enacted. The second option—a "truth-in-packaging" law for physicians—may be more achievable and still approach the goal of fair, complete, and honest care. Given the central importance of the physician-patient relationship to the practice of good medicine, and of honesty to that relationship, it would seem reasonable to require at least that before patients enter into a relationship with a particular doctor, they must be made aware whether the doctor will withhold information about or access to certain forms of medical care.

When asked where she learned to recognize and agreed to take on the expanded physician's role that primary care pediatrics seems to call for, Dr. A said simply, "It's what pediatricians are supposed to do." The moral imperative couched in the phrase "supposed to" is not self-evident; its content and implications need analysis and debate from ethical, clinical, and pedagogical viewpoints. We may all agree that pediatricians are "supposed to" be able to diagnose and treat diseases of children and help ensure healthy growth and development of the children in their practices. The consensus begins to falter, however, when we wonder what pediatricians are "supposed to" do in regard to abusive parents, inadequate community resources, or insufficient funding for child health care. The accord may break down entirely when we ask what pediatricians are "supposed to" do with their religiously based moral convictions in the face of patients or families whose behaviors or needs ask the doctor to compromise or set aside those beliefs. What *are* pediatricians supposed to do?

It is important to hear, through these doctors' voices, how seriously they take that question and how much is packed into their answers by virtue of their own backgrounds and religious traditions. The professional ethics—the moral imaginations—of these four pediatricians is intricately enmeshed with their practices and with their beliefs, "patient experiences and social priorities."[5] Lessons for medical ethics from these articulate, compassionate physician voices include the need for attention to the content and centrality of the physician-patient relationship as an ethical obligation and a moral good, and attention to matters of policy and guidance regarding the interrelation of religious and professional ethics.

5

ETHICS, FAITH, AND HEALING

Jewish Physicians Reflect on Medical Practice

LOUIS E. NEWMAN[1]

Healing has long been associated with divine power and, accordingly, the earliest physicians were frequently individuals in positions of religious authority. Certainly within western religious traditions, the ability to heal has frequently been closely connected with God and/or God's chosen representatives.[2] Moses intercedes with God to heal his sister Miriam's leprosy,[3] Elijah's prayers restore life to a deceased child,[4] and, of course, Jesus' power to heal is confirmation of his divinity.[5] In many native and nonwestern traditions as well, the shaman is both healer and religious leader.[6] Likewise, the opening words of the famous Hippocratic oath reflect an awareness of the close connection between healing and religion: "I swear by Apollo the physician and Aesculapius . . and all the gods and goddesses. " This long and widespread association between healing and divine power is hardly surprising. If, as Job declares, it is God who gives life and takes it away (Job 1:21), healing is nothing less than a manifestation of this very power channeled through human practitioners. From this perspective, it is no exaggeration to suggest that medicine is the most inherently religious of all professions, for it aspires to preserve and extend that most precious of divine gifts, life itself

Modern western medicine, grounded as it is in the natural sciences, shares little if anything with this traditional, religious view of healing. Especially in recent decades, as the state of medical technology has advanced dramatically, the scientific character of medical practice has been greatly reinforced. Medical education continues to reflect a strongly scientific, mechanistic perspective; medical students are taught the biochemistry of the human organism, the appropriate pharmacological remedies for various diseases, and the technologies available for

diagnosing and treating medical conditions. Even the growing interest in "alternative medicine" and the movement toward more humanistic training of physicians has done little to alter the prevailing scientific orientation toward medical training and practice. Any suggestion that physicians possess special religious power or play a specifically religious role would be dismissed out of hand by most modern practitioners and patients alike.

It is this contrast between the traditional religious and modern scientific conceptions of medical practice that frames this study. My goal here is to explore the possibility that remnants of a more religious orientation toward medicine continue to play a role in the lives of some contemporary physicians. Aware that some physicians are, after all, people of religious faith and active in religious communities, I set out to discover how, if at all, their religious commitments intersect with their professional practice. In particular, I was concerned to investigate the ways in which the personal values and religious beliefs of some physicians influence their sense of professional responsibility, their relationships with patients, and their understanding of the healing process itself. To this end, I conducted extensive interviews over a period of three months with six pediatricians and pediatric specialists, all of whom identify as committed Jews and lead active Jewish lives. In questioning them about their personal backgrounds, religious commitments, and the values that guide their professional lives, I attempted to discern the intersection between religious symbols, values, and experiences, on the one hand, and the moral virtues of medical practice as they see them, on the other. What I discovered was a nexus of connections richer and more subtle than I could possibly have anticipated. As a result, I quickly abandoned any hope of establishing clear, causal connections between specific religious beliefs or practices and specific professional attitudes. In their place, I discovered that each of these physicians is profoundly aware and appreciative of the religious dimensions of his medical practice, even if not all would identify those dimensions in similar ways or even construe them as "religious."

THE PARTICIPANTS

". . . a doctor, like a writer, must have a voice of his own, something that conveys the timbre, the rhythm, the diction and the music of his humanity. . . ."[7]

In choosing participants for this project, I attempted to select individuals with significant Jewish commitments who also had an interest in issues of faith and medicine as well as the willingness and inclination to discuss them with me.[8] In the interests of ensuring some commonality of professional experience and providing a basis for comparing their views, I decided to interview only pediatricians and pediatric specialists.[9] I also attempted to achieve some diversity with respect

to number of years in practice and to include those with both liberal and conservative religious orientations, in order to minimize the possibility that my responses would be skewed by such factors.[10]

Plainly, the small sample of participants ensured from the start that the results of these interviews would have no statistical significance. I cannot claim that the views these individuals shared with me are representative, even of the small subset of physicians to which they belong. My point is not to generalize in any way from these individuals to others who are engaged in pediatric care, or who are Jews, or who practice in the Midwest; still less am I working toward a comparison of this group of physicians with any other. Instead, my goal has been to explore the moral and religious contours of medical practice as they are experienced by one small—but very thoughtful and articulate—group of practitioners. These results will have significance if their voices resonate with other health care professionals and/or if they prompt scholars of professional ethics to investigate a broader range of issues or examine old issues from a new perspective.

