks in therapy and one which endures as prerequisite for all the work that occurs in the psychotherapeutic relationships. The working alliance of the psychoanalyst and the neurotic analysand may provide the prototype of an idealized understanding of informed consent in any context. Here the "experimenter" and "experimental subject/patient" have one overriding goal in their joint work together: to understand as much as possible of the motives of the life of the latter. The ambiguities of communication are taken with utmost seriousness and respect. The overdetermined as well as self-determined quality of human action is appreciated in each step of self-understanding. The psychotherapeutic partners recognize that an articulated statement may have many levels of meaning, conscious and unconscious, and that not all can be appreciated simultaneously. Informed consent in the psychotherapeutic experiment occurs not once, but continually, as the partners work together to bring into conscious awareness that which had hitherto been unknown.

The transaction of an informed consent inevitably relies on the use of language, which is meant to clarify, but which might also confuse or conceal. Unless one assumes that an articulated statement can be understood literally, it is always a challenging task to discern meaning in what people say. This is especially the case with psychiatric patients. When a hospitalized patient announces that he wishes to be discharged immediately to attend to important business matters, he may be responding to mundane necessity or he may be manifesting psychotic
grandiosity. His statement of intent may be a veiled test of his physician: "Do you really care about me?" or it may be a realistic protest of his incarceration. If his condition were serious enough to warrant treatment with Electro-Shock Therapy, could his consent for the procedure be considered reliable? Would the consent of a near relative be acceptable? Conversely, in face of a potentially life-threatening illness such as starvation due to catatonic schizophrenia or psychotic depression, would an articulated refusal be contraindication to treatment? Due-process reviews such as competency or commitment hearings are often employed to ensure that individuals' rights are adequately safeguarded, yet such hearings are cumbersome, expensive, time-consuming, and may be psychologically traumatic themselves. However, they do guard against conflict of interest and are relatively impartial. Of special merit: Each case is decided individually and not by some all-inclusive or overriding policy.

An example from clinical experience illustrates the difficulties of attending to the meaning in articulated statements, when such statements contain manifest ambivalence:

Mrs. J. was admitted to the plastic surgery service of a teaching hospital for skin grafts on an ulcerated foot. She was transferred to the psychiatry service when she became disruptive at night. She was brought to a teaching-working conference where the residents and medical students met and interviewed the patients of their colleagues, whom they would care for evenings and weekends in a "group practice" arrangement. Medical student A was designated to interview Mrs. J. The interview went something as follows:

Medical student A: Good morning, Mrs. J., could you tell us something about how you came to be here and how we might be of help to you?

Mrs. J.: I don't want to be here and I don't want to answer any questions.

Medical student A: How long have you been in the hospital?

Mrs. J.: Don't talk to me.

Medical student A: Have you been told why you are on the psychiatry service?

Mrs. J.: How would you feel if someone made you come to this conference?

Medical student A: I think I know how you feel. (Pause) Are you married?

Mrs. J.: (Angrily) Don't you think that's a little bit personal, Sonny?
Medical student A: Would you rather not answer that question?

Mrs. J.: (Pause) I've been married twice and divorced twice.

From that point on, the interview proceeded relatively smoothly with Mrs. J. disclosing relevant aspects of her life-history and current situation. After the interview was concluded, Medical student B inquired if we had obtained informed consent for an interview. Although hospital rules do not require a formal informed consent for an interview, the question was germane, especially in view of Mrs. J.'s articulated statement that she did not wish to be interviewed. However, when offered the option of not answering the question, she chose to answer in personal detail. At least, we could say Mrs. J. was ambivalent about the interview, an ambivalence which she disclosed in her manner of relating to Medical student A and which, as it turned out, characterized many of her relationships with other people. Medical student A, by respecting her need for distance and control and by not responding defensively or punitively to the negative side of her ambivalence, was able to establish himself as someone worthy of Mrs. J.'s trust. As Mrs. J. became less antagonistic, she was able to acknowledge her fears of surgery without becoming overwhelmed by them. When it became necessary to amputate her ulcerated foot, she was able to accept some emotional support from her physicians and family and make realistic adjustments to her changed life-situation. Although there was no correct solution to Medical student A's dilemma, the interview could have been terminated for lack of adequately informed consent. He would have technically protected Mrs. J.'s rights, or at least her prerogatives, thereby missing an opportunity for a therapeutic encounter.

BEYOND THE IMPASSE

The act of obtaining an informed consent involves us in two contradictory movements simultaneously. On the one hand we strive for a conceptual clarity in the full disclosure of the enterprise for which we wish to obtain consent. On the other hand we abandon such abstract clarity on behalf of the person from whom we wish to obtain such consent: the form must be understandable. In actual practice one movement stresses the information in the consent form itself. Here the conceptual clarity is attained in adversary arguments, usually in a review committee. The other movement stresses the consent itself, which is obtained from the patient/subject. In this step we must trust the integrity of the investigator not to violate the trust of the experimental subject, i.e., he must communicate what is in the form. It is this communication which is problematic with psychiatric patients. Psychiatric patients especially may not have the capability to understand the information in the forms or to express their will unambivalently.

Solutions to this dilemma that focus on the "information" aspect of the informed consent are inadequate. An examination of the subjects on the contents of the form would disclose more about test-taking skills
than the subjects' intentions. A categorical exclusion of psychiatric patients would ensure against violations in the informed consent, but in itself risks violations of certain rights such as the right to participate in the search for knowledge about one's own illness. The traditional "proxy consent" substitutes another person for the experimental subject, a person who presumably is more capable of understanding the information in the consent form, but who may or may not be in a good position to speak for the interests of the patient/subject. As long as our criteria of adequately informed consent rest on the information transmitted, only a case-by-case review will strictly satisfy our demands, yet from a practical standpoint this is unrealistic.

Therefore, the trust of a fiduciary relationship as the ultimate criterion of an informed consent has been stressed with the full realization that such trust can never be measured or quantified. The model of such a relationship is the doctor-patient relationship, where the doctor's interest is to serve the needs of the patient, and the patient's interest is to participate in his health care. This is symbolized for modern medicine in the patient-benefit tradition of Hippocratic Oath. The physician-scientist, however, has a conflicting loyalty to the outcome of his investigation; he is committed to search for the truth. For this reason his trust cannot be assumed. It may then become necessary to separate the roles of the physician-friend and the physician-scientist in obtaining informed consent (Guttentag, 1953).

If we keep in mind the simultaneous movements in obtaining an informed consent, the basis for separation becomes evident. We have

Patient \(\xrightarrow{\text{fiduciary relationship}}\) physician-friend

( attending physician )

\(\xrightarrow{\text{focus on process}}\)

(adversary relationship)

physician-scientist

or more generally

Patient \(\xrightarrow{\text{fiduciary relationship}}\) patient's advocate

(or "trustee")

( attending physician )

\(\xrightarrow{\text{focus on process}}\)

(adversary relationship)

experimenter

Informed consent is thus formally a two-step process recognizing the two movements that inevitably occur in obtaining an informed consent. In formalizing this as a two-step process, we avoid confusion as to the relative emphasis on the information and on the consent. Both are important but must be handled in different ways. The patient is not required to negotiate in both an adversary and a fiduciary mode simultaneously, which might be especially difficult if he also felt himself to be dependent on that same person for his health care.
The patient's advocate might well be the attending physician, the physician-friend, if he were not also the physician-scientist. Other candidates for this role would vary depending on the setting. A close relative or legal guardian might be able to speak in some instances for his or her relative or ward. A nurse in other settings might be the person who would best know the interests of the patient. In a research institute or state mental hospital, a specially trained lay person (paid or volunteer) might assume the role of the patient's advocate.

Another merit of this system is that it offers a second level for review, which is practically more feasible than reviewing each signature, each transaction. The content of the consent form would continue to be reviewed by the local Institutional Review Board. The process of obtaining the consent would be the subject of a different kind of review by either the IRB or a national site visit. It would be the task of the second review with the focus on process to determine that the transaction of the informed consent was being handled properly. One feature of this review might be, for example, to determine who might best serve the role of patient's advocate in the particular setting. Another important task would be to assure that those who assumed the important role of advocate were capable of listening to and speaking for the patient, not merely articulating their own political commitments or ideologies.

The notion of informed consent has evolved into a central position in our medical and scientific procedures involving human beings. It serves to focus our thinking and practice on the ethical dimensions of our activities. Obtaining informed consent is problematic with psychiatric patients for the same reasons that all our dealings with psychiatric patients are problematic. It is the focus on informed consent which forces us to rethink our value of rationality, our tradition of intellectual clarity, the ambiguities attendant to communication through the symbolism of language, and how we deal with ambivalent affects. In so doing we might decide to disenfranchise those dissimilar from ourselves, or we might come to recognize something of ourselves in the psychiatric patients with whom we are concerned. This may be a humbling experience, especially if our concept of ourselves has tended to stress the cognitive side of our being, but it may be a humanizing experience as well. The view of informed consent stressed here has emphasized the relatedness of people more than their autonomy. This approach brings us into closer proximity with human suffering than may be comfortable, but it seems at least a minimum ethical requirement for participation in those procedures for which we have come to expect an informed consent.
FOOTNOTES

1 Prior to World War II one could cite the Code of Hammurabi, the Oath of Hippocrates, and Thomas Percival's Code of Medical Ethics (1803), but basically medical ethics derived from tacitly understood religious and cultural traditions. While these traditions are still valid and valued, the list of guidelines with which a physician/investigator must be familiar is extensive and includes the following: The Principles of Medical Ethics of the American Medical Association, Opinions and Reports of the Judicial Council (AMA); the Nuremberg Code (1947); the Declaration of Helsinki, adopted in 1964 by the World Medical Association; "The Institutional Guide to DHEW Policy on Protection of Human Subjects," (NIH) 72-102, published in 1971; the American Hospital Association's 12-point Bill of Rights. The psychiatrist should also be familiar with the AMA Principles of Medical Ethics with Annotations Applicable to Psychiatry. The rate of increase in federal and state statues and the trend of recent judicial decisions really necessitates specialized legal and investigative behavior.

2 The schizophrenic and the scientist are epistemologically antithetical poles for modern civilization: each is problematic to the other. The tension rests in our confused phenomenology of perception. (Cf. Merleau-Ponty, 1962) What is a valid perception? The schizophrenic trusts his unique perception of reality even though his delusions, illusions, and hallucinations conflict with almost every other person's perception of reality. The scientist, on the other hand, doubting with Descartes everything except the fact that he is doubting, does not even trust his own perception but requires instead consensual validation, the validation from other senses, other perceptions.

It is sometimes said that it was the existence of such phenomena as illusions, delusions, and hallucinations that engendered Descartes' distrust of perception. Indeed the clear and distinct notions of "reality" by which we assess "nonreality" and define "psychosis" owe much to the Cartesian method and its attendant consensual objectivity. Its liability has always been in the realm of the interpersonal, the realms of reality which are experienced, not observed, and which, if communicable at all, can only be understood through the rich ambiguities of language. Psychological science -- and the same might be said of ethical "science" -- has always been plagued by problems of methodology insofar as the experimenter by virtue of his interaction with the experimental subject participates in the outcome of the experiment. In order to achieve the kind of objectivity that was possible in classical physics before Heisenberg recognized the influence of the observer on the observed, it was necessary either to limit the focus to observable behavior or to deliberately involve the experimenter as a partner in the experiment, which was Freud's novel solution. Ethics faces a similar methodological dilemma. Either it may strive for a conceptual clarity on a
level of abstraction, which risks loss of empathic contact with the emotions and motives of the people whose values are considered, or it may focus on personal interactions risking the ambiguities of such communications. In this sense ethics may be said to follow epistemology. In the critical tradition of analytic philosophy, ethics may be seen as an attempt at clarifying principles of behavior. In the phenomenological tradition (the so-called "post-critical epistemology" of Michael Polanyi, 1952, and that of Bernard Lonergan, 1957) ethics attempts the at least equally difficult task of understanding and reconciling human commitments and decisions. The knowledge required is self-knowledge: Know thyself.

It is difficult to see these two alternatives as mutually exclusive options. The phenomenological view is in many ways antecedent to any critical undertaking, and the only option is whether or not and how to attend to the personal ambiguities in the decision-making process.

3 There is a stark contrast between the flagrant irrationality of the psychotic and the appearance of rationality in those who are only minimally neurotic. Often psychotics are referred to as "orphans" or "therapeutic orphans" when deemed incapable of participating in ordinary human affairs including giving informed consent. This metaphor is illuminating because it suggests estrangement from the human family as well as somewhat arbitrary notions as to what might be required for inclusion. Indeed the notion of "orphanage" from a "family" suggests that a look at the early experiences in family life may be warranted -- a perspective that is familiar to most psychiatrists in their attempts to understand conflicts in human affairs.

It may seem an obvious truism to say that an adult thinks differently from a child or that a psychotic thinks differently from a sane man. But unless a sane adult can recognize or recall antecedents of his own world-view in that of the child or psychotic, he has little hope of being able to communicate with that person.

Respect for autonomy that does not respect fiduciary interaction may be a confusion of "autonomy" with "autism" and "solipsism." If subject and object are seen on different levels of human value, there is no prospect of mutuality. "Not that anyone but a madman has ever taken solipsism seriously: arguing for it, except in soliloquy, is to acknowledge the "other" whose consensus is sought. The argument is then frivolous, quo dialogue, while absolute monologue is the madman's privilege." (Jonas, 1966, p.32)
REFERENCES


Donald Campbell calls attention to ethical concerns in an unusual way in his article "On the Conflicts Between Biological and Social Evolution and Between Psychology and Moral Tradition." He advances the thesis that "present-day psychology and psychiatry in all their major forms are more hostile to the inhibitory messages of traditional religious moralizing than is scientifically justified." In making this point, he draws on biological evolution (group selection and genetics of altruism) "to support a thesis about basic biological human nature that is in agreement with traditional religious moral teachings." This curious juxtaposition of moral tradition and evolutionary genetics is causing quite a stir, a controversy that I believe is well deserved. Yet there is something quite disconcerting about both his thesis and his way of going about justifying it. Among the many questions that are being asked are the following: Is Campbell right about (a) his major thesis, and (b) his views on social evolution? If so, what are the implications -- professionally, socially, politically? What kind of data would be necessary to confirm or disprove his hypothesis? Is this an area for scientific research at all? Is Campbell serious, or is this an elaborate philosophical tease? What does it mean to rethink the ethical assumptions of one's profession? Has Campbell done this? Is he stimulating others to do so?