Robert Karasov completed his medical training at the Mayo Medical School and now practices pediatrics in one of the largest medical groups in the Twin Cities. A person of enormous energy, he juggles multiple commitments: chairing his Department of Pediatrics, serving as the president of the board of a newly established Jewish high school, serving as a *mohel* (one who performs Jewish ritual circumcision), and helping his wife raise their five children. Straddling the Conservative and Orthodox Jewish communities, Karasov is very traditional in his religious practice, but generally liberal in his theological perspective. Asked about the personal experiences that have made him the sort of doctor he is, he responded, "Being married for twenty years, and all the natural ups and downs . . . raising five children . . . and the ups and downs you have as a parent—that has made me a much better doctor."

David Lee, born in Minneapolis and trained at the University of Minnesota, has practiced pediatrics for twenty years and speaks with pride about the loyalty of his patients. Studious by nature and clearly drawn to medicine partly for the intellectual challenges it offers (he was a math major in college), he is a shy man who appears somewhat self-conscious as he answers questions in a slow, measured way. Jewish summer camp was among the most formative experiences of his teen years, a tradition that continues with his children. He is now traditional in his Jewish practice and struggles to integrate his Judaism with the other dimensions of his life. Asked what aspects of his practice he is most proud of, he responded, "Being intellectually honest, educating parents and patients, and realizing how to accommodate the idiosyncrasies of my patients."

Mace Goldfarb has been practicing pediatrics for more than thirty years in a small clinic of mostly Jewish physicians. He considered internal medicine, but he

was drawn to the resilience of children and the chance to watch them grow up. As he approaches retirement, he reflects on the changes that have taken place in medicine over the course of his career. He and his wife, who is a Jewish educator, have visited Israel several times and have raised their children (all now grown) with a strong sense of Jewish identity. In the late 1970s and early 1980s, he twice volunteered a few months of his time to work in refugee camps in Cambodia and Uganda. When asked how those experiences had affected his perspective on medicine, he answered, "I enjoyed humanity more. I wasn't as disease-oriented, or as scientifically [oriented]. There were things I couldn't explain, and yet you can give people solace. [I realized the importance of] giving comfort and just realizing what people are going through. I appreciated the lives of people."

Daniel Kohen is a behavioral pediatrician with an international reputation for his work on hypnosis. Trained at Wayne State University, he has been practicing for twenty-eight years, including more than five years with the U.S. Health Service on a Navaho reservation. A consummate storyteller with a quick wit, he is outgoing and clearly thrives on the relationships he establishes with patients, often children suffering from chronic pain or exhibiting a range of behavioral problems. He inherited his basic Jewish values from his parents, but his Jewish identity has been formed most decisively by his experiences as an adult. He and his wife now attend services regularly at their Conservative synagogue, although he admits to being less active than he would like. In describing his therapy with patients, he commented, "My best work is when I'm working intuitively." On the wall of his office is a large poster of Einstein with the caption, "Imagination is more important than knowledge."

Stacy Roback is a pediatric surgeon who began his medical training intending to go into academic medicine and certain that surgery was the one specialty he would never choose. A person who values the opportunity to see the results of his efforts promptly, he answers questions about his professional values confidently and without hesitation, reflecting the sort of decisiveness one might expect of a surgeon. The only adopted child of Jewish immigrants who fled Eastern Europe during World War II, his Jewish values were influenced by their Zionism and concern for social issues. He expresses a deep sense of comfort with Jewish ritual, although he is considerably less certain about his faith in God. In response to questions about relationships with patients, he mused, "I guess I was a little bit more of a 'holistic-y' type guy before that word was even on the map. . . . To me it's a lot more of a personal encounter than an event-driven encounter. I just find it not within my frame of reference to drop out of the picture."

Galen Breningstall is a pediatric neurologist who began his career in an academic position at Temple University but then moved into private practice in search of more extended and meaningful relationships with patients. Given the nature of his practice, he frequently finds himself in the position of having to inform parents that their children have life-threatening illnesses. A quiet, pensive person, he answers questions directly and wastes no words. In college he was a student of the humanities who discovered an aptitude for science only late in his career, at about the same time that he grew disillusioned with Eastern Orthodoxy and found his spiritual home in Judaism. He is now a member of an ultra-Orthodox synagogue; he covers his head and wears the traditional fringed garment (*talit katan*) at all times. On his application to medical school, he wrote, "There is a calling which comes from one's needs and I accept and affirm this calling. It leads me in the direction of academics, reading, and study in the humanities and sciences. There is also a calling which comes from one's being needed and I accept and affirm this calling. It leads me in the direction of the directionless, the perplexed and hurt. Medicine is the profession wherein I can listen to both these callings simultaneously." Today he continues to affirm the truth of those early insights.

In a series of extended interviews with each of these doctors,[11] I heard stories of the events that shaped their lives as individuals and as professionals, listened to their reflections on professional responsibility and on the qualities of their relationships with patients. I asked them about the values that inform their medical practice and the religious/spiritual experiences that have shaped their lives as individuals and as professionals. Their answers to these questions gave me some insight into the contours of their professional moral lives and enabled me to understand the sorts of moral choices they must make day by day and the ways in which they think about those choices.[12] In what follows I make no attempt to analyze the views of each physician in his own right. As I quickly discovered, the ways in which their responses coalesced were more instructive than the individual differences among them, important as they might be. In fact, they held a number of significant perspectives in common; in presenting these perspectives I hope to convey some of the moral and religious dimensions of medical practice as they collectively experience it.

THE MORAL DIMENSIONS OF MEDICAL PRACTICE

Physicians have moral responsibilities that move in several directions, toward patients and their families, colleagues, their employers, and society at large. For the purposes of this study, I have restricted my focus to the first of these spheres. As a practical matter, physicians typically spend the greatest proportion of their time with patients, and so that would appear to be the natural context in which to raise questions about their professional ethics. Moreover, whatever the actual distribution of their time, caring for patients arguably is the essence of physicians' professional life, the work for which they are trained. Certainly, it is the locus of

the richest interpersonal experiences that physicians have in their professional lives.

As I explored the nature and meaning of patient relationships with these physicians, two dimensions of professional experience emerged as focal points of moral responsibility: experiences of power and of powerlessness. In the remainder of this section, I briefly sketch the ways in which both power and powerlessness figure in the lives of these physicians. In the section that follows, I turn to the moral dimensions of these dialectically related experiences. As I will suggest, the distinctive virtues that these informants identify as central to their professional lives—compassion, humility, and hope—express themselves both in the ways they exercise their (considerable) power and in the ways they experience their own powerlessness. I turn next to a consideration of how these experiences and the virtues that they call forth reflect a religious dimension in the professional lives of these physicians. In the concluding section of the paper, I reflect briefly on the implications of these findings for those who attempt to study the ethics of professionals, as well as for those engaged in medical education and those (especially rabbis) who seek to address the religious needs of Jewish physicians.

Power and Powerlessness

The power that pediatricians and pediatric specialists exercise may be so obvious that no extended discussion of this point is required. First and foremost, their special training and expertise enable them to diagnose and treat illnesses, from relatively trivial respiratory infections and rashes to life-threatening cancers and heart conditions. Quite literally, they hold the health and the very lives of our children in their hands. And, of course, dramatic advances in medical technology have further enhanced this power, especially with respect to the treatment of premature infants and newborns with congenital abnormalities. The pediatricians and pediatric specialists I spoke with were obviously well aware of the ways in which parents—especially first-time parents—rely on their advice and their power to heal. More than once they acknowledged that they liked being trusted; clearly, they derive some professional satisfaction from being able to use their expertise to help others. Karasov and Goldfarb both remarked on the fact that it is "a good feeling" when parents rely on their judgment, a sentiment that the others would very likely share.

Patients encounter the power of physicians in a myriad of other ways. Physicians control access to medication, to tests and special therapies of all sorts, and, in many health plans, to specialists with expertise in the particular area of concern to the patient. As parents have become increasingly well informed and proactive about the health care their children receive, they turn to pediatricians

with requests that specific tests be performed or that certain specialists be consulted. In such situations, pediatricians must make decisions about how to exercise their power to give or withhold access to these medical services.

But physicians play powerful roles in the lives of their patients in far more subtle ways. Frequently they are privy to intimate details of a family's situation (e.g., the state of the parents' marriage or the emotional difficulties that an adolescent is experiencing). In these situations and others like them, these physicians must make choices about whether to counsel their patients and, if so, how; whether to be more or less directive; whether to give advice gently or firmly or not at all; whether to provide more information or less (especially in cases where more information might lead to more anxiety); or whether to follow up on a patient's situation more or less aggressively. In cases where there is widespread consensus on the proper course of treatment, some of these decisions are dictated by standard medical practice. But just as often they are matters of discretion, depending in part on the sort of role that the doctor chooses to play—as educator, counselor, family friend, or surrogate parent. Each of these roles is plainly possible, and each brings with it a subtly different kind of power to influence the lives of patients and their families. The opportunity to play any of these roles in the lives of their patients, whether or not doctors choose to embrace it fully, is yet another inescapable dimension of the power that physicians can exercise.

Yet, for all the power they wield, these physicians are acutely aware of their limitations. Their individual knowledge is limited, and each of these doctors spoke of the need not infrequently to consult others for a second opinion, even if only to confirm their own judgments. Some talked of diagnoses they had missed, especially early in their careers, sometimes with disastrous results. These experiences were invariably chastening. Karasov spoke of misdiagnosing a child's acute appendicitis as an experience that "will stick with me for the rest of my life," and Breningstall recalled a missed diagnosis of meningitis that resulted in a child's death as probably "overt error and incompetence." Aware that they cannot be perfect, they also recognize that they cannot allow errors, however serious, to immobilize them. In Roback's words, "You have to cut your losses and move on." However they choose to deal with their mistakes, the very fact that doctors are limited and imperfect practitioners presents a moral challenge: how to minimize the likelihood that they will make errors that compromise the quality of the care they provide and how best to learn from those errors when they do occur.

Moreover, the state of medical knowledge is itself imperfect, a fact that physicians may appreciate more fully and accept more readily than do patients. Goldfarb commented, "So much of what we do in medicine is untested. . . A lot of what we do is trial and error." That being the case, physicians often face questions about what therapies to employ and especially about when it might be

appropriate to recommend alternative, nontraditional therapies to their patients. Some of the doctors I spoke with indicated that parents increasingly are aware of alternative treatments and press them to endorse these nontraditional therapies, or raise pointed questions about why they will not. In responding to these requests, physicians must decide how best to fulfill their duty to care for patients when their own power to provide a cure may be limited or in doubt.

In some situations, the physician's power is not simply limited but entirely absent. When a patient dies—notwithstanding the physician's best efforts and the use of all the resources available to medical science—physicians confront their ultimate powerlessness. Kohen spoke at length about his first confrontation with that reality as an intern: "I remember feeling a combination of helplessness and sadness, and being hit in the face with the reality that doctors really don't save lives, at least not all the time, or don't cheat death, at least not all the time. I learned that very early and I'm glad for that. . Sometimes the patient dies and that's the way it is. . . I learned that the operative word was 'influence' and not 'power' and not 'control.' " At such points, the practitioner is faced with a different moral challenge: What is my responsibility to my patients, or to their families, when I am powerless to heal them?

The foregoing list of experiences and questions by no means exhausts the moral terrain through which pediatricians and pediatric specialists must travel daily in the course of ordinary practice. Yet, as these issues surfaced, it became apparent that the moral texture of their professional lives is multifaceted. With power, in all its forms, comes responsibility, although the best ways of exercising that power and the precise extent of that responsibility are rarely clear-cut. When confronted with the limitations on one's power, or its absence altogether, the moral questions that arise are hardly less profound. For even when they find themselves unable to do successfully what their professional training has prepared them to do, they continue to feel a responsibility to the well-being of those entrusted to their care. In such cases, the challenge is to define and fulfill a kind of responsibility that can no longer be defined or fulfilled strictly within the bounds of professional competence.

As I listened to these physicians discuss these aspects of their moral duties to patients, I was struck by the extent to which certain characteristic virtues repeatedly emerged as central to their professional lives. Indeed, they often used virtually identical language to describe the ways in which they respond to certain sorts of situations, or think about their role as physician and the values that guide their practice. These values and virtues are what might be called the "goods internal to the practice of pediatrics," as these six physicians see them.[13] That is, the moral challenges facing physicians who treat children can be met most successfully when certain characteristic human qualities are cultivated; this particular professional activity appears to necessitate these sorts of moral traits. Three such virtu stand out—compassion, humility, and hope.[14] As I describe the perspectives these physicians, it will become apparent that in many instances these "gooc are interconnected, and sometimes they are not distinguishable. Still, it will useful to consider each separately.