In the remarks which follow, I will not be able to answer all these questions. Instead, I would like to draw on the epistemological work of Michael Polanyi to illuminate what I consider to be the ethical issues at stake in Campbell's thesis. To anticipate the argument, I believe that Campbell is performing a needed service by calling moral tradition into consideration. I believe that he is misled in his manner of doing this. But in so doing he inadvertently brings to our awareness certain of the limitations (boundary conditions) of behavioral science in relation to value questions.

There is a certain irony in Campbell's project that is unsettling, as ironies tend to be. In making an appeal to moral traditions, he relies on a physicalistic (materialistic) world-view that would ultimately seem to undermine the moral traditions he endorses. By adopting the reductionist view -- reducing moral considerations to the physical, i.e., translating social concerns into biological -- he would seem to obviate the necessity for moral concern at all. If Campbell were right that there is such a thing as genetics of altruism or even social evolution, then his whole enterprise would be trivial from a moral point of view because (1) if altruism were determined genetically, our species' complement of altruists would be determined at birth as an either-you--
have-it-or-you-don't proposition, and there would be no motive for striving for human betterment; and because (2) the sort of evidence Campbell adduces would come from the computer-stimulated mathematical models, which only specialists would understand, and therefore would prove to be small incentive for energetic attention to moral concerns in the world of human affairs.

One is led to question Campbell's motives, not so much to discredit him, but to understand him and the methods he uses for raising ethical concerns in the context of scientific psychology. I have said that I find his thesis ironical, which is not to say frivolous. Considering irony as his method, along the lines of Kierkegaard's Concept of Irony, gives a clue to the issues at stake. Perhaps we have become so estranged from moral arguments in the world of modern psychological science that we need an indirect discourse such as Campbell's to shock us into realizing our moral stance. Kierkegaard suggests two alternatives that seem to apply to Campbell: "Either it is one of those infinitely deep ironies which encompass the most trivial things with profound seriousness, and in this way mock everything most profoundly; or else it is nonsense, one of Socrates' weak moments when an ironic nemesis allowed him to lapse into the category of the infinitely trivial." Indeed, throughout Campbell's article there is a flavor of Socrates in the agora, where on the one hand he seems to have all the answers, and on the other, he seems innocent of any assumptions himself, and all the while he seems dead serious about the overall importance of the enterprise, however tentative he is about the particulars.

Using awareness of irony as a clue to understanding Campbell and the enterprise he undertakes, I am led to a consideration of the context of Campbell's thesis and an epistemological consideration of the conflict between psychology and moral tradition. It is here that the work of Michael Polanyi becomes illuminating.

Polanyi sought to understand scientific thinking on the grounds of the commitments held by scientists. His work is motivated, he tells us, by admittedly political concerns. He opposes the view, derived from Soviet Marxism, that "the pursuit of science should be directed by public authorities to serve the welfare of society." He holds instead that "the power of thought to seek the truth must be accepted as our guide, rather than be curbed to the service of material interests." He speaks of witnessing the "dissolution of European culture," and I believe Campbell is no less serious when he advances his thesis about the dissolution of inhibitory moral traditions.

Polanyi describes a phenomenon he calls "the moral inversion." He sees two conflicting ideals of our age, the pursuit of a moral purpose and its intellectual skepticisms "locked in a curious struggle in which they may combine and reinforce each other."

One of the curious features of modern epistemological orthodoxy, Polanyi notes, is the desire to protect knowledge from the
excesses of religious dogmatism. As knowing came to be separated from believing, and as modern man lost the capacity to accept any explicit statement of his own belief, so also he lost any inclination to acknowledge moral beliefs. Since no society could live up to Christian ideals, they came to appear as hypocritical (literally less than critical) and were repudiated. Yet, Polanyi maintains, unacknowledged moral passions could not be repudiated and often surfaced in some other guise. He witnessed this phenomenon in what he calls the dynamo-objective coupling of Marxism.9 After we have illustrated the principle by this example, we may inquire of its operation in Campbell's thesis.

In the dynamo-objective coupling, the coupling of objectivistic skepticism and moral passion, alleged scientific assertions that are accepted as such because they satisfy moral passions, will excite these passions still farther, and thus lend increased, convincing power to the scientific affirmations in question, and so on. Moreover, such a dynamo-objective coupling is also potent in its own defense. Any criticism of its scientific part is rebutted by the moral passions behind it, while any moral objections are coldly brushed aside by invoking the inexorable verdict of its scientific finding.

In the Marxist example, one sees a coupling of utopian ideals (liberty, justice, and brotherhood) and an objectivistic view of the social order, viz., dialectic materialism. By covering moral passions with a scientific disguise, moral sentiments are protected against depreciation as mere emotionalisms. They acquire instead a sense of scientific certainty; on the other hand, material ends are impregnated with the fervor of moral passions.

Polanyi also sees Freud's interpretation of culture as a moral inversion in which Freud's own moral commitments are disguised as scientific statement.10 I find this case more complex and problematic, hence less illustrative. Nonetheless, there can be no question that moral inversions operate quite commonly in the fields of psychiatry and modern behavioral science, as I have discussed elsewhere.11 These disciplines, bound by the tenets of positivism, disclaim any moral intentions. Yet the vast enterprises of psychiatry, psychoanalysis, behavior modification, and counseling proceed according to value judgments with the metaphors health/illness, or the measurements normal/abnormal surviving as surrogates for the moral terms good/bad (valued/disvalued).

Campbell's thesis provides us with yet another example of dynamo-objective coupling. In asserting the value of moral traditions, Campbell appeals to a scientific theory of social evolution. He states: "I can only hope that by raising [my] conclusion in the context of modern scientific concerns about the problems of complex social coordination and the population genetics of altruistic traits, I can make the point more convincing to psychologists and psychiatrists than Mowrer12, 13 and Menninger14 have been able to do." If one were to discredit the scientific branch of Campbell's thesis, the moral argument would remain. If, on the other hand, one were to ignore the moral branch of his argument, then it would be possible to appeal to the scientific branch.

147
In some way that is not quite clear in Campbell's article we are asked to consider the conflict between psychology and moral tradition as analogous to the conflict between biological and social evolution. Starting from the solid ground of biological evolution, Campbell explores social traits in urban humans along lines analogous to the survival of social insects (ants, bees, and termites). It should not be forgotten that biological evolution as a scientific theory accounts for the origin of distinct species (defined as those organisms which interbreed in a natural environment). It is an extrapolation beyond Darwin's intention to use evolutionary theory to account for individual differences within the species. Social evolution is such an extrapolation, moral metaphor resting on science and disguised as science -- elegant as poetry but misleading as science. If altruism cannot be appreciated as a moral value, perhaps it will appeal as adaptive for survival in human urban civilizations. But we should remember "adaptation" and "survival" are other such metaphors poetically derived from the natural science of Darwin.

In assessing the merit of Campbell's work there are numerous approaches one might take according to the branches of his argument with which one wishes to deal. It is ultimately for the geneticists to deal with the genetics of altruism issue, although I personally find that less than edifying. Polanyi was concerned with the proximity of moral inversions and totalitarian political systems. Indeed, many political theorists point to the conservative political implications of Campbell's thesis. I think the main contribution of his address is in its ironical provocation of ethical concerns. He has, I believe, in essence sketched the boundary conditions of psychology as a science to deal with value questions. These questions are central to psychologists as people and as scientists; and yet to raise such ethical questions with much impact, one is almost forced to the reductio ad absurdism of social evolution.

If Campbell had made an impassioned plea for these moral values directly and on their own merits, his address might have received little attention. Instead, he needed a literary device, a metaphor, which social evolution provides, for raising value questions in a form analogous to the other sorts of questions raised within the discipline. This is a rich source of hypotheses, Campbell suggests, and indeed he is right. Whether they are proved or even provable may matter little, because they have stimulated numerous psychiatrists, psychologists, behavioral scientists, social scientists, and even a few philosophers and literary critics to think about ethics in novel ways.
REFERENCES


2. Ibid. p. 1103.

3. Ibid.


6. Ibid.

7. Polanyi, Personal communication.


10. Ibid., p. 233.


I would like to begin my remarks by applauding the efforts of the Association to include the perspective of the humanities in this symposium. I strongly believe that society would benefit not only by the greater participation of humanists in discussions of vital issues of the day, but also by an increased awareness on the part of other professionals, especially health professionals and scientists, of the need for a broader educational base in the humanities.

My own place in the humanities is with philosophy. If philosophers are known at all for their contribution to the resolution of problems of the sort facing this symposium, it is with what has come to be called biomedical ethics. Yet there is another way philosophers can and do contribute to such concerns, and it is on this other way that I am going to focus today. If we need a name for this enterprise, let's call it the philosophy of medicine. Rather than try to explain what a philosopher of medicine does, I prefer in the time available to me here to give a concrete example. Let me say this much in preparation, however. Philosophers in general try to get clear on the major concepts involved in an area of concern. A philosopher of medicine, then, tries to clarify the major concepts in medicine. Thus, he is interested in what is meant by "disease," by "health," by "ill-health," by "act of commission," by "act of omission," and so on. The correct analysis of such concepts often becomes central to some very practical concerns. For example, the distinction between the acts of omission and acts of commission is often used to defend a charge of moral or even legal culpability if we shut off the machines on a patient in irreversible coma, but to excuse our action if we simply let such a person die by not turning the machines on in the first place. Now if this distinction isn't justified, we need to know it, and analysis of the crucial concepts is a major step in that direction.

My own research interests have just recently focused on questions concerning the relation between physical health, disease, and illness on the one hand and what is called mental health, disease and illness on the other. As is often the case in situations like this one, the terminology and even the methodology of the older, more established physical sciences, and especially physical medicine, have been transferred to the younger and less methodologically stable areas of social science and psychological medicine, often automatically and without considered judgment. Of particular interest to me is that there seems to be a strong motivation to assimilate as part of the same general pattern the relation between a physically natural condition for human beings and deviations from that condition.
Taking this apparently innocent dichotomy uncritically has, I think, had damaging consequences. For example, it has allowed one pole of a dangerous pair of extremes to emerge as part of our cultural attitude toward mental ill-health. This is the view which begins with the observation that mental ill-health, like cancer or legionnaire's disease, is not only involuntary in its acquisition, but that there is really nothing one can do for oneself or by oneself in order to get rid of it. It follows in the case of many physical disorders that the person should not in general be considered as bearing responsibility for the manifestations of the disorders. If the analogy to the mental is now extended, and if the manifestations of mental life are seen to be human action, then the tendency in the case of mental disorder is to disassociate the individual from responsibility for his actions. The consequence is that he may no longer think of himself, and society may no longer think of him, as a responsible agent.

The other pole I mentioned, and one equally as dangerous, has it that the attainment of mental health, totally unlike that of physical health, is simply a matter of exercising sufficient will power. Failure to get over one's problems merely demonstrates a weakness of will and is to be condemned—the ultimate in responsibility.

In order to avoid problems like these it is important that one get straight on the analogies and disanalogies between, on the one hand, physical health with its implication of a physically natural condition of persons, and physical ill-health taken as a deviation from that condition; and, on the other hand, mental health with its apparent implication of a psychologically natural condition with psychological ill-health viewed as a deviation from that condition. Presumably one of the consequences of a successful study of these connections would be to discover whether the basis of the distinction between psychological health and ill-health really rests on an objectively solid notion of a natural psychological state for persons. Moreover, we would be interested, especially in the context of this symposium, in whether the distinction between mental health and ill-health can in fact support the institutional and legal differences that it now pretends to support.

I cannot hope to do justice to these questions today, for among other reasons, I do not yet know the answers. Indeed, I consider it something of an accomplishment just to have gotten clearer on what the questions are. For the remainder of my time, then, I would like more than anything else to report a few observations I have made beyond the discovery of what the important questions are.

First of all, it is worth taking a look at the history of the natural/unnatural dichotomy itself. The most significant structural influence on the development of the natural and unnatural rests with Aristotle and his conception of science and philosophy. Aristotle was an essentialist. As such, he held that one cannot come to know the meaning of a thing-word, words like "dog," "person," and so on, without knowing at least some of the true sentences in which that term
appears. There is, he believed, a logical connection between knowing the referent of a word and knowing in which sentences it truly occurs. To put it a little less technically, according to Aristotle a thing, such as a person or a dog, just by virtue of being that kind of thing, has certain characteristics that it cannot lose without ceasing also to be the kind of thing it is. The list of just those characteristics is taken to constitute the nature of the thing.

Aristotle's view that things like persons and dogs have a nature in this sense led him to propound a very specific position with regard to the question of how it is that changes take place. It is a position that very clearly differentiates him from the claims of the modern scientists like Galileo, and even further from contemporary science. For Aristotle, as a thing changes it is really actualizing the kinds of changes that are already potentially within it and are determined by its nature. In this sense, all objects are moving in a certain direction, toward a certain purpose—to actualize what is potential in their nature. The problem is that events may impinge on the object from the outside and interfere with its development. Such occurrences may result in a failure to fulfill the actuality of the object. When the object is in this condition, it can be said to be deviating from its nature.

Aristotle likes to use the example of an acorn developing into an oak tree by actualizing the potential within it. Deviation would occur if someone were to step on the acorn and smash it.