Compassion

"I remind them [medical students] that for all its technological power, med cine is not a technological enterprise. The practice of medicine is a special kir of love."[15]

The roots of compassion lie in our ability and willingness to recognize t humanity of others, to see in them creatures like ourselves, and so to exhibit co cern for their well-being. Given that physicians devote their lives to caring f others, perhaps it is not surprising that when asked about the qualities that mak a good physician, several of these doctors listed compassion and caring above a And while this perspective may be shared by physicians of all sorts, I sensed th it was particularly important to the ethos of those who care for children. Som stated that they were drawn to pediatrics in particular because children are mo vulnerable than adults, less able to care for themselves, and thus more in need c the care that they can provide.

Compassion, as these physicians understand it, is intrinsic to quality medic care, not extraneous or superfluous. As Roback put it, "It was my observatic early on that the people who cared were in fact the best doctors. . . . I still thin that's probably correct. [There were] people with a great fund of knowledg and/or who were very skilled with their hands, but if they didn't care, somewher in the patient encounter it became adverse." Goldfarb offered a utilitarian expla nation for the fact that compassion is essential to medical care: "You can't giv direction or advice to people if they don't think you like them or that you feel the are something special." In short, patients will not take your medical advice t heart if they don't feel that you care about them as human beings. Perhaps that i because, as many have observed, patients don't deal with their medical problem from a comfortable, therapeutic distance; they live with them and know that medical condition, if serious or long-lasting, affects all aspects of their being. Little wonder, then, that they are better patients if they sense that their caregiver appreciate their human situation, as distinct from caring about their medical cor dition.

Thus, all these doctors readily affirmed that compassion for patients is al about attending, in the words of the Christian ethicist Paul Ramsey, to "the patier as person."[17] Even as he questioned clichés about treating the "whole person," Le

acknowledged the essential truth of that orientation: "I only treat the part of the patient that's relevant, and often that's more than the part they're complaining about." This view was especially striking coming from Roback, insofar as surgeons are often stereotyped as interested in fixing discrete physical problems rather than attending to the situation more globally and over the long term. Commenting on the importance of dealing with the guilt that parents commonly feel when their children have a serious medical condition, he observed, "You have to deal with those problems. Actually, you don't *have* to deal with them. You could choose to ignore them. But somehow I don't think your obligation stops with your putting a bandage on the kid."

Given this way of thinking about compassion in medical care, it stands to reason that developing strong relationships with patients is central to their practice. Kohen put it most succinctly: "It's the enduring relationships that make a difference to me." But each in his own way talked openly about how showing compassion contributed to the deepening of their relationships with patients. Breningstall, reflecting on the unfortunate case of parents whose two young children were both diagnosed just weeks apart with Krabbe's disease, a degenerative and usually fatal condition, commented, "[T]hose kinds of relationships with patients is really what I find interesting in medical practice. Helping people to deal with bad news. Helping people to find positive aspects of the situations that are frequently devastating and terrible. Being there and hearing the feelings and emotions of the parents of the patients." Karasov, speaking from the perspective of a general pediatrician, reflected, "So much of what we're dealing with is stuff that's going to get better on its own anyway. Really what we're doing as doctors is reassuring people and letting their bodies heal themselves. It's more the emotional comfort that we give them, rather than the physical healing." And Goldfarb noted that treating people is "about giving people a chance to open up, not about the disease but about their lives and what they do, what makes them tick."

Compassion and its correlate, concern for the human situation of the patient, can express themselves in numerous concrete ways. Sometimes it means ordering tests that one knows will produce no new information of medical significance, as a way of relieving the anxiety of parents concerned about their children's health. At other times, it means suggesting to parents that they explore alternative therapies, even if one has little confidence that they will work, again because doing so is important to their emotional well-being. Almost invariably, it necessitates listening attentively for what the patient is saying "between the lines," seizing opportunities to address the emotional and psychological dimensions of a medical condition, as well as the willingness to show through one's gestures and in the tone of one's voice that one appreciates the existential situation of those one treats. However it may be expressed, all of the physicians who participated in this study insisted that compassion must be more than just a *feeling* or *attitude;* it

must be *translated into action* in a way that enables the patient to recognize th physician's concern.[18] Indeed, Goldfarb noted at one point that he was not esp cially adept at this: "It's an area that I don't feel as comfortable with as probab I could. I'm not as emotionally involved as I could be." Yet, at the same tim he acknowledged that he regarded this as a failing: "It's something I would striv for. I think it's important."

Often the caring and compassion demonstrated by these doctors far exceede what might be necessary to maintain a strong therapeutic relationship. Perha the most striking example of this was Roback's response when one of his patien dies, even if that happens years after his surgical intervention. In addition to sen ing a personalized condolence letter to the parents, he makes an effort to atter the funeral, and he makes a charitable contribution in the patient's memory. H talked matter-of-factly about the father of one patient who died three years ag and who continues to invite him to have lunch each year, just because the fath finds it valuable to stay connected. Fully aware that these steps go above ar beyond the call of duty as most physicians would define it, he still insists that h actions are part and parcel of his professional responsibility: "I just can't see n doing those things. It just doesn't seem to me to be like putting the ribbon arour the box. It seems to me like it completes the circle, whatever that means, for m Maybe not even for them, but for me." Clearly, such expressions of compassio serve no utilitarian purpose in terms of caring for the patient. Rather, for Robac they are expressions of human solidarity with those who have experienced tragedy. He recognizes that for parents in such situations connecting with him a means of dealing with their grief, and participating in that process is part what he signed on for when he chose to become a pediatric surgeon.

For each of these doctors, then, compassion entails a willingness to extend th scope of their involvement in patients' lives, to demonstrate not merely profe sional concern for the aspects of their condition that they have been trained treat but human concern for their condition as a whole. In some measure, as w have seen, they view this level of concern as integral to providing medical care the narrower sense. And yet it is equally evident that compassion often expresse itself in ways that are quite extrinsic to the therapeutic encounter. In the fin analysis, it involves reenvisioning one's professional role in the lives of those o serves and with it the very purpose of the professional encounter. Kohen put most dramatically: "Though I'm not sure that I've ever written it down on the sy labus, or in the objectives for my rotation, what I want to teach residents is ho to nurture the souls of their patients." In whatever individual ways each of the doctors might state this, it is their awareness that their patients have souls—a that proper medical care must reflect that fact—that underlies their manifo expressions of compassion.