It is important to see that this dichotomy between the natural state of the object and deviation from that state is not at all based on the notion of frequency of distribution of characteristics in a population; it is not a notion settled by a statistical norm. Rather, it is a distinction said to be inherent in the very essence of things. It is objective and independent of the conventions of human classification.3

The influence of Aristotle's way of drawing the distinction between the natural and the unnatural cannot be overestimated. For years the opinion persisted that so long as an object was acting in accordance with its nature, no explanation of its behavior was desired or required: "Why is it doing that? Well, that is what it is supposed to do." This had a profound effect both on science and medicine. Take, for example, the development of psychology. The attitude was that man's mental life would be forever free from the speculative eye of scientific investigators. Indeed, it was accepted that abnormal behavior could and should be explained, but that, in the true Aristotelian style, there could be no explanation of normal human behavior. It was Freud who ultimately dispelled this last remnant of the Aristotelian frame of reference by providing what he believed to be an explanation of all human activity, both normal and abnormal. Whether or not one accepts or rejects the specific features of Freudian psychology is, of course, not the issue. Rather, it is that for the first time an explanation of all human behavior had become a real possibility.
The methodological shift that marks the end of the Aristotelian world view and that lays the foundation for the golden age of science is the rejection of essentialism and its replacement by the tenets of empirical science. But this shift raises a critical question for the philosophy of medicine. Can the view of the world reflected by the methodology of empiricism support a nonconventional distinction between the natural and the unnatural? That is, to put it in terms more specific to our concerns here, can contemporary empirical thought justify a nonstatistical, nonconventional distinction between man's normal condition and deviations from it, between health and ill-health?

If we look at this question in terms of physical medicine, I think the answer is yes. However, this is by no means the universally agreed upon answer. Some would say, for example, that once essentialism ceased to be a part of scientific orthodoxy, health and ill-health were finally revealed to be what they had been all along: relative concepts. After all, it is argued, if health is a matter of what is good for the organism, and if what is good for the organism is inherently relative to societal or individual perspective, then the same relative conclusion applies to health.4 I think this sort of argument is off the mark in physical medicine, and I shall try to show that shortly. The point to be on the lookout for, however, is that, even if I am right about the objective character of health and ill-health in physical medicine, there seems to be no similar reply now available to secure the objective status of health and ill-health in the psychological case. But more of that in a moment.

Physical health and ill-health are objective, nonrelative concepts because they have an objective foundation in terms of functional ascription.5 Although the truth of ascriptions such as "The function of that object is to sit on" may be dependent on our act of selecting out that consequence to emphasize, the truth of functional ascriptions such as "The function of the heart is to pump blood" is clearly independent of such criteria. Moreover, the descriptive and explanatory role of functional ascription statements about organs, tissues, cellular parts, and biological processes is solidly based in contemporary scientific empiricism and is quite capable of supporting a dichotomy between the natural and deviant conditions of organisms. Thus, the function of the heart is to pump blood precisely because pumping blood is a consequence of heart action and because the heart exists in the form it does because it results in pumping blood. This latter claim, that pumping blood is the consequence which explains why the heart has its present structure, is easily verified as a truth of natural selection. It follows that when the heart ceases to pump blood, there is clear deviation from its function.

What I am arguing is that there is an adequate basis on which to support an objective distinction between a physically natural condition for organisms in general and persons in particular and deviation from that condition. The question that remains is whether there is a similar foundation to support an objective distinction in the psychological case. And this is critical since the existence of many of our societal,
institutional, and legal attitudes toward persons we call mentally de-
viant depend on such a foundation. Moreover, even assuming that we
could find such a basis, the question would still remain as to whether
it could support the specific character of those attitudes and espe-
cially what looks to be the great extremes in the laws and practices
that presently exist.

The fact is that at the present time there is not sufficient in-
formation to determine either that such a foundation does exist or
what such a foundation might be like. In the absence of such method-
ological information we have done what might be expected of practical
scientists and technologists. We have adopted statistical norms, dis-
tribution frequencies, as our guide. And, of course, there is nothing
wrong with this procedure under the circumstances. The problem is that
many of the laws and institutional practices that now exist presuppose
an actual methodological basis. And, further, several of these laws
and practices are so much in the extreme as to be actually pernicious
in the absence of such a structure. We can only conclude, therefore,
that where the laws reflect these unwanted and unjustified practices
they ought to be changed. And the sooner the better.
FOOTNOTES

1. This paper was originally written for presentation to the symposium "Mental Retardation: Interdisciplinary Responsibility and Public Interaction," sponsored by the Fort Worth Association for Retarded Citizens on a grant from the National Endowment for the Humanities. In effect this paper is an outline of a number of ideas springing from research done during my tenure as a Fellow of the Institute on Human Values in Medicine of the Society for Health and Human Values under National Endowment for the Humanities grant #EH-10973-74-365.


3. Leon R. Kass is one of some contemporary writers who in my judgment argues that health and ill-health are to be understood in these terms. See "Regarding the End of Medicine and the Pursuit of Health," The Public Interest, Number 40, Summer 1975; and an unpublished paper "Teleology and Darwin's The Origin of Species: Beyond Chance and Necessity?" delivered on October 11, 1974 at St. John's College, Annapolis, Maryland.

4. There are a number of contemporary writers who maintain that health and ill-health are relative concepts in the sense specified. For example, see H. Tristram Englehardt, Jr., "Explanatory Models in Medicine: Facts, Theories, and Values," Texas Reports on Biology and Medicine, 32 (Spring 1974), and his."The Concepts of Health and Disease," presented to the faculty and students of Southern Methodist University.

A BEGINNING STUDY OF SOME USES OF ALTERNATIVE 
HEALING SYSTEMS BY PATIENTS 
IN A METROPOLITAN HEALTH CENTER 
by LaVerne Rocereto

PURPOSE OF THE STUDY

A cross-cultural section of clients who utilize the services of a large metropolitan health center were studied to determine their attitudes, beliefs, and use, if any, of alternative systems of response to illness. The data collected would be used to provide the nurse and other health workers with (1) a wholistic frame of reference to create a milieu where the client could freely discuss beliefs; (2) to recognize some of the many variables that may affect the health-teaching needs so more individual teaching can be planned with the client and his family. The study was intended as a first phase of a more detailed project that would investigate other cultural and ethnic variables that influence health and illness.

RATIONALE FOR STUDY

Scientifically educated health workers must understand that someone who is ill, or in need of any health supervision, does not always first seek out or accept the traditional health worker. There are, as there have always been, a variety of nonscientific healers and systems who render service to those who need help. Attitudes of health and illness are to some degree culturally determined. All people do not use the scientific medical facilities even when they are accessible and affordable. They may resort to some alternative systems of response to illness; for example, the use of marginal and lay healers and the reliance on folk remedies. Oftentimes, they may use a combination of scientific and nonscientific systems.

Yet little opportunity has been provided to the client to discuss his feelings about these other systems and how he may rely on them to treat illness or maintain health. There is often a reluctance on the part of the client to admit to a belief because of possible ridicule or displeasure by the health worker.

If the role of these systems in the life-style of the client is not understood by the health worker, health teaching may be negatively affected. An open exchange of ideas between client and health professional could reduce the reticence that many people have to admit to the use of other than a traditional, scientific, health-care system.

A more tolerant and less judgmental attitude about the importance
of these beliefs to many people could create an environment in which the health worker could be better able to identify possible harmful effects of these practices and help the client to understand this. Reinforcement could be given in those instances where psychological support is provided by these systems with no deleterious physical effects. This milieu should strengthen any health teaching needed by the client and help the professional to be more cognizant of a wholistic approach to health care.

ASSUMPTIONS

1. Informants would not be identified.
2. Clients would have the right to refuse to be interviewed.
3. No attempt would be made to persuade or influence people to use nonscientific healers or healing systems.
4. Clients would only be interviewed if their physical conditions permitted. The researcher would confer with the head nurses each day.
5. Interviews would not be taped, in conformance with a request from the hospital Executive Director.
6. No attempts would be made to solicit any information that could indicate nursing care was being evaluated.
7. Family members, if willing, could also be interviewed.
8. The researcher, at all times, would consider the comfort, welfare, and needs of the client and nursing staff and would not interfere with any necessary nursing or medical care.

METHODOLOGY

Through the use of structured and unstructured interviews, the data were gathered.

The following is a sample of how the purpose and goals were stated:

The questions were guides for the interviewer and were not necessarily phrased exactly as stated. Rephrasing occurred in some cases, according to responses from the clients.

SAMPLE:

I am Dr. Rocereto, a nurse faculty member of the University of Pittsburgh School of Nursing. I am doing some research at Presbyterian-University Hospital. I am studying the use of healers, other than scientific medical healers, to determine how nurses can become aware of the role of these healers for many people, and to see how nurses can plan health teaching for patients who may use both scientific and nonscientific medicine. The more the nurse can understand about your beliefs and attitudes, the more individualized will be your nursing care.

I have some questions that I would like to ask you, if you care
to participate.

There will be no attempt to identify anyone who participates. I am not evaluating nursing care. I am only seeking to gather information about the possible use of healers or folk remedies.

Would you be interested in spending some time with me?

Sample Questions:

1. Have you ever used any type of nonmedical healer? (faith healer, spiritual healer, reader-adviser, naturopath, i.e., one who has not been educated within a formal system of healing.)
2. Do you know of anyone who has?
3. Why do people consult these healers?
4. What benefits do they feel one derives from these healers?
5. What services do they provide that scientific medical healers do not provide?
6. Do you feel that the nurse should ask the patient if he does use other healing methods?
7. How could the nurse help you or someone who does use lay healers?

INTERVIEW SUMMATIONS:

WHY PEOPLE USE ALTERNATIVE SYSTEMS AND SOME IMPLICATIONS FOR NURSING

1. They are available.
   a. They are there when you need them.
   b. One seldom needs an appointment.
   c. They have a long history of being used by family and friends.
2. They are cheaper.
3. They do get results; while cures are not always effected, neither are they in the professional medical system.
4. They are often used first. If results are not forthcoming, then a scientific healer would be consulted.
5. They provide a more trusting and empathetic environment. They seem to care more about the person.
6. People often categorize disease into what is treatable by the medical profession and what could be treated by folk healers.
7. When use of alternative systems of healing does not seem to conflict with medical therapy, the nurse should reinforce the positive aspects of this support system, but explain any negative features that could be harmful to the client.
8. People have always searched for causes of diseases. There are still no absolute explanations for many illnesses. The medical profession cannot answer everything, so many people feel they cannot lose anything by consultation with lay healers.
9. Both systems of health care still function simultaneously in all classes and cultures; in some, to a very limited extent, in others, to a larger extent. Nurses should know what healers are used in the community.
10. The lay system can reinforce the medical system. The client often feels the need to use both and does not limit use to one exclusively.

SELECTED INTERVIEWS

The following vignettes are representative of the kinds of comments offered by those people who were interviewed. While these are almost verbatim accounts of individual interviews, the remainder of the one hundred interviewed do not suggest any new material.

1. FIFTY-SEVEN-YEAR-OLD RETIRED MALE NURSE

Up to the age of two years, I had been doing well, but I began to lose weight and I was not eating well. My parents were Pennsylvania Dutch and later told me I had what they called "wasting away of flesh" or "decaying." Nothing the local doctor did helped me. I was taken to a pow-wow for treatment. When I became a nurse, I used to put down these kinds of healers and my father would sharply reprimand me and say, "You wouldn't be here if it wasn't for that pow-wow doctor."

I was told that the old pow-wow doctor stripped me and laid me across her knee. She muttered incantations in Pennsylvania Dutch that were supposed to be Bible verses. She made a bag out of acefetidid and it was to be worn around my neck. Another bag was to be hung on a door hinge and kept there until it dropped off. My father was told to put a small bone under his pillow. When the sun came up over Blue Hill, he was to take the bone down to the river and throw it over his right shoulder. He was not to look back to see where the bone went. He was to be silent during this whole procedure.

The day after this, my mother said I started to eat and began to gain weight again.

As I said, I used to be skeptical, but something else happened to me in later life that makes me less likely to scoff at nonscientific healing.

I developed degenerative arthritis of the 5-6-7 cervical spine. Some friends bought me a copper bracelet four months ago, and I have never taken it off since. After the third day of wearing the bracelet, I was able to stop taking the Valium. I occasionally get pain. I take one Valium and the pain stops.

2. A FORTY-FIVE-YEAR-OLD PROFESSIONAL NURSE

I know that scientific healers don't cure warts like my remedy. My German mother talked about it. You take a potato and get the pulpy part of the eye. Rub that over the wart and throw it away where the sun won't hit it. To throw it, you take the piece of potato in your right hand and throw it over the left shoulder. When it dries up, the wart will fall off. It takes a few days usually. I know it really works.
3. A FORTY-SIX-YEAR-OLD MALE

I live only fifty miles from Pittsburgh. That's not really much anymore. We really can't get doctors right in our area, so most of us have to come here. It's not a bad drive but you don't like to do it often. So I don't use doctors except for serious things—I had a melanoma. When I was a child, we had an old family doctor who was really loved. We felt close to him and never hesitated to go to him even if it wasn't serious. Those days are gone. I don't feel a closeness to a doctor when I don't know him.

I have been told different things by each doctor. Even my chemotherapy was delayed two extra days because one said he would order it but didn't.

Many people in my area use naturopaths and chiropractors. I won't. I don't like any doctors, not even using an aspirin—only as a last resort. But I know people like those healers because they are there when you need them. They aren't too expensive. Maybe if medical doctor visits were covered by insurance, people would not use the other healers. I'm not sure because I know wealthy people who don't go to a medical doctor even when they can well afford it.