Humility

For these physicians, the need for humility arises in a number of contexts. First and foremost, awareness of their own limitations necessitates a certain humility. Most noted that this awareness developed slowly over time, as their store of experience increased. In Lee's words, "after being in practice for a while, you learn never to be absolute unless you're 100 percent sure." In his case, this awareness often expresses itself in the qualified way he speaks to patients: "It looks normal to me, but just in case, we're going to have this reviewed." Karasov pointed out that this experience can be both positive and negative and that both sorts of experience engender humility. "You start out in practice and you learn *the way* to do things. . . This is the way you were taught. . . Over the years you have experiences. . . You get kicked in the teeth a few times, you have patients complain, you learn what works, what doesn't work. . . Suddenly, what you had learned was fact . . . things that you were so cocky about, you learn aren't true. So you get more mellow and more humble."

Of course, this attitude is especially reinforced when these physicians reflect on mistakes that they have made. Speaking of one case in which he missed a diagnosis with tragic results, Goldfarb reflected, "You hope you learn from it. It keeps your humility up. That's why they call it the practice of medicine, because you're constantly practicing. You really don't have all the answers." Potential mistakes, as well as actual ones, led some to reflect on this need for humility. Karasov put it starkly: "Every patient who walks through the door is a potential save or a potential screwup. So it keeps you humble." For Karasov, recognizing the power that he wields—to cure or to destroy lives—reminds him to be exceedingly cautious. In short, knowing what they don't know, and knowing how serious their own mistakes can be (and sometimes have been), these physicians affirm the importance of cultivating humility. While none reflected directly on the question of what would happen to their professional practice if they failed to acquire this virtue, it is not hard to infer the answer from the stories they related. Somewhat paradoxically, then, the very power they have over the lives of their pediatric patients reinforces a certain humility, for that is what helps ensure that they will wield that power responsibly.

But humility is rooted as well in the awareness that medical science is limited. Goldfarb put this most succinctly in quoting Maimonides, the great medieval Jewish philosopher and physician: "The art of healing is vast and the mind of man is puny." Most often, these physicians articulated the importance of humility in the context of their awareness that the results of what they do are so often unpredictable. Patients get well who they expected would not, and vice versa. Reflecting on this fact, Karasov commented, "It's made me a lot more humble.

Not being too dogmatic about what the outcomes are going to be. There is jus a lot you can't predict about how kids are going to turn out." Speaking as a specialist, Breningstall echoed much the same sentiment: "On a given day if I understand 10 percent of what I see, it's a good day. . . There are a lot of enigmatic things that come my way. After having done the conventional thing, following the standard scientific route, you are left with saying that I really don't know what's going on here. I know vaguely this kind of thing, but it's not a satisfying explanation that you are really looking for." In short, medical science, for all its advances, remains a long way from being able to explain all that physicians encounter in their everyday practice. Humility, then, reflects a sense of awe at the complexity and mystery of life, a point to which we will return later.

Finally, Kohen noted that his work with patients is inherently collaborative, so, even when successes occur, he can take at best only partial credit. His understanding of what it means to be a physician is deeply informed by that reality: "I'm a facilitator and a teacher. As such I can be called a healer, but not in the traditional sense of the word, where people come in here with a problem and come out without it. It doesn't work that way. This is a partnership, but mostly what I do is help people unlock doors. They've got to walk through the door. They've got to do whatever they need to do in that room. I can help them manage that along the way. . . . I don't want to claim credit."

Quite apart from mistakes he may have made, or the state of medical knowledge in general, Kohen's sense of humility comes from an awareness of how healing takes place. The healing process requires the active cooperation of the patient, without which all the physician's expertise will not produce the desired results. Lee echoed the same sentiment when he said, "If someone gets better, I don't consider that I healed them. They say that doctors think they're God, but I know I'm not God. So I don't think doctors should credit themselves when their patients get better, other than that they made the right diagnosis." The same point is expressed metaphorically by Rachel Naomi Remen, a pediatrician whose work with cancer patients has earned her national recognition: "Seeing the life force in human beings brings medicine closer to gardening than to carpentry. I don't fix a rosebush. A rosebush is a living process, and as a student of that process, I can learn to prune, to nurture and cooperate with it in ways that allow it best to 'happen,' to maximize the life force in it even in the presence of disease."[19]

Hope

In the course of treating patients, these physicians often recognize that their well-being, and sometimes the specific outcome of their treatment, may depend on the patients' own attitude. Accordingly, several of them expressed the value of

being hopeful and communicating a strong, positive message to patients. Lee was most explicit about this point, and it came up repeatedly in the course of our conversations: "It's important to be hopeful, to offer a positive approach"; "I have very positive expectations. I'm a very strong optimist. I think that may make a difference"; and "I think positive expectations are helpful. Just think what the opposite does." Although Lee acknowledged that he had never conducted a study to show that positive messages actually shorten the course of an illness, it was apparent that he believed that children in particular, given their impressionability, do respond to direct positive messages. Goldfarb seemed to assume that as well: "When you have a parent that's positive, thinking about getting better and working towards it, you've got a kid who gets better much quicker too." For both these doctors, then, giving patients and their families hope that a painful illness or even a chronic condition will get better is an important, if not essential, element in the healing process.

Kohen, who specializes in treatment that relies on the mind-body connection, confirmed the essential role that hope plays in treating patients: "What do expectations have to do with outcomes? I think they have everything to do with outcomes. If someone expects to be ill . . that's going to contribute to them staying ill. Whereas the converse is also true." For that reason, he will sometimes test a patient's psychological readiness to let go of the physical condition that's troubling him or her: "Would it be okay with you if these headaches went away, even if we couldn't explain how that happened?" Recognizing that expectations affect outcomes means that providing patients with positive expectations is part of the physician's responsibility; to fail in this regard would be (at least potentially) to adversely affect the healing process.

Breningstall focused on the value of hope for the parents of children with difficult conditions. "Both the notion of conveying to parents that they have a certain competence, that there is an expectation that they will be able to surmount whatever situation they are dealing with at the moment, trying to give them confidence, things can improve—that's a very important part of things. Giving people that feeling that they can make choices, and that those can be good choices, is an important part of what we do." Here providing hope is less about affecting the result than it is about helping parents cope with the difficulties of a seriously ill child. For Breningstall, and I suspect for others as well, providing hope is closely related to compassion as it was described above. Insofar as one cares about the human situation of the patient (and in pediatrics that must include the patient's family), one's responsibility is to give them the confidence and resources necessary to cope with that situation.