4. THREE RELATIVES OF A TERMINALLY ILL MAN ASKED TO BE INTERVIEWED WHEN THEY HEARD WHAT I WAS DOING

One woman, about fifty-five, told me about her brother who went to a famous faith healer at every opportunity and never missed a radio or TV performance on healing.

"I told him over and over how foolish he was and he finally had to go to a doctor for the operation. What good did this person do him?"

The other relative, about the same age, interrupted and reminded her that the man always felt good otherwise and seemed to be more at peace with himself than the rest of them. He used to say that he could not give them a reason but he just felt good.

As children they had all been familiar with home remedies. They felt they would never have been able to afford a doctor for every ail-ment. They would not hesitate to use a medical doctor but would also continue to use stand-by remedies for those things which they would not consider serious enough to consult a doctor about.

The man, about sixty, said he thought many nurses and doctors were bastards who were unapproachable and made you feel unimportant and dumb. The lay healers make you feel good, like you are someone special. Even in a large room with hundreds of people, you feel very special. That alone can make a sick person feel better.

5. A THIRTY-EIGHT-YEAR-OLD FEMALE

My family always used chiropractors and naturopaths. They made us feel good. I'm not even sure if a medical doctor was accessible to us, but I remember my mother always said that doctors today might know more but they do not give you the time you need. I believe strongly in meditation. It requires extreme concentration but this aids in healing.
I also use Lourdes water and certain passages from the Bible before I meditate. I'm sure you know that lots of study is being done on meditation and I think medical doctors might be surprised at the findings. The chiropractor I knew got a lot of results from his regular manipulations but he encouraged relaxation, which, I think, is a big part of meditation. I had to have surgery so I came here. I have been treated kindly, but in a detached way. I know the staff can not spend a lot of time, but even if they would call you by name or knock before they come into your room, it would make you feel like they considered you. I've been reading a lot about National Health Insurance and I think it will only be worse. More people will be trying to get more care. I suppose we would have an increase in doctors and nurses, but they will be so busy you'll really get short shrift. I hope National Health Insurance won't put the other healers out of business. I think a nation as big and complex as ours can find room for both.

6. A FORTY-ONE-YEAR-OLD MALE, BORN IN UNITED STATES—GRANDPARENTS CAME FROM FRANCE

"Yes, I believe in faith healers and any healers who can help a person get better. Medicine can't explain everything. Can you, or anyone tell me exactly how I got leukemia? How many times have you asked the doctor what caused something or how do you get a complication and he tells you he really doesn't know?

"The nurses always tell you to ask your doctor and then you still don't get a straight answer.

"I've often wondered why some people get better and others die and they seem to be equal in all other ways. Some people heal quicker than others and maybe there is a good reason for this, but I don't think it's all scientific."

This patient had two books written by prominent faith healers. He would have no objection to being asked about his use of different healing systems if the nurse would really listen to what he said.

7. A FIFTY-NINE-YEAR-OLD MALE, AMERICAN BORN. (NO SPECIFIC ACKNOWLEDGMENT OF ANY ETHNIC GROUP)

This incident was observed by the researcher in a clinical unit.

The resident doctor had told the patient he needed a hemorrhoidectomy and would be scheduled the following day. The patient replied that he would use Preparation Eight since it had helped before. The patient did not get a chance to say anything else.

"O.K., if you know more than the doctors, go ahead and use it. I'll discharge you now."

Since the patient's family background was known to me, I was aware that he had an invalid wife who was being cared for by a neighbor, but the neighbor had to return to work. The patient wanted to return home, make more definite arrangements for the care of his wife, and then he
would have been willing to return to the hospital for the necessary surgery.

In the meantime, Preparation 8 would help.

When I explained this situation to the resident, he understood and returned to the patient's room.

If the nurse had not been aware of the patient's problems and what had prompted his remarks about the remedy, she would not have been able to act as interpreter to the doctor, and the patient may not have received necessary treatment. Social Service was also contacted to help locate a temporary housekeeper for the patient's wife.

8. A SIXTY-SIX-YEAR-OLD POLISH LADY

"Three years ago, I was in Boston to visit my son. I had suffered from arthritis for years and I tried everything—medical doctors, drug stores, any remedy someone would tell me about. I had little relief and each year I got worse. My son insisted I see an acupuncture doctor whom he had heard about. The treatments were $25.00 and you needed about eight. He told me to stay until I finished the treatments and I have not had any severe pain in three years. Occasionally, I get some discomfort and I take aspirin and it helps. I would recommend this to anyone. I was never helped by the medical doctor. All he kept saying on each visit was, 'There's no real cure for this, Mrs. X. You have to learn to live with it. I'm not afraid to tell anyone this and I'm glad I did it.'"

This patient felt that nurses should know about these other options open to patients and not scoff at their effectiveness.

9. A FORTY-FOUR-YEAR-OLD RUSSIAN ORTHODOX WOMAN (A PROFESSIONAL NURSE)

"My community still has a lot of people who believe in "old grandmas" as healers. They know all about what to use for infections, arthritis, and alopecia. Sometimes in the doctor's office at home, if he doesn't really know what to do, he will see if there is an old grandma in the waiting room. She can help with the diagnosis.

"They have used moldy bread. We were always taught to keep a piece of this in the house. It is used to rub on infections. Flaxseed and tomato can be used to draw out infection. My grandmother always had nettles in her garden. Persons with arthritis would come and put their hands into the nettle patch and I guess the irritating effect helped the arthritis. I just saw one of your instructors whom I knew. She was telling me that her son's beard was falling out. I told her to go get an old grandma. If she couldn't do that, go to a slaughter house to get fresh tallow from the lamb to rub on his skin. That always helps alopecia. Another thing we used was garlic for high blood pressure.

"I know some Slovak women who used water and matches to help with some illnesses, but I don't know much about that."
"I remember when I worked in a hospital where some old homeopathic doctors still practiced, we had to bring the patient different brews every fifteen minutes. I often wondered if the brew helped, or was it the fact that someone had to check them frequently and at least see them. (The investigator is reminded here of the necessity of rituals in healing for many people.)

"I think nurses do jump to the wrong conclusions about lots of things. The other day I had bifocals on and when a student nurse approached me to ask a question, I looked up over the bifocals and I must have appeared to be frowning. She asked what she said that irritated me and I tried to explain but I don't think she really believed me."

This lady definitely felt nurses should ask about the patients' beliefs in healing systems and allow for more dialogue.

10. A SIXTY-TWO-YEAR-OLD FEMALE, FIRST GENERATION POLISH

My sisters and mother used a lot of concoctions. They liked to go to the church for healing services. I can remember a man who came every summer and set up a tent. People flocked to him because he talked good and only passed a hat. No one had to give anything.

I have used medical doctors because I have high blood pressure and a bad heart. My sister-in-law wanted me to go to some healer recently but I had to go somewhere else. If I did go with her, it would not mean I would give up my doctor. I know I need his medicine and supervision. My sister-in-law said you feel good after you go to a service and she goes even when there is nothing wrong with her. But then, she would only go to the doctor as a last resort.

I almost lost faith in doctors when one accidentally severed the nerve in my leg. I have some paralysis.

I never gave my children any home remedies. I would buy medicine in the drugstore because if I told the pharmacist what they had, he would recommend something to me.

Who can afford to always run to a doctor and who could get an appointment right away even if they had the money? That's why I liked the man at the drugstore.

I think, until this generation, children always followed whatever type of healing was used by the parents. Now, they all have minds of their own and do as they please. I have a granddaughter who eats only those funny foods from the health store and passes up decent cooking. A lot of her friends do this too. She calls it "back to nature" and maybe she is going to use the old ways. She seems to do the opposite of what everybody else does so she will probably have her own way of treating things.

I wouldn't admit my beliefs about using these "back to nature" remedies if I was using them because no one thinks you should use them.
My granddaughter would probably tell you without even being asked.

11. FORTY-SIX-YEAR-OLD BLACK MALE

I have asthma and high blood pressure so I use what the doctor orders, but I travel a lot and sometimes I have run out of the asthma medicine. Then I get whatever product the drugstore has that I heard is good. But I wouldn't keep using it. I'd be afraid something could happen to me. I think most people try to follow their doctor's advice, but in an emergency anything helps.

After my surgery this time, I had severe constipation. My son came to visit me and he was eating his lunch. The cherries looked so good and I asked for a few. I was not allowed food at the time but I figured a few couldn't hurt. I only ate three, but shortly after, I had a good B.M. and felt better. I did throw up once. I thought I'd better tell the doctor what I'd done, in case it made me worse. All the doctor said was, "O.K., it worked this time, but don't try it again."

I have not used faith healers but I think it is because I have so many medical problems that I have been coming to doctors most of my life. I think they help many people. When my doctor told me I needed surgery, I right away thought I had cancer. (Patient kept pointing to his forehead as he said this and twice repeated his belief about cancer.)

I always think of cancer when I think of surgery. I was so afraid that if I had had more time, I might have sought the services of a faith healer--or anyone who might help me through the frightening experience. I went to the hospital the next day, though, so I didn't do it. My family all prayed for me and I prayed too. I was so alone that I talked to God and I must admit, I don't do a lot of that.

12 FIFTY-SEVEN-YEAR-OLD WOMAN BORN IN FLORENCE, ITALY. MOVED TO U.S. AT AGE 5, BUT HAS VISITED FREQUENTLY AND RETAINS TIES WITH HER BIRTHPLACE.

"I have never watched those faith healers on TV--I don't have time for TV. My aunt watches those shows a lot and she has even put her hand on the TV or radio like some of them tell you. She says it helps her arthritis. But my aunt will listen to anyone. She spends more money on hocus-pocus than she would on a doctor.

"I always use (mentioned the name of two patent cold and cough remedies). I gave them to my children and they still use them. I swear by these. I always believed that hot fluids and rest would make anyone feel better. I use these not only for a cold, but anytime I don't feel good. The hot fluid will flush your body and rest never hurt anyone."

The interviewer posed the question about what, if any, belief the patient or her family may have in the Italian version of the evil eye.

"No, no, that belief is gone. Maybe a few old people still believe it, but I know that I don't."
The interviewer interjected that many young people have begun to buy facsimiles of the horn that many people believe will neutralize the effects of the evil eye. Before anymore could be said, the patient pushed up the long sleeve of her robe and showed me the horn on her watchband. She smiled and continued: "This red horn is not the real thing. You probably know it is often a coral shade. This is a cheaper version. I always keep it on me. You know something about the evil eye, don't you? I'm not sure why I wear this. I'm not sure I really believe in it, but what's to lose by using it?"

Unfortunately, this interview was terminated at this point when patient was called to another department for tests. I believe more could have been explored about her beliefs, once this common point was established. She was scheduled for discharge the next day so a follow-up could not be arranged.

13. SEVENTY-YEAR-OLD IRISH-AMERICAN MALE BORN IN PITTSBURGH

"You know I have Parkinson's disease. I'm not in here now for that, but when I was in one hospital for another illness, I had a bad experience because no one cared about me. I developed severe bedsores over my buttocks; you could see my bone. At home, my family always watched for that and I had good skin. When my son questioned the nurses about why this happened, he was told that they had very little help and I could not be turned often. I've worked with finances all of my life and I really can't see why better care can't be given when all that money is charged. My neighbor's daughter wanted to work a few days a week and the hospital wouldn't hire her because they said they had no money for extra nurses. But in the meantime, I got the bedsores and I suffered and the hospital collected more money because I stayed longer. I'm not the kind to sue, but I think I could have made a case.

"I don't go to anybody except a doctor when I get sick, but my father always told us about some people they used when he was a little boy. One old lady saved his life with some kind of brew she made. He said it sweated the poison out of him and he lived. So my father always had faith in anyone who was successful in helping someone to get better.

"Maybe if I were very ill and the doctors gave up on me, I would try anything. I guess if my insurance ran out and I had no one to help me, I'd use what was cheapest."

The patient said the only things he was asked on admission dealt with money and insurance. He said if the questions were asked "in the right way," he probably would tell the nurses if he was using any kinds of medicines or nonscientific healers. But he added that if he thought they were being "smart," he'd probably keep quiet because it would be "none of their business."


"I firmly believe in using prayer, both individual and group. I am not sure that I would go to any lay healer. I cannot see that they do help many people. I think they are showmen, out for money. I know lots
of people who use different healers, however; and I think it's because many of them fear doctors. They have had bad experiences. My doctors are very good and compassionate. We always seemed to have good family doctors. I have met cold and aloof doctors, and I see no value in them regardless of how expert they are.

"My family frequently used 'plain remedies' for colds. One I will always remember was milk, garlic and butter—all boiled together.

"One thing I don't like about nurses, especially, is how they talk to each other while working on me. The other day, when the nurse was trying to draw blood and was having trouble, the talk was all about the date the night before. I know nurses need to have a social life, but why can't they talk to the patient? Maybe they have to talk about other things to keep their mind off their hard work, but it just doesn't seem right.

"I asked for a pain medicine a few days ago and no one brought it. My wife went to the desk and reminded them. Still, no one came. My wife told me they were sitting out there at the desk. She went back and did not leave until someone got me the pain medicine. My wife did not know what they were talking about, but I needed the pain medicine and it made me very angry. I felt like I was not important or maybe they didn't believe I had the pain.

"I know a friend of mine went to some kind of healer and he always said that even if the man didn't do anything to him, he always left feeling better because the healer was so kind and understood how bad he felt. Maybe that's why other people go too. They need sympathy."

This man said he would not care if the nurses asked him about what kinds of remedies he might be using. He could see that if asked in the right way, it could help both nurse and patient.

15. A FIFTY-THREE-YEAR-OLD, SECOND-GENERATION GERMAN FEMALE

"I do not believe in faith healers or prayer. I prayed very hard a few years ago and my husband still died. I have been very reluctant since then to have faith in anything. I had a Christian Science neighbor who almost died because she rejected treatment—her family finally intervened and sent her to a hospital.