When I discussed hope as an element of medical care with Sheldon Berkowitz, a pediatrician who was not a subject in this study, he explained the issue in relation to one aspect of the physician's power. Doctors plainly have the power to shatter the parents' world when they deliver bad news about the health of their child. That being the case, compassion requires that one attempt to "soften the blow" by offering some hope; without it, you simply leave them hanging with no support to help them process the information you have given them. In this physician's words, "hope is essential."[20] Hope, then, is an essential, indispensable virtue in medical practice, both because it sometimes promotes healing itself (a phenomenon that some doctors in this study linked to the placebo effect) and because, like compassion, it is intrinsic to physicians' duty to respond to patients' and their families' human condition. Hope, in short, has both instrumental and intrinsic value, as it both contributes to healing and represents one expression of compassion, which is a value in its own right.

Given the striking uniformity of these doctors' responses about the major virtues necessary to medical practice, it was surprising that they pointed to a great many different ways in which they came to recognize them. Some pointed to the values that they learned in their family of origin. For Kohen, Lee, and Roback, the values of compassion and caring for those less fortunate were major components of their upbringing. These values, they recognize, express themselves now in their medical practice but would almost certainly have been evident no matter what career path they had chosen. Breningstall, Goldfarb, and Karasov also noted that their sense of compassion, and in some cases of humility, had been instilled in the course of their medical training itself. Each pointed to specific role models (some positive, some negative) whose example taught a valuable lesson about the qualities essential to medical practice. For many, personal experience has played a role as well. Breningstall noted that he lost a son to Sudden Infant Death Syndrome (SIDS) and that, in his words, "that was a very powerful factor in forming [his] approach to individuals with devastating problems. . . . Unfortunately, having personal tragedy helps make you a better doctor." Kohen was acutely aware that his work with the Navaho opened his perspective dramatically, giving him an appreciation for the fact that "we're all on this planet together" and "we all need to help one another."

Interspersed with these reflections on the ethics of medical practice and the virtues of compassion, humility, and hope, these physicians spoke extensively about their religious perspectives, on life in general, and on the practice of medicine in particular.[21] Their responses to questions about their belief in God and about "sacred" moments in their practice provide important evidence about the way they understand their responsibilities as professionals and their mission as physicians. We turn next to these religious dimensions of medical practice.

THE RELIGIOUS DIMENSIONS OF MEDICAL PRACTICE

Religious ways of understanding the world and one's place within it were strongly in evidence in these doctors' comments about their professional lives. Four distinctly religious dimensions of medical practice emerged from these interviews: God's role in the healing process (and the corresponding value of prayer), awareness of the miracle of human life, the physician's role as pastor attending to the spiritual needs of patients, and medicine as a "calling." After looking at each of these dimensions, we will consider how these religious attitudes are related to the virtues of medical practice discussed in the previous section.

Each of these physicians spoke eloquently about the mystery inherent in the healing process and the way in which supernatural powers beyond his control affect the outcomes of medical interventions. Lee stated this most succinctly: "I've had experiences that I can't explain in any other way, other than that there are some forces at work beyond the realm of natural laws as we understand them." Others likewise recognize the existence of supernatural forces that they cannot explain scientifically and struggle with whether those forces conform to belief in the God of traditional theism. As Karasov put it, "I know there are mysteries of the universe. I don't try to figure it out too much. I just know that there are mysteries and forces that affect healing and whether you want to label that as 'God'—I suppose God is as good a label as anything else." Kohen, too, struggles to figure out what to make of those forces in the world: "I not uncommonly have experiences with patients that are not easily explained. I can choose to understand that from a . 'that's about God' perspective. Sometimes I feel like I know that and other times I feel like it doesn't matter. . . There's a lot of stuff that happens in our daily life that I'm very clear that I don't understand. And I'm very clear that it's real and that it has something to do with powers that abound. Most of the time I'm very content to say, 'That's about God in our lives.' I don't understand it other than that."

The striking fact here is not that these physicians struggle to make sense of their religious intuitions about the world in relation to their scientific outlook, but that all of them appeared very comfortable with the uncertainty inherent in acknowledging a mysterious, unknowable element in their lives. Even Roback, who was least certain about belief in God, did not find it threatening: "I'm not uncomfortable with belief in God. I'm comfortable in saying, 'I hope there is.'" This awareness of the a-rational component of experience, and a corresponding openness to the possibility that some divine force is at work in the world, was a frequent refrain in our conversations.

Beyond acknowledging the possibility of God's existence, these doctors often expressed a sense that their professional work was complementary to God's.

Breningstall expressed the strongest views: "God rules the world and really is the ultimate achiever. [I subscribe to] the whole notion that the world doesn't operate by miracles. Everybody has to play their role and do their job. [All our] strengths, talents, and accomplishments are God-given, so that when you reduce it to the ultimate, you're doing your job, but the real credit for what is accomplished is a credit that goes to God."

Goldfarb and Karasov similarly acknowledged a key role for God in the healing process: "I do believe in God. . God plays a big role in healing. What we do isn't quite as important as God's role." "You can't wait for a miracle or for God to do the cure, so you do everything you can on the medical side and hope you get some help from the other side. . . . You're God's partner." Others endorsed a similar perspective in less explicitly theological terms: Kohen—"I'm happy to be a partner with whatever power is responsible [for healing]." Roback—"I take it as far as I can and whatever forces come into play from that point on, I'll take all the help I can get." Each of these physicians, then, approaches his work with a sense that his professional success (as measured by his ability to heal patients) depends partly (some would say, ultimately) on forces beyond his control, forces that most of them are comfortable calling "God."