"My mother always used her own remedies. She brought me through a bout of bronchitis that the doctor said would have killed me. He told my mother I was not going to last until morning. He had done all he could. She used mustard and onion poultices.

"When the doctor came in the morning, my mother told him he was not going to like what she'd done. The doctor told her that since it brought relief, he could not quibble about it.

"I, myself, would use old stand-bys. If it is the last resort, what does the patient have to lose by trying it? When you can't get
a doctor, you do need something like the home remedies."

The patient indicated that she would not mind if a nurse asked her about any beliefs in lay healers or home remedies. She told me that she thought many people felt guilt about the use of these things and deny any use of them. She herself would be more willing to count on faith and prayer if she had been successful. When people have good experiences, they'll keep using these things.

APPLICATION OF THE FINDINGS TO NURSING CARE

Few systematic attempts have been made in nursing education to look at the interplay of cultural beliefs and the clients' use of nonscientific healing. While this study did not focus on specific ethnic groups, the information gathered verified that clients from a variety of ethnic backgrounds do resort to many kinds of healing activities that do not fit into the category of traditional scientific medicine.

Any information about the client's belief system can help the nurse to develop a more personalized nursing care plan through the nursing process. Briefly stated, the nursing process is an interactive, problem-solving process used by the nurse as a systematic and individual way to plan and implement nursing care needed by the client. The phases of the nursing process are assessment, planning, implementation, and evaluation.

If the assessment is to be complete and view the client in a wholistic framework, the nurse should gather as much data as possible about the physical and psychosocial cultural forces that influence the client.

It is important to know if a client is using nonscientific healers or folk remedies and what effects this might have on the nurse's health teaching. If the client knows that the nurse is gathering this information, not to ridicule or chastize him, but because she wants to involve him as a partner in planning his care, he will be more amenable to discuss those beliefs which may differ from the nurse's.

It is also possible to incorporate the clients' use of various healing practices into their care—i.e., herbs, massage, relaxation, and exercise measures, yoga, etc.—so there can be a successful coordination of culturally traditional and modern healing practices for those clients who use both.

The assessment, with client input, can heighten the nurse's awareness and sensitivity and response to the client by considering his belief system in health teaching.

More time has to be spent with the client in the assessment stage to develop more trust so people feel free to discuss covert beliefs. The covert patterns in a culture are often more secretive and valued and seldom talked about. Discovering these patterns takes more time and must be developed in a trusting atmosphere.
The nurse must make a sincere effort to ask questions that will help the clients to share their health practices so health teaching can consider these factors.

The nurse must explore and examine her own attitudes and beliefs, and if possible, the foundation for these beliefs. Nurses have frequently been socialized into a society that has stereotyped racial and class and ethnic attitudes. Ethnocentrism can limit the opportunity to understand and appreciate that not only the scientific medical system operates in our society. The idea that because we are all "Americans" we will hold to the same beliefs has to be changed. The melting-pot myth is still believed, so people in this society may be viewed as a homogeneous mass.

Another mistaken idea is that only "strange" or "exotic" cultures use nonscientific healing. Indigenous and scientific healing modalities may be found side by side, with the latter not aware of the former. Professional groups may hope for their demise but in some areas they seem to be increasing in popularity, especially where the modern professional health system reveals gaps, uncertainties, and disappointment in health care. Few professional health workers are aware of an indigenous health system or practitioners in their communities. These systems and practitioners cannot be cast aside as ignorant, primitive, superstitious, or irrelevant. When health workers do this, they fail to realize the importance of the indigenous healing system and miss the opportunity to understand peoples' values and to provide the link with the modern health system. A culturally sensitive nurse will see that folk caring practices need to be further studied and appreciated and integrated into client care when they are not in conflict with needed medical therapy.

IMPLICATIONS OF THE STUDY

I. Formal courses

1. There has been little inclusion of anthropological concepts into nursing education. Students may have taken general and cultural anthropology courses but these usually do not integrate the concepts in a way that is meaningful to the nurse to plan care. Transcultural nursing courses are being developed and should be a part of every baccalaureate nursing program. These courses need to be taught primarily by nurse educators with a background in anthropology. Interdisciplinary consultation should occur, but the responsibility must rest with nursing educators so the proper integration of cultural and health concepts can occur.

2. As a part of the transcultural nursing course, field experience should be included. This is not the same detailed kind that is provided when a student in anthropology does field work to gather ethnographic data. The field experiences needed by nursing students could focus on getting to know more about the communities and the people who usually use the
health centers. Another type would be a short experience in an ethnic community that is different from the nursing student's. These basic experiences would be a starting point to develop a more humanistic, culturally sensitive nurse who looks at people, is eager to learn more about them, and tries to discover what makes up their "real" world and how they perceive health and illness.

3. As part of the formal course, a variety of learning experience could also be planned if the student cannot go out to the client. One example would be to bring the persons from different cultural and ethnic groups to class to discuss their perceptions and expectations of health and nursing care.

4. Independent individual and group projects, as part of seminars, can be planned, and the sharing of experiences would be meaningful to the whole class.

II. Informal courses

1. Since it has only been in very recent years that cultural health concepts are being included in some nursing curricula, there are several hundred thousand nurses currently employed who need in-service and continuing education to help them become aware of cultural differences when they plan nursing care with clients.

2. Nurses usually see the need to update their technical skills and are willing to attend programs of this nature. They are less likely to see why cultural variations in health would be important. As indicated previously, they often see patients as all alike unless they look different or speak differently.

3. These nurses do not have much experience in judging the influence of cultural factors in the nursing process unless such was included in a continuing education program taken since their graduation. If they did have an anthropology course it is likely, at this point in time, that the assessment of the uses of alternative healing systems and other cultural variables were omitted.

4. Through seminars the nurses could share their experiences and problems encountered when caring for clients from a different culture or with a different life-style, share their feelings about people who differ in beliefs from their nurses, and consider approaches which could be used to plan and implement nursing care that would consider these variables.
CONCLUDING STATEMENT

Both student and graduate nurses need to have some theoretical constructs that focus on cultural variations and health practices. They also need follow-up experiences that allow them to observe different ethnic groups, share these findings and discuss ways that nursing care can be planned to allow for cultural differences.

Health agencies have a responsibility to provide time to create an environment that permits more dialogue with clients. Too often this kind of activity is not seen as important and the nurse is told not to waste time by not "doing a task." When investigators do studies to determine nursing tasks and time involved to do them, they seldom focus on the assessment and health teaching activities of the nurse. Because these interactions vary considerably in length of time necessary to meet client needs, one cannot put a time schedule on them, but they should not be overlooked.

I will teach a course in the new curriculum at the University of Pittsburgh that will integrate transcultural nursing concepts. One component will deal with alternative healing systems.

I have also submitted a proposal to the Director of Continuing Education to plan and implement a series of workshops to help the graduate nurse who does not have a background in social sciences. This will be on my own time. I believe there is an urgent need for this and I am very eager to do it.

As I get even more involved in transcultural nursing, hopefully I will develop new ideas and experiences that will help both nurses and the consumers of health services.
The influence of Dietrich von Hildebrand's contribution to contemporary theological and philosophical ethics has yet to receive the attention it deserves. At a time when the tendency is growing in ethical thought to approach the problems of morality through different aspects of subjectivity alone, and through the continuously changing elements of man's moral structure, von Hildebrand's concern with the unchanging objective determinants begins to be more and more significant. He adds a badly needed--even if not very popular--complement and counterpoint to present trends in ethical thinking. The consideration of being not as existent but as "important-in-itself" opens avenues for philosophical and religious ethics not fully explored by other authors. The purpose of this study is to present some of these elements in his thought.

The nineteenth-century discovery of values by German philosophy—or according to some opinions the rediscovery of the Platonic concept of goodness—was one of the most original and significant contributions to a philosophy of human self-understanding. The value-concept from the time of its discovery was strongly influenced by different forms of subjectivism. The Hildebrandian phenomenological analysis, however, showed that its deepest root is independent from the valuating person; in fact, in his later periods he proved that value-endowment is a primary element of reality and so precedes the person who perceives it. In his system, therefore, valuation became a matter of perception; value-judgment was replaced by value-response; and a phenomenological axiology was developed into a metaphysics of values. By reducing values to being he also eliminated to a great extent the traditional distinction between ontology and ethics, and thereby restored normative relationships between objective reality and human self-realization by actions.

It was von Hildebrand's expressed intention to discover an objective metaphysical foundation for values, and, in opposition to Kantian transcendental idealism, to demonstrate that the practical postulate of Kantian ethics does in fact have an objective foundation in which both the person's moral self-transcendence and his religious experience are grounded and basically determined.

The earlier period in his investigation was dedicated to an anthropological problem. In order to show that moral goodness in man does originate in objective rather than in subjective sources, he analyzed the different stages of human self-realization in the realm of morality, and demonstrated that there is nothing in man to exercise a determining influence on his own moral goodness. It was at this period that freedom became a prerequisite for morally significant actions and responses.
in his system—rather than their cause—and through the analysis of man's moral structure he proved that goodness in the process of moral self-realization originates in the objectivity of moral values.

The central problem of his later ethical investigations was the metaphysical justification of the objectivity of values. By grounding them in being as "important-in-itself"—opposed to being as such—he also grounded the foundations of man's own religious experience in the ultimate source of being, the Absolute Being, who is his system became the Absolute Value. This development in von Hildebrand's thought proves that a phenomenological study of permanent essences—the original task of the Old Circle of Phenomenology—inevitably leads to a metaphysics.

The results of his early investigations were already brought to completion at the beginning of his career and were published in Husserl's Jahrbuch, who considered him one of his best students. A dividing line between von Hildebrand's early and later periods of development is not easily found. His break with Scheler in 1922 in a certain sense already marks the beginnings of a new direction in his thinking, but he did not reach the high point until much later with the publication of his works on Christian ethics.

In the first part of our study we shall present epistemological and anthropological assumptions in his system and then proceed with the analysis of his value-metaphysics.

I. Value-Perception and Value-Response

In order to disprove the claim of man's moral autonomy in a Kantian sense, in his early works von Hildebrand provided a step-by-step analysis of moral self-realization, which in his opinion originates in value-perception and is completed by value-response. His phenomenological analysis—with noticeable Husserlian influence—reveals that moral goodness is determined by participation in moral values rather than by factors internal to the moral constitution of man, or by the structure of morally significant actions. Taking for granted the existence of values and of moral values in particular, he insisted, in opposition to Kant, that moral values can belong only to persons.

An intuitive openness, a contemplative receptivity, is the beginning of any personal contact with reality. Where he departed from this fundamental thesis of phenomenology was the distinction he introduced between the objective and subjective content (Inhalt and Gehalt) of consciousness. The objective content is obtained by a merely receptive attitude and is entirely determined by the qualities of the observed reality. The subjective element, on the other hand, is part of the self, the first step, as it were, in the person's turning toward the qualitative riches of the object. The contract between the two elements is the basis of explaining the difference between cognitive and responsive acts.
A. Cognitive Acts

The most direct and immediate way of confrontation with reality is the intuitive act of cognizance or perception (Kenntnisnahme, Wertnehmen). It is a strictly receptive act: "The whole experience consists in a mere possession of something, found on the side opposite to us." While the Husserlian "transcendental idealism interprets taking cognizance of something as a construction of the object and thereby denies that we are able to grasp the real object as it is," von Hildebrand emphasizes the objectivity and passive receptivity of the act. It does not contain elements of the subjective consciousness (Gehalt) and fails to bring about any activity in the subject. Because of its "immediateness" (Unmittelbarkeit) this act brings the person closer to the value, and thereby he is able to penetrate it more deeply, resulting in a richer and more objective participating in the qualitative content of the value. The depth and qualitative richness of this experience, however, is not to be identified with the clarity of perception: "The clearest value perception ... is not the deepest one, in which the value is most immediately and most completely experienced."

Recognition (Erkennen) of the fact that something is valuable is another cognitive confrontation with reality. It is differentiated from the passivity of cognizance by an active element, namely, by the fact that it is a manifestation of the person's value-awareness (Bewusstheit). Whereas cognizance is characterized by its nearness to the value and by its depth in penetrating reality, recognition stands in a "constant, never changing distance" from the object. Its positive contribution to the cognitive process consists in revealing the person's state of mind concerning the actuality of a value.

Abstract knowledge (Wissen) is another mode of confrontation with reality. It is an indefinite form of consciousness, a state of mind well expressed by saying, "I know about it." In this act we possess "not ... the objective content but only the phenomenon ... as a 'result';" rather, "We grasp the reality from the outside only, without being able to penetrate its foundation." The content of abstract knowledge can be obtained by reasoning processes or as a result of previous experience; consequently, it is not affected by the presence of the object. Compared with cognizance, it remains theoretical.

B. Responsive Acts

Value-responses are characterized by the fact that through them the person commits himself somehow to the qualitative riches of the value-endowed object. He imparts the content of his subjective consciousness (Gehalt) to the object. "All responses necessarily presuppose cognitive acts; they are essentially based on cognitive acts," von Hildebrand insists. The type of cognition in fact determines to a great extent the nature of the responsive act.

The response that corresponds to the intuitive possession of a value through cognizance is called conviction (Stellungnahme or Überzeugung). By this act von Hildebrand says, "I allot the content
of my subjective consciousness out of myself to the possessive reality ... always as a response to certain qualities in it."  

Conviction is the first expression of intentional involvement with the object; it is the inner word of yes in the person's consciousness to the qualitative content of the reality. It unites the person somehow with the value made present through cognizance. It represents an addition to the world of realities. This addition—-he insists to avoid the possibility of an idealistic interpretation—is "an answer to the world of objects ... situated in the subject by its very essence. It relates to the objective world as a correlatum, but it never amalgamates with it."  

The articulation of cognizance becomes either a theoretical or a volitional or an affective response. Theoretical responses are difficult to separate from cognition, because they add nothing to what was perceived in the object: "We repeat from outside, as it were, what the object told us in knowledge."  

In volitional responses "my ego gives itself to the object in the must (Soll)," which originates in the conviction. The meaning of this must "includes an aspect of reaching out of the self toward realization; ... [it is] a distinctive incompleteness in itself, which goes far beyond the intentional nature of value responses," finding full realization in the action. The theme of these responses, therefore, is directed to a "not-yet-real fact with the specific interest of bringing it into existence."  

The nature of the "subjective must" (Sollgehalt) in a volitional response depends on the quality of the value to which a response is given. Higher values call for a more personal and deeper "must" in the response. This difference then reveals categories in the world of values. There are values, von Hildebrand says, "which bear all their importance in themselves." Consequently, he continues, in these cases the "objective content of our consciousness (Inhalt) ... is a must on the basis of its own nature alone, independent of us." In other cases "the objective content of our consciousness assumes a relationship to the person, the element 'it is a must-in-itself' is replaced by the awareness it is important-for-me," revealing thereby the value-category of important for the person.  

Affective responses do not"presuppose that their object is not yet real." They also have a spontaneity not found in volitional responses; they cannot be commanded by our will: "Love ... is always granted to us as a gift." Finally, these responses "have no command capacity with respect to our bodily activity to any action."  

In von Hildebrand's conception the nature of values determines the objective characteristics of responses; but the mode of perception too has a significant influence, since it is nearness to a value and not the clarity of perception that determines the force and originality of conviction. If a person, for example, learns the presence of a value through recognition or by abstract knowledge, the possibility of giving adequate responses is reduced because the value is not so immediately present to him as through cognizance. Therefore, the objective content of consciousness (Inhalt) can be influenced or falsified by precon-
ceived judgments, by cultural substitutes, or by other human factors. Then, if a responsive attitude grows out of such an inadequately established value-presence, a discrepancy arises between the objective exigency of the value and what the person recognizes or knows as an adequate response. As von Hildebrand said: "[t]his amounts to a conflict in actual experience, to a discrepancy between what is formally considered right and what is 'felt' as valuable." In other cases of inadequate responses, the clarity of recognition or of knowledge takes the place of the immediacy of intuitive cognizance, leading to similar discrepancies.

The realization of moral goodness occurs on several levels in the person. The first one is "the sphere of actions"; the second one is "the sphere of concrete responses" as "immanent activities"; and "the last fundamental sphere is that of ... the lasting qualities of a person's character, i.e., the sphere of virtues and vices."29

C. Source of Goodness in Responsive Acts

In search for the proper source of moral goodness or wrongness in the action, von Hildebrand distinguished between formal and material conditions of value endowment. Formal Conditions describe the external correctness of an action, but have no influence in determining the specific rank or quality of goodness attached to it. When these conditions are fulfilled, actions "are all equally correct from the moral point of view, but by no means are they thereby equal in their moral value." It is the fulfillment of the material conditions that determines "the specifically proper moral value of an action and the particular rank attached to this value."30

Formal conditions are described in terms of the centrality and the depth of experiences. An experience is central if it originates "in the ultimate point of reference in the person," in the "ego proper." By this characteristic the person gives himself totally to the experience, "this experience-content becomes the 'most important thing' for him."31 Depth refers to the degree and manner of personal involvement with the value, and thus it depends both on the qualitative content of the value and on the person's value-sensitivity. "The deeper a volitional response originates, the richer its moral significance becomes."32 Although the fulfillment of these formal conditions does not guarantee the moral goodness of an action, their absence indicates a lack of response-relationship and thus precludes the possibility of such endowment in the action. In these instances von Hildebrand talks about "actions without consciousness" (gewissenlose Handlungen).

Among the material conditions the most important one is the morally relevant value, which determines not only the goodness of the action but also its specific rank: "Response to the higher value is ... the carrier of higher moral values in itself."33 The determining influence of the morally relevant value is transferred to the action through the "response relationship" (Antwortbeziehung), which is the positive turn- ing of the will toward the value-endowed reality. This is the second material condition, expressed "in the form of a 'must' as a response to the value of the reality, [it] means a very special penetration of the value."34

177
Since it connects the objective value endowment of a reality with the moral significance of the action, the act of willing becomes the carrier of moral goodness. As von Hildebrand put it, "as a value response, the act of willing alone is able to become the carrier of positive moral values; it is only through this connection that the value of a reality and the degree of this value have an influence upon the degree of the positive moral value embodied in the act of willing." The turning of the act of willing "is the carrier of the moral action ... the primary and direct carrier of the moral value." The value-endowed object, von Hildebrand insists, is the only source for the will to be properly motivated: "Only the values of a reality, for whose sake the act of willing is being directed to the reality--only these values have an influence on the positive moral significance of the act of willing, and of the action itself."

D. Moral Wrongness of an Action

Von Hildebrand takes the existence of negative or "disvalues" for granted. Without ever justifying this assumption, he simply states, "The nonexistence of a positive value is a disvalue as much as the existence of a negative value." He is convinced, however, that a direct response to them is an impossibility in itself. The opposite of a moral value response, the "evil action in the strictest sense," is a satanic attitude, motivated by the hatred of God, and as such it does not belong to the field of human morality.

On the level of human actions "simple union with a disvalue ..., a 'disvalue-response' is an impossibility in itself." This is an axiom expressing "a necessity which lies in the nature and meaning of value-responses. Just as enthusiasm over something worthless for me, or disgust with something known as valuable for me, is clearly an impossibility in itself, so is this self-commitment to a disvalue. Rather, ... we must seek the proper field of really wrong actions in the failure of a value-response.

This failure originates in the moral structure of one's personality and manifests itself in the turning of the will toward, not what is important in itself, but to the merely subjectively satisfying. Such a turning in itself is an indifferent act and under certain circumstances even justified, but when it implies an indifference to, or a conscious turning away from the important-in-itself, it becomes a source of moral wrongness.

Such is the case "when the objective value and disvalue have completely equal significance for me. ... [Here] the 'must' applied to the content in spite of its known disvalue ..., is the carrier of the wrongness of the action." Similarly wrong is the action when, after a conflict between the value and the "for-me-important," the action is directed to the realization of what is good for the person only.

Moral wrongness in an action cannot be reduced to a wrong choice, as it was done by Scheler, because it is precisely the difference in the value content of the alternatives that determines the choice. We
prefer the more important alternative. Consequently, the "choice of the phenomenologically lower value rather than the higher one ... is an impossibility in itself, a response which is no longer a response." Through a distorted perception a person may prefer the apparently more important alternative over the objective good; "such an 'incorrect' choice renders the action morally faulty, ... but never makes it wrong in a strict sense of the word."42

In opposition to Kant, von Hildebrand also insisted that the awareness of a duty is rooted in value-consciousness: "Every duty-consciousness, ... which as an experience does not grow out of a material value, must appear to us blind."43 The intention to achieve moral goodness or fulfill a duty cannot, therefore, replace the necessity of response to a moral value. In the case of such substitution the response is not given to the value, but to what is important for the person. Consequently, these dutiful actions are endowed with a disvalue because a response to what is important-for-the-person has replaced the authentic moral value-response.

A more detailed study of man's moral structure (omitted in this essay) explains for von Hildebrand the interdependence between the capacity to perceive (or its lack) and man's ability (or its absence) to issue appropriate responses.44 It is only in this context that an adequate presentation of freedom is possible. In his view, human freedom is inseparably connected with the polarity in man's moral structure between the "value-responding center" (man's basic orientation toward the world of moral values) and the negative centers of "pride" and "concupiscence" (forces opposed to value-sensitivity within man, results of original sin). To the extent a person is able to overcome the blinding influence of the negative centers he is becoming more and more free to turn toward and respond to the call of moral values. It is precisely in this gradual growth in value-sensitivity that von Hildebrand finds the deepest meaning of human freedom.45

In the analysis of moral value perception and of man's moral structure von Hildebrand shows that moral goodness is determined from without by participation, rather than by internal factors. In his reaction to subjectivistic interpretations of morality he contributed much greater significance to the nonconceptual, passive-receptive cognizance or value-perception than to the function of understanding and judgment. Consequently, a tendency to perceptionism prevails in his thought, which then influences his metaphysical justification of values. By making cognizance "the highest form of philosophical penetration ... into all ... necessary facts rooted in the essence,"46 he did not give sufficient weight to man's capacity of interiorizing values by understanding and by constructive affirmation, and thus, as we are going to see in the following part of this essay, his value-system develops in a static Platonic direction.
FOOTNOTES

1. A complete bibliography of von Hildebrand's works is found in Balduin V. Schwarz (ed.), The Human Person and the World of Values, A Tribute to Dietrich von Hildebrand by his Friends in Philosophy, New York, Fordham University Press, 1960, xiii-210 pp., a Festschrift.


3. The main sources for this period are Die Idee and Sittlichkeit.


6. D. von Hildebrand, CHE.


   Graven Images, Substitutes for True Morality (in collaboration with Alice Jourdain), New York, David McKay, 1957, 204 pp.


8. In the translation of these and similar terms, we are using the corresponding expressions found in von Hildebrand's works in English even when these terms are different from the literal translation of German expressions.

10. D. von Hildebrand, What Is Philosophy? Milwaukee, The Bruce Co., 1960, viii-242 pp., at p. 16. Die Idee, p. 136. Cognizance "in the first place is characterized by the fact that it does not contain elements of the subjective consciousness (Gehalt) from the side of the subject, and its whole richness is based on the objective content (Inhalt) lying on the opposite side." "Ist ... in erster Linie dadurch characterisiert, dass es keinerlei Gehalt auf der subjectiven Seite besitzt und seiner ganzer Reich tum in dem gegenständlichen Inhalt beruht."

11. Die Idee, p. 208. "Das klarste Wertnehmen ist ... nicht das tiefste, in dem der Wert am nächsten und restlosesten gefühlt wird."

12. In his understanding of recognition he relied on Reinach's thought; see: Die Idee, p. 144.


14. Die Idee, p. 148. "A characteristic property [of recognition] is the specific relationship with the actuality of the reality ...; an act of appropriation, an insight of 'so-it-is,' an act of very precise grasping which unfolds in a single instant; unlike the long-lasting possession in cognizance, "ihm ist eine bestimmte Beziehung zum Bestande des Sachverhaltes eigen ...; ein sich 'Eigenmachen,' ein Eingehen, dass es so ist, einviel punktuelleres Einschappen, das gleichsam in einem Moment sich vollzieht, nicht ein ruhendes, lange andauerndes Haben wie die Kenntnisnahme."

15. Die Idee, p. 149. "Nie ein ... Inhalt sondern nur der Sachverhalt, gleichsam als 'Resultat' für mich da. ... Wir halten die Sachverhalte nur ganz von aussen fest ohne bis in ihr Fundament vordringen zu können."

16. CHE. p. 197. The same point was already emphasized in Die Odee, pp. 150-151.


19. Die Idee, p. 197. "Im Subject gelegene Antwort auf die Gegenstandswelt ... . Sie entspricht der Gegenstandswelt als Korrelat, niemals aber verschmilzt sie mit ihr."

20. CHE. pp. 198-199.


22. Die Idee, p. 171. "Die im Sin des Soll gelegene Beziehung über sich hinaus zur Realization, ... eine besondere Unabgeschlossenheit in sich, die über das intentionale Wesen jeder Wertantwort noch weit hinausgeht."
23. CHE. p. 200.

24. Die Idee, p. 174. "Wie derselbe seine ganze Wichtigkeit in sich entfaltet. ... Ein Inhalt, (der in diesem Sinne wertvoll ist) soll sein lediglich auf grund seiner Natur in sich, unbekümmert um uns ... steht die Bedeutsamkeit, die en einem Inhalt haftet, phänomenal in bestimmter Beziehung zu mir, ... das Bewusstsein 'das soll an sich sein' wird ersetzt durch das: 'es ist mir wichtig.'"


27. see: Graven Images.


29. CHE. pp. 342-343.


32. Die Idee, p. 215. "Je tiefer eine Willensantwort ansetzt, um so ethisch bedeutungsvoller ist sie."

33. Die Idee, p. 223. "Die Willensantwort auf einen höheren Wert ist ... als solche Träger höherer sittlicher Werte."

34. Die Idee, p. 223. "In Form des 'Soll' als Antwort auf den Wert des Sachverhaltes, ... bedeutet ein ganz besonderes Eingehen auf den Wert."


40. Die Idee, p. 227. "Reine Vermählung mit dem Unwert, ... Eine' Unwertantwort' ist ein Unmöglichkeit in sich. ... Eine im Wesen und Sinn der Wertantwort liegende Gesetzmäßigkeit. Wie eine Begeisterung über etwas, dass als unwertvoll mir bewusst ist, ... rein und seiner selbst willen unmöglich ist, so diese Hingabe an der Unwert. Vielmehr müssen wir einem Fehlen der Wertantwort ... suchen."

41. Die Idee, p. 240. "Wenn mir der objective Wert oder Unwert völlig gleichgültig ist. ... Dieses 'Soll', das dem Inhalte samt seiner Unwerte bewusst gilt, ... ist der Träger der Schlechtigkeit der Handlung."

42. Die Idee, pp. 229-230. "Einen Vorzug des phänomenal niedrigen Wertes von dem höheren ... ist ein Unding in sich, eine Antwort, die keine Antwort mehr ist."

"Macht solch ein 'unrichtiger' Vorzug eine sittliche Fehlerhaftigkeit der Handlung ... nie aber eine schlechte Handlung im prägnanten Sinne."

43. Die Idee, p. 232. "Jedes Pflichtbewusstsein, ... dass nicht im Erlebnis aus einem materialen Werte fliesst, muss uns als blind erscheinen."

44. see: Sittlichkeit.