Given that fact, it is hardly surprising that most of these doctors report occasions on which they have consciously called on that divine force to assist them or their patients. Goldfarb recalled times in his practice when he has been faced with a situation in which he was not sure what to do: "I didn't know where I was going, and all of a sudden, I had a realization that this is what I should be doing. . It was almost like it was infused into me somehow; [there was a] guiding hand, in other words, saying that this is the right way to do it." On those occasions, he has felt a distinct sense that God was aiding him in reaching the right decision, something that he has consciously prayed for at other times. Breningstall likewise has sought divine assistance at difficult moments in his practice: "I think there are lots of times when you pause and ask for help as you're going into a situation, [such as] 'I really need some support and strength to meet with these parents, or to do this or that, I feel pretty helpless and inept right now. Please give me the strength to deal with this in an adequate way.' "

Lee and Roback were explicit about the fact that they sometimes invoke this power to help patients deal with their illnesses. Lee affirmed, "I do believe in prayer, in the power of prayer. But there has to be an appropriate intention [i.e., not a prayer for the physically impossible]. . . I think positive thoughts help. I probably have encouraged people to pray . though I certainly haven't prayed with them." Roback, again in a less explicitly religious vein, commented, "You sort of feel like any positive vibes that you can throw at a situation certainly aren't going to hurt. I don't think I ever go through the verbal recitations that make it

sound in a conventional sense like a prayer. But I suspect it's probably pretty much the same thing. . The sentiment and the agony and the time investment and the spontaneity of it are pretty much the same." So, even if these doctors feel uneasy about engaging in prayer with their patients—something they suggested would feel awkward and even inappropriate to their role as physicians—they openly acknowledged that they themselves pray. The divine power that they see at work in the world is something they rely on and seek to invoke in the course of their professional work. Whether expressed in formal prayer or in a less God-oriented language, these physicians sometimes feel the need or desire to ask for help from a power greater than themselves. Judging from their testimony, these prayers are expressed both on behalf of their patients and, perhaps just as often, on their own behalf, as a way to give them strength or comfort as they face difficult professional challenges.

A second, closely related religious dimension of medical practice is a sense of awe at the nature of human life, especially its intricacies and the resilience of the human spirit. When given a quotation from Rachel Naomi Remen to the effect that physicians have a "front row seat on the mystery of life" and asked to say what they have learned from their own front row seat, Roback responded,

> The thing that I've learned is that it's very dependent upon literally an infinite number of things happening in concert at the same moment in time, and if they are not, it's over in less than the blink of an eye. It's very, very, very fragile. If there is anything that is the most convincing argument for me about the concept of a supreme being, it's that the orchestration of this whole thing really does qualify as a miracle. . . . Even in a biologic sense, it's a miracle. And we don't even know yet how big a miracle it is, though it seems to me that every day and every week, the idea of how incredible the whole thing is comes to the fore. . . . It's a biological concert, but if the third string violinist is not hitting a note that's exactly right, and I was sitting in the auditorium and listening, I probably couldn't tell, but in a biologic model, it's a fatal flaw. That, to me, is fairly extraordinary. We're all sort of standing on a rug that could be jerked out literally at any moment. It's pretty amazing what goes on. And we're only at the periphery of it.

Both the fragility and the complexity of human life impress Roback and plainly evoke a sense of awe. For his part, Karasov was clear that this sense of awe grows with one's years in practice. He noted that, after a certain amount of experience, you learn that you cannot learn everything and that the goal is not the mastery of all there is to know. At that point it becomes possible "to appreciate what you don't know instead of just being scared by it."

Other physicians expressed a similar sense of religious wonder but focused on the power of the human spirit that they frequently encounter in their practice. Kohen noted, "I'm in awe of how parents of handicapped kids do their lives. . . I think that that's got to be power that comes from God. I don't know where else it comes from." In reflecting on his experiences with terribly impoverished families in Thailand, Goldfarb noted, "[Y]et there's a real humanity there, a real love of life. I think that's God's flame." Goldfarb went on to comment on mothers who are drug addicts and similar heart-wrenching situations: "Every person that I see has some sort of spirit, a wonderful spirit. Sometimes it's a question of arousing that spirit, because it's been dampened a lot." Similarly, Breningstall spoke about a sense of wonder and amazement that he feels repeatedly when he observes the power of the parent-child bond, particularly in cases of severely impaired children. It comes as no surprise that physicians have occasion to witness a good deal of human suffering, as well as to observe the power of individuals to cope with their trials and to rise above the obstacles that life puts in their way. The striking point is that these doctors use explicitly religious language to describe these situations. While most were not prepared to attribute human suffering to God, they readily do so for human resilience.

But the religious dimension of medical practice emerges not only in the physicians' perspective on healing and the mystery of human life; it affects the very way in which they understand their role as physicians. Several of the doctors spoke with acknowledged that they are sometimes called on to play a "pastoral" role with patients. When asked if he had had anything that he would call a "sacred moment" in his medical practice, Roback recalled dealing with parents after they have lost a child in surgery: "Sacred moments are those difficult times when it's you and the family and you've got those critical few moments when people are grabbing on to the meaning of what you're saying and [trying] to have something come out of it that is somehow comforting or spiritual . . . for me personally they tend to be fairly, almost like religious experiences." He spoke at length about the special connection that develops in such situations between the parents and the surgeon, precisely because he is the last person who had contact with their child during his or her life. "To the extent that you can answer all the questions, and relieve the burden and lessen the guilt, ease the transition . . . there isn't anybody else that can do that." As he put it, in those moments, "[Y]ou're more pastor than doctor." Clearly, Roback is comfortable in this pastoral role and understands it as part and parcel of his responsibility as a physician to offer spiritual comfort in whatever ways he is able.

Other physicians, dealing with less dramatic situations, also noted that attending to the spiritual concerns of patients and their families is integral to their practice, or should be. Noting that there is definitely a "pastoral component" to a

doctor's work, Goldfarb talked about how grateful bereaved parents are when he visits them. Both Kohen and Karasov acknowledged that they don't explore the spiritual dimensions of the patient's life as fully as they should, given how valuable this exploration can be. Karasov observed, "[T]he whole other part of this alternative approach [to medicine] is spirituality, asking people where they get their spiritual strength. . [I]t's clearly documented that that stuff helps; it's not quackery. . Periodically I'll make little attempts to ask some questions, but not well at all. That's an area that I'd like to get better at. It takes some skills that I don't have yet." Kohen, for his part, simply noted that these questions should properly be as routine as "Where do you go to school?" though he recognizes that he tends to be passive in this regard, waiting for patients to raise spiritual concerns. Still, he regards it as his responsibility to respond to those spiritual concerns when they do arise.

All of the physicians acknowledged that this pastoral dimension of their work was something for which their medical training had not in the least prepared them. Yet in the course of their work they had come to recognize the importance of these matters and even to relish the opportunity to have an impact on their patients' lives in this more profound way. One could speculate that, as years of experience made the ordinary practice of medicine more routine, they naturally became more attuned to new challenges and new opportunities to care for their patients. In any event, judging from their testimony, spiritual care is a significant dimension of their medical practice, even if it happens on relatively rare occasions and even if (as for Karasov and Kohen) they still struggle to integrate it fully into their practice.