46. CHE. p. 15.
II. Ontology of Values

Cognizance, being the deepest mode of penetration into the content of reality, reveals not only the intelligibility of an essence, but also its "importance." In his early works von Hildebrand referred to this fact and to the differences in the categories of importance, but did not reflect systematically on their implications. The objectivity of moral goodness in man, and the structure of value-perception and value-response, remained an assumption in his system in need of further justification until the elaboration on the foundation of values was made. The starting point in this effort, and a landmark between his earlier and later periods, is the analysis of the "important-in-itself." Von Hildebrand's service to current philosophical and theological ethics, in Richard Egenter's opinion, lies precisely in the fact that he provided a metaphysical foundation for Scheler's material value-theory, and by modifying it to a significant extent he succeeded in developing an ontology of values very much in harmony with "Philosophia Perennis."2

A. Analysis of Importance

Certain realities appeal to the person, not only by their intelligibility, but also by their "importance." This is the "characteristic which enables an object to become the source of an affective response or motivate our will."3 Aristotelian philosophy, in von Hildebrand's opinion, failed to grasp the intrinsic difference between goodness that corresponds to certain immanent needs in the person, and goodness that appears on the horizon of human consciousness without such relationship. This precise difference is the focus of his investigations.

When an object appeals to a person only through its capacity to cause pleasure, one perceives the lowest category of importance, the "subjectively satisfying." This perception ignores the different higher ranking qualities of the object, and as such, if "not a distortion, it is at least an incomplete vision" of reality. If the "merely subjectively satisfying becomes a general point of view of our approach to life and being,...(it) implies a blindness to the significance which beings objectively possess;...it implies a falsification of the universe."4 To make it worse, when desire for pleasure determines the function of the morally negative centers, subjective satisfaction itself becomes an element of moral evil in the person.

When a reality appeals to us not on the basis of a desire for pleasure but on the grounds of a conformity between its qualities and objective needs in the person, we are confronted with a higher category of importance, the objective good for the person. In this case, says von Hildebrand, the reality is perceived "as something which is objectively in my true interest ... which is in the direction of my good."5 In classical philosophy such an object is called bonum personae, the good of the person.
The goods found in this category have a common characteristic, namely, the capacity to render service to the person according to his lower (ordinary) and higher (spiritual) needs. Therefore, the objective good is a gift for the person because it is "in agreement with man's true interest, and...its significance is rooted in...the nature of a human person." Consequently, "an objective good for the person is not only a category of motivation, but also an objective characteristic of a being."6 The ultimate reason for its value, however, lies not in the qualitative content of the object, but in the fact that it corresponds to the needs of the person. As von Hildebrand said: "An objective good bestowed on a person has a value simply because of the value of the human person."7

The last and highest category of importance appeals neither to desires nor to needs, but "to our free spiritual center." Instead of offering satisfaction for immanent needs, it calls for a response with "the character of abandoning ourselves, a transcending the boundaries of our self-centeredness, a submission of some sort."8 An object with such motivating force is called the important-in-itself. The perception of this importance calls not only for the abandonment of legitimate and objective needs in the person, but also compels him to sacrifice already obtained objective goods. This perception implies an obligation to respond.

Importance thus conceived is an original datum of reality. To approach reality from the point of view of its axiological content, in von Hildebrand's opinion, is just as objective and original a way of confrontation as the effort to penetrate its intelligibility. Importance "has as much an original and objective meaning as the question of truth and existence." In fact, truth and importance are on the same metaphysical level: "Importance is as fundamental as being....As the ultimate fulfillment of our quest for truth can only be offered by the anatomy of being..., so equally, the inevitable metaphysical question of importance can only be answered by the autonomously important, the important-in-itself, the value."9

In opposition to Scheler, von Hildebrand emphasized10 that the difference between the important-in-itself and the other types of importance is not gradual, but essential, categorical. Emerich Coreth points out that, by considering values "as real properties of being." [von Hildebrand] develops an ontologically very important correction of contemporary value-philosophy.11 By reducing the important-in-itself to a primordial datum of reality, and thereby grounding values in being as such, he was able to defend their objectivity against Scheler's, Rickert's, and Hartmann's subjectivistic position.

B. Value Is a Property of Being

The difference between the subjectively satisfying and the objective good for the person is found on the level of motivation. The ultimate
reason why an object is able to offer pleasure or satisfaction lies in the correspondence between the person's needs and the qualities of the object. Therefore, on the level of qualitative content there is no essential difference between an objective good and the merely agreeable reality.

The important-in-itself, on the other hand, reveals something in the object that is independent of any motivating power or need in the person. The importance of justice, for example, cannot be deduced from the importance of something else. In von Hildebrand's words: "The relation between a being and its value, insofar as a direct importance in itself is concerned, is not empirical and contingent but is rather necessary and intelligible. In contemplating charity, we grasp at once that it is necessarily good;...we understand that it is so and must always be so."12

There exists a tendency in man to grasp truth, yet the value of truth cannot be identified with its suitability to satisfy this tendency. Similarly, "there exists an importance-in-itself-which cannot be reduced to a mere relation to something else."13 Although it may correspond to certain needs in the person, the authentic value excludes any "for" relation by its nature, and its intelligibility cannot result from such relationships. "Value is an ultimate datum in the same way as essence, existence, truth, knowledge--these we cannot deny without tacitly reintroducing them."14 Existence, intelligibility, and valuedness are, therefore, three different, original, and irreducible properties of being.

Importance reveals itself with self-evidence and permits no demonstration by way of abstract reasoning. An effort of this type would originate in abstract, conceptual knowledge, rather than in the direct and immediate grasp of reality established by cognizance. Consequently, such reasoning would place us at a distance from the self-evident givenness of an in-itself-important reality, rather than bring us closer to it. Every argumentation is ultimately based upon self-evidence; therefore, the effort of finding reasons why a given reality is important-in-itself has no meaning. "A value which evidently reveals itself in its intrinsic importance is much more intelligible than any proof could make it, and renders superfluous any question of why it is important."15

Value, therefore, is an ultimate datum of reality which, though connected with the intelligibility of a being, is not identical with it. Contemplative intuition reveals that the important-in-itself "not only is but ought to be." This weight added to a reality by its value is rooted in the depth of its being, on the level where the reality affirms itself in its existence and intelligibility. As he put it: "The important-in-itself reveals itself as ultimate datum, not only in the general sense in which every necessary intelligible quiddity which can be grasped only by an original intuition is an ultimate datum, but also in the specific sense in which being and truth are ultimate data."16
In postulating the originality of value, von Hildebrand considers goodness, a transcendental property of being, under a new aspect. The important-in-itself implies more than correspondence to sensitive or intellectual appetite; it expresses a dynamism inherent to the notion of being. The value-endowed reality ought to exist and calls for a response for its own sake. Consequently, the Hildebrandian vision of the structure of being opens new avenues in explaining the relationship between God and the created world as well.

C. Categories of Values

Unlike Scheler, von Hildebrand never made any effort to construct a complete hierarchical scale of values, but presumed nevertheless that the realm of values is divided in three basic ways. Besides the formal value of being as such, we find ontological values attached to the nature, or such-being of particular realities, and there also are the hierarchically very diversified categories of qualitative values.

Categories of qualitative values are established by their themes; he termed these groups value-families or domains of values. Within each hierarchically different domain single values again can rank higher or lower. He insisted, however, that there is no continuity in the world of values.

The formal value of being in general "is rooted in being as such, as opposed to nonbeing. It is the value which 'to be something' embodies: the value of having an essence and existence as such, without any reference to the specific character of its nature."17 This value is so formal, abstract, that it is difficult to perceive it in a reality independently of its ontological and qualitative values. Considered only in the light of this value endowment, a reality "is in a certain way neutral." The obligation of responding to it appears only under restricted circumstances. In a case of lying, for example, the deception of another person "need not in every case be morally illegitimate," says von Hildebrand, but "the disrespect for the value of being as such" is always manifested by "not conforming ourselves to reality in our affirmation, although the very nature of affirmation implies the claim to do so." The general value of being also calls the person to pay continuous respect to reality as such, and retain a conscious relationship with it; hence results the immorality of day-dreaming and illusion-seeking: "The dignity and intrinsic majesty of being, of reality as such, ... forbids us to ignore reality and take refuge in illusions, whatever content may be."18

The idea of being includes the fact of value-endowment also, even if "the notion of value and the notion of being are not identical."19 Consequently, the general value of being as such is somehow present behind all forms of value-endowment, but it is far too formal or abstract to become the source of other values. The different ontological and qualitative values cannot be deduced from it.
The reluctance of the Old Circle of Phenomenology to analyze the fact of existence in separation from permanent essences is revealed in von Hildebrand's effort to associate the formal value of being as such with the specific essence of a reality in which it appears to be absorbed. This effort make it particularly difficult to see how these values differ from the ontological and qualitative values, since they too are ultimately rooted in the *perfectio essendi* (using Emerich Coreth's words). As von Hildebrand put it: "The ontological values and, above all, the qualitative values cannot be reduced to anything else or deducted from the notion of being; on the other hand, they are themselves being." Due to the above restriction he cannot proceed any farther in this analysis; in his words: "Here we touch a typical mystery which we can only state without being able to penetrate it fully with our reason." Only the recognition of a value attached to the more or less restricted necessity with which a given reality exists could have carried him farther.

The category of ontological values is rooted in the such-being of realities, and is best described as the riches by which the nature of one reality is distinguished from another. The highest ranking member of this category is the ontological value rooted in the nature of man himself. The uniqueness of this ontological value is best perceived in its contrast to qualitative values.

a. Qualitative values can be matched with corresponding negative counterparts called disvalues. The moral value of humility, for example, stands in clear contrast with pride as its antithesis. However, no such antithesis to the preciousness of a human being. As the author put it: "There is no contrary antithesis to a person, but only a contradictory one, such as the nonexistence of a person; and this nonexistence such is not yet equivalent to a disvalue."22

b. Qualitative values, especially moral values, have an independence of their own; they stand in clear distinction from their bearers and from the attitudes that realize them. Many of them can be conceptualized and named accordingly. Ontological values, on the other hand, seem to be inseparable from the nature of beings. As he said: "The nature of generosity or veracity or humility has a full eidos of its own. It is something definite which allows us to substantize these values; whereas the ontological value of the person resists to such procedure and forces us to refer constantly to the person himself."23

The ontological value is immanent in the nature of a person, it is inseparable from what he is, whereas moral values in a certain way transcend the being that is endowed with them. In fact, the being participates in their qualitative riches. This substantizing of moral values somehow attempts to bring the Platonic and Aristotelian views on goodness into a synthesis. Authentic qualitative values, like the moral and aesthetic ones, correspond to the Platonic conception of transcendental goodness; and the ontological values can be best related to the Aristotelian vision of immanent goodness.24
c. The ontological value is inevitably realized with the person's existence. Moral values, on the other hand, are realized through freely chosen attitudes or virtues in the person's life, and can be lost when the person loses his virtue. "Such loss of virtue is a moral evil." On the other hand, the presumed annihilation of a human person by God's decision would be a physical evil only. "The former is a real dissipation of a moral value; while the latter is only a withdrawal of the ontological basis necessary for the realization of the moral value."25

Since qualitative values, and moral values especially, have to be realized by free responses, there exists a hierarchical difference in the degree to which they are possessed: "We can say, for instance, that one man is more reliable than another, more just, more generous." On the other hand, the "ontological value as such cannot be possessed by one person to a different degree than by another."26 Differentiation within the ontological value-category is determined by the hierarchically gradation in the nature of different beings. The ontological value is "so much embodied in a being ... that we are tempted to form one concept embracing the whole--the specific being as well as its value." The relationship between a being and its ontological value, therefore, in no way can be described as a participation in the value. Qualitative values, however, are clearly participated in by their bearers. "The ontological value is immanent to the being; but moral values transcend the being which is endowed with them."27

d. Unlike the ontological value, qualitative values have a dynamic tendency toward existence: "Qualitative values should be realized; their existence is itself something having a value. Qualitative disvalues should not be realized; their nonexistence is itself a good."28 In the realm of moral values this dynamism is expressed in the moral obligation. The fulfillment of this tendency, however, does not lead to the existence of these values as distinct entities, but relates them to their bearers. The fulfillment of moral obligation, for example, indicates that moral values should be realized by and found in human persons only.

It is through endowment with qualitative values, and with moral values especially, that we can ultimately focus on the goodness or evilness of a reality. Negative qualitative value-endowment can neutralize the inherent ontological and general value of a being to such an extent that in certain cases it becomes evident that a given state of facts should never have come into existence. In other words, without the qualitative values the ultimate goodness of this world cannot be ascertained.

The very diversified realm of qualitative values is dialectically united by the "polarity" of these values. This is a characteristic that excludes the simultaneous presence of certain qualitative values in the same bearer. Polarity can assume different forms.

A qualitative and yet very radical opposition exists between positive values and their negative counterparts, the disvalues, such as justice and injustice, pleasure and pain, truth and falsity. According to von Hildebrand, this polarity "is distinguished from formal
contradictory exclusiveness by the fact that its negative counterpart is not a mere absence of the positive, but is itself something possessing an essence of its own." Moral evil is more than the mere absence of moral goodness. "It is something qualitatively incompatible with it; indeed antagonistic to it." The fact of this hostile antagonism also "implies the absolute primacy of the positive with respect to the negative." 29

D. Comments

The tendency of Hildebrandian phenomenology to "bracket" the fact of existence, i.e., to give priority to the consideration of the essence of realities and of their value-endowment, leaves the intriguing question of unifying principle open: Is order and unity in reality explained by referring to existence or to value-endowment? One-sided concern with existence leads to materialistic or idealistic monism in philosophy. The neglect of its consideration, however, opens the dangers of metaphysical pluralism, especially when value-endowment is so strictly tied in with the diversified qualitative perfection of realities. Hence the origin of Platonic overtones and static tendencies in von Hildebrand's thought.

Since the importance of existence is not considered, the concept of potentiality is not found in his system either. Consequently, there is little room for historical or cultural change in the realm of values. Historical evolution is replaced by the gradual transformation of one's personality to the eternal demand of values: "Authentic progress refers to a change in the extent to which one lives up to the true goal of one's moral life." 30

If unity is not found in existence participated in by the diversity of beings, the only possible explanation of hierarchy and order in the realm of values is by a reference to God. Values in von Hildebrand's conception therefore are rooted in the Divine Essence, they are the reflections of God's infinite importance. In this Augustinian solution every response to values, to moral values in particular, implies a direct relationship to the Absolute Value: "Morally relevant values, and above all moral values, are linked to God in such a way that in affirming them and giving a positive response to a value-endowed good, we implicitly conform to God and respond to God." Importance-in-itself in the order of perceived realities is ultimately grounded in the absolute importance of God's Essence: "With the datum of value before us we can grasp ... that the Absolute Person of God must be absolute goodness and beauty." 31

Different types of values speak of God's presence in this world in different ways, the category of moral values bringing the clearest message. They "speak of God in a specific way. God is the Goodness, the Veracity, the Justice, the Charity, and every moral goodness of a human being contains an element of similitudo Dei." 32

It is beyond the scope of these essays to enter into the principle area of von Hildebrand's investigations and present his views on moral values, or discuss the details of his anthropology. It is only through these questions, though, that we could give a full picture of his contribution to contemporary ethical thought, and show how his
metaphysical system is complemented by a perceptive analysis of man's moral structure and by a detailed description of constitutive elements in moral life.

His epistemological assumptions and ontological conclusions are clearly connected. Cognizance, the nonconceptual and contemplative penetration of reality, in his view is not identical with a merely empirical perception, because it also includes the data received from one's own consciousness. It also exceeds the depth of sensual perception, inasmuch as it is directed to the full penetration of the content of reality. Nevertheless, its content is fully determined by the perceived reality and manifests no subjective addition. By postulating this mode of perception as the most original and only authentic source of responsive attitudes, the constructive role of understanding and affirmation did not receive due consideration.

These epistemological presuppositions made it possible for von Hildebrand to chart an original course for his thought and avoid a Kantian idealism as well as a Schelerian value-subjectivism. With the help of these tools of his own making he could convincingly demonstrate that value-endowment is in fact a primary element of reality, radically independent of subjective factors. At the same time, however, he was unable to incorporate into his system the data resulting from the importance of existence. By "bracketing" the fact of existence--consistent with the original presuppositions of the Old Circle of Phenomenology--and by postulating a passive rather than a constructive intellectual confrontation with reality, a somewhat one-sided system emerges in his thought.

Values, moral values in particular, are given in the diversely effective capacity to elevate man beyond his tendency to pride and concupiscence. The personal contribution is basically exhausted by their discovery and by the efforts of giving to them appropriate responses in order to realize a state of value-endowment. Man's constructive capacity is exercised through the gradual transformation of his own dispositions by rendering himself more and more to transcend a merely self-centered and this worldly life.
FOOTNOTES


3. Dietrich von Hildebrand, Christian Ethics, New York, David McKay Co., 1953, x-470, at p. 24 (Quoted as CHE.)

4. CHE, pp. 82-83.

5. CHE, p. 50.

6. CHE, p. 84.

7. CHE, p. 93.


9. CHE, p. 73.


12. CHE, p. 88.

13. CHE, p. 102.

14. CHE, p. 95.

15. CHE, p. 103.

16. CHE, p. 104.

17. CHE, p. 147. The corresponding terms in his earlier works are: the "value of existence" (Existenzwert), and the "value attached to the fact of existence" (der Wert des Existentialsachverhaltes). See: "Die Idee der sittlichen Handlung," Jahrbuch für Philosophie und phanomenologische Forschung, Vol. 3, Halle, Verlag Max Niemeyer, 1919, pp. 194-195.

18. CHE, pp. 148-149.
24. CHE, pp. 133-134. "Perhaps the difference between qualitative and ontological values explains in some way the difference between the Platonic and Aristotelian approach to the good. ... Insofar as a value in the most typical sense of the word is at stake (i.e., a moral or aesthetic value), the Platonic view is more correct; insofar as an ontological value is at stake, the Aristotelian seems to be more correct."

Richard Egenter correctly insists that von Hildebrand does not embrace a position of value platonism, even if some of the terms in text would leave him open to such misinterpretation. Op. Cit., p. 385.

25. CHE, pp. 135 and 137.
26. CHE, p. 135.
27. CHE, p. 138.
29. CHE, p. 143.
30. Dietrich von Hildebrand, Trojan Horse in the City of God, Chicago, Franciscan Herald Press, 1967, xii-263 pp., at p. 79.
31. CHE, p. 160.
32. CHE, p. 134.
THE DILEMMA OF ARTIFICIAL LIFE SUPPORT,  
An attempt at clarification  
by Béla Somfai

If a patient with a heart pacer becomes irreversibly comatose, may the family insist that the pacer be turned off? If so, why bother with the incision? It is more humane and expedient simply to poison the patient. If Karen Ann Quinlan may be separated from the respirator, why can we not separate the Tay-Sachs fetus from the mother's uterus?

In deciding these questions the difference between ordinary and extraordinary measures provides little help for the doctor.

It seems to be a foregone conclusion for Roman Catholic moral theology that Karen Ann Quinlan should have been allowed to die. Judge Muir's decision not only prevented her dignified death, but also rendered thousands of other irreversibly comatose patients the prisoners of their doctors. After all, Pius XII had already stated that the use of extraordinary measures in maintaining unconscious life, or any life for that matter, is not necessary. As Fr. R. McCormick stated: "When you cease extraordinary effort, it is the disease that kills, not the withdrawal.

To investigate the accuracy of this position let us suppose a not altogether theoretical case: if a patient with a heart pacer becomes irreversibly comatose, may the family insist that the pacer be turned off? May the doctor comply with the request (even if the patient is capable of spontaneous breathing)? The Pope's teaching seems to suggest an affirmative answer to this case too. But then why bother with the incision? It is much more humane and expedient to simply poison the patient.

In distinguishing between the two cases one could argue that the heart pacer, at least after its insertion, becomes an ordinary means (readily available, without much inconvenience, and effective in stabilizing a pathological condition); in fact it becomes part of the environment upon which the patient's life depends. This argument, however, is applicable to the respirator too: inasmuch as the measure cannot cause inconvenience to the unconscious patient, it is effective in stabilizing a pathological condition, and the patient's survival depends upon its function. The intention of applying these measures, the circumstances, and their effects are very similar, both at the time of their application and at their supposed withdrawal. On the other hand, from the point of view of the family in both cases the source of inconvenience is the condition of the patient, and not the use of the measure.
The difference between ordinary and extraordinary measures is found to a significant extent in circumstantial and personal factors; as Fr. McCormick said, these are "code terms" to summarize "personal and circumstantial judgments."4 In fact, as the thrust of Fr. McCormick's argument indicates, through these distinctions "quality of life arguments" are introduced into the consideration of terminating unconscious life. Consequently, in our opinion, they do not provide adequate ground for the justification of withdrawing life-supporting measures from irreversibly comatose patients. Decisions based on the difference between such measures lead to the slippery slope: the difference between hastening the arrival of death by withdrawing life support, by turning off the heart pacer, or by suppressing vital functions with poison is only a matter of degrees in efficiency. If Karen Quinlan can be separated from the respirator because of the burden she causes to the family and to society, the Tay-Sachs fetus, destined for permanent unconsciousness and for death shortly after birth, could also be separated from the mother's uterus for the same reasons. The circumstances, the nature of the acts, their effects, and the intention of the agents seem to be very similar in both cases.

One can of course show that in the agent's intention there exists a difference corresponding to the difference between the act of accepting death by not using extraordinary means any longer, and the act of causing death by direct termination of life. Although these differences will not eliminate a certain degree of ambiguity inherent in any moral decision,5 in the case of a conscious patient's decision they nevertheless provide a sufficiently reliable ground for the external separation of the virtuous choice from suicide.

When it comes, however, to the withdrawal of an already introduced and effective life-supporting measure from an irreversibly comatose patient, one can no longer find a correspondence between the intention of allowing death rather than causing it, and the action. The withdrawal of effective life support will be the cause or one of the causes of death, and thus it achieves more than the intention of allowing death would indicate. In the traditional terminology this is a discrepancy between the finis operantis and operis. According to William May's analysis, the "content" of the act (causing death by withdrawal of support) "specifies the performance in such a way that the agent cannot not intend the act to have the meaning that it has"6 (namely death).

In our opinion it is the patient's exclusive right to decide on the artificial support of his life. He alone can refuse the acceptance or the continued use of extraordinary measures and thus accept death as a result of his disease. The person and circumstantial elements of this decision are not accessible to anyone else, and thus--not excluding the need for advice and external help--we believe he is the one who has to consider the financial burden on his family and on his community, the effects of the treatment, the degree of inconvenience, etc.
Since not all the distinguishing elements of extraordinary measures are available for the doctor's scrutiny, he has to make his decision on artificial life support according to the covenant relationship he enters with his patient. In this relationship he accepts an obligation, qualified by the explicit or implicit consent of the patient and by the availability of suitable means, either to cure him or at least to make his condition stable and/or bearable. He does not undertake any obligation to delay the arrival of death; in other words, his task is to combat diseases, not death. In this effort he may even indirectly shorten the patient's life, for example by treating leukemia with poisonous medicines, or by increasing the endangering dosage of analgesics beyond the point of respiratory arrest. It is his right to withdraw any treatment that fails to provide the agreed purpose for which it was originally introduced (therapy, stabilization, or comfort), giving the patient simply the necessary information on the uselessness of further such, or of any, treatment.

Irreversible coma permanently prevents a person in the exercise of his right to make decisions about the acceptance of death, but it does not transfer this right to anyone else. Consequently, the guardian can only represent the correctly presumed will of his ward, hence the importance of the "living will" for the family and the relatives (though its legal binding or excusing force is almost nonexistent for the physician at the present). In the absence of a certitude concerning the will of the patient--this certitude has to exclude the possibility of reasonable doubt--the guardian can only make decisions in therapeutic matters. He cannot then order or approve the withdrawal of life support and thus cause the death of his ward. Radically incapacitated, the comatose patient totally depends on care and protection. It appears to us that the death-dealing significance of life support withdrawal is a categorical denial of this protection. Without a proof beyond reasonable doubt one cannot assume that death serves the best interest of a person however feeble his condition.

Irreversible coma in itself, however, does not change the relationship between the physician and the patient. He has to proceed in making decisions on the basis of the covenant relationship, and offer therapy, stabilization, or comfort. It remains his right and duty also to withdraw any measure which no longer achieves any one of these purposes, giving now the necessary information to the guardian.

The purpose of the above considerations is not to prolong the dying process of the comatose patient, but to provide safeguards against making judgments on the worthlessness of qualitatively deteriorated human lives and correspondingly, against making death-dealing actions. In the era of socialized health care there remains another aspect of the question, namely the availability of prolonged financial support for irreversibly comatose life.

One of the recognized and more generally applicable elements of determining the difference between an ordinary and extraordinary means...
FOOTNOTES


2. "...since these forms of treatment (resuscitation) go beyond the ordinary means to which one is bound, it cannot be held that there is an obligation to use them... Consequently, if it appears that the attempt at resuscitation constitutes in reality such a burden for the family that one cannot in all conscience impose it upon them, they can lawfully insist that the doctor should discontinue these attempts, and the doctor can lawfully comply." Pius XII, "The Prolongation of Life," The Pope Speaks, 4(1957), p. 397.


   This consideration is the more important for Roman Catholic positions, since in some documents the Church relies heavily on such analysis and speaks of "intrinsically evil or disordered" acts. Rather than to suggest that this is the only possible approach or the best one, we simply indicate that the structure of "human act" in its relationship to the agent's intention remains one of the criteria in determining moral goodness in man.

7. Diagnostic treatment is subsumed under therapeutic measures.
INDEX

Names in Bold type refer to Part II

BIBLIOGRAPHIES
Dyer, Hausman

COURSE OUTLINES
Dyer, Somfai

EXPERIENCES IN CLINICAL SETTINGS
Benjamin, Cebik, Graber, Larson, Margolis, Rizzo, Self

HEALTH PROFESSION SPECIALITIES
Medicine
   Brody (Family Medicine), Dyer (Psychiatry), Parmett (Medical Student)
Nursing
   Rocereto
Physical Therapy
   Purtilo
Psychology
   Margolis

NON-MEDICAL SPECIALITIES
Botany
   Larson
Literature
   Hendrick, Hunter, Osterman (English and Medical Ethics), Schroeder
Philosophy
   Agich, Benjamin, Brody, Cebik, Graber, Hausman, Self
Religion Studies
   Dyer, Purtilo, Rizzo, Somfai

STUDENTS
Brody, Dyer, Osterman, Parmett, Purtilo

STUDY OF HUMAN VALUES PROGRAMS (and Development of Programs)
Benjamin, Brody, Hunter

SURVEYS - INTERVIEWS
COSTELLO, Hausman, ROCERETO, Self

THEMES DISCUSSED
Artificial Life Support -- SOMFAI
Consent -- DYER
Death -- CEBIK
Doctor-Patient Relationship -- DYER
Evolution and Ethics -- DYER
Health, concepts of -- HAUSMAN
Hildebrand, Dietrich von, Value Metaphysics -- SOMFAI
History of Medicine -- Schroeder
Lay Healing -- ROCERETO
INDEX (cont.)

THEMES (cont.)
Medical Ethics -- Dyer, Larson, Parmett
Medical Practice, Philosophy of -- Dyer
Placebo Effect -- BRODY
Public Policy and Health -- Costello, Osterman
Schizophrenia -- Agich
Value Analysis -- COSTELLO