Finally, some of the doctors in this study clearly regard medical practice as a "calling," that is, as a kind of religious responsibility. Kohen was explicit in this regard: "I think it [medicine] is holy work. I don't have any doubt about that." He related this to the Jewish concept of *tikkun olam,* "repairing the world," a commitment that he has come to appreciate increasingly as he has grown older. Goldfarb echoed the same sentiments, though it was less clear how frequently or explicitly this guides his sense of what it means to be a doctor. Breningstall, for his part, reflected at some length about the role that God wanted him to play, the work that he was put on earth to do. "The one question that does inspire, time and time again . . . is, okay, what do You [i.e., God] want from me now, what am I supposed to be doing? Am I doing what I'm supposed to be doing? . . . Clearly, in this very complicated world there was some reason why I was supposed to have acquired a medical education and was supposed to have acquired competence in pediatric neurology. Given that that's the case, am I doing what I'm supposed to be doing?" Breningstall's questions betray a deeply religious conception of his profession and, so too, of the duties that it entails.

The religious components of these doctor's lives—as evidenced by their sense of awe, in their roles as partner with God and pastor to patients and their sense that practicing medicine is holy work—raise a number of questions. Are these religious ways of understanding life and medical practice related to the moral virtues that these physicians identified and, if so, how? How did they come to understand their professional responsibilities in this way? What can their reflections teach us about professional ethics and the ethics of physicians in particular? While this very limited study has yielded rich reflections on the role of the physicians, their moral responsibilities to patients, and their religious perspectives on life, these interpretive questions have yet to be faced. I want now to suggest that what we can learn from this material is both extremely suggestive and, in certain respects, quite inconclusive.

AT THE CROSSROADS: MORALITY AND RELIGION IN PROFESSIONAL LIFE

The ethnography of the physician's care lags far behind the phenomenological description of the experience of illness. . . We do not possess an adequate scientific language to capture the essence of the doctor's experience. What the doctor feels is most at stake—what is most relevant to practice—slips through our crude analytical grids.[22]

The preceding sections capture two dimensions of these physicians' reflections on professional life—its moral contours and the distinctive virtues of medical practice, on the one hand, and its religious components, on the other. The interpretive question that must be faced at the conclusion of this investigation is whether these two sets of reflections are interrelated and, if so, how. Having set out to investigate the ways in which religion shapes the moral lives of these physicians, I confront the problem of looking for connections between the religious and moral lives of these professionals that they themselves did not make explicitly. Two quite different ways of interpreting this material suggest themselves.

On the one hand, it is tempting to conclude that the religious attitudes of these physicians do indeed shape their professional ethics in a number of ways. In the first place, the virtues that they identify as central to their professional lives—compassion, humility, and hope—have religious overtones, as they describe them. Caring for children as people (in addition to caring for them as patients) correlates with their sensitivity to the spiritual dimensions of their patients' lives and their conviction that these matters require their attention as physicians. Their sense of humility appears to flow not only from the awareness of their human fallibility but also (and perhaps primarily) from their sense that they do their professional work in the context of God's work, that they are at best partners with

those powerful, mysterious forces that bring about healing. Finally, their commitment to providing hope seems closely related to the pastoral role they are sometimes called on to play, whether by bolstering the spirits of their patients when they cannot heal their bodies or (less dramatically) by encouraging their spirits to aid in the healing process itself. Each of the virtues of medical practice, then, appears to correlate with the religious perspectives that these doctors bring to their work.

Moreover, there is evidence here that they understand their work as a whole in a religious context. At least for some of the doctors I interviewed, the practice of medicine is holy work, religiously as well as professionally satisfying. That does not mean that these physicians necessarily practice medicine differently because they are religious. Indeed, it is entirely possible (perhaps likely) that their patients would not recognize them as religious people and, at least most of the time, would not notice that they performed any of their professional duties any differently than do nonreligious physicians. Yet, from the physician's side, the entire meaning of a professional encounter is altered if one sees it as a kind of holy work, an opportunity to "repair the world," or as an occasion for marveling at the mystery and wonder of human life. Quite apart from shaping the particular choices they make or the ways in which they understand professional virtues, religion might transform the experience of practicing medicine, the significance that it holds in the life of the provider. The evidence of those who see medicine as a calling, a "profession" in the truest sense, suggests that they interpret the significance of their work lives in a more expansive way.

In short, one possible conclusion from the evidence assembled here is that religion profoundly shapes the professional lives of these physicians, even if in general they have not consciously thought of themselves in these terms. If, as they attest, providing compassion and hope are as essential to medical care as providing penicillin and regular physicals, it could be partly because they understand healing as something they provide with God's help and with profound respect for the divine spark present in all human life. To those who study religion, it would come as no surprise that one's religious perspective on life could tutor one's sense of professional responsibility—from the way physicians talk to patients and parents about difficult issues to the way they think about routine questions of prescribing drugs and choosing between alternative courses of treatment. In short, it could well be that these physicians practice medicine as they do because they are the sort of people they are, people shaped in part by their religious commitments or, absent firm commitments, by their openness to religious experiences of the world.

Yet this conclusion, however plausible, must not be accepted uncritically, for there is another way to interpret the evidence, a way that does not assume a causal connection between their religious views and their professional ethics. To see that this is so, we need only ask the following question: How shall we interpret any of

the hundreds of decisions that these doctors regularly make—to order a particular test, to refer a patient to a specialist, to write a condolence letter to the parents of a deceased patient? Quite clearly, the way these physicians make these choices reflects the way they think about their responsibility and the best way to discharge it. But that, in turn, is shaped by numerous factors, not all of which may be conscious, much less consciously religious. As they related in our conversations, they have been influenced by the sort of medical training they received, the mentors who guided them (especially in the early years of practice), their parents and family members, a host of personal experiences of all sorts, and, perhaps most of all, thousands of patient encounters. The sources of their moral experience are multifaceted, a complex web of influences that have led them to their current views of what it means to be a physician and what sorts of moral responsibilities this profession entails. As they face the moral challenges of exercising their power and confronting their powerlessness, they do so as individuals whose moral character has been developed both within and outside their professional practice.

Moreover, the evidence suggests that their sense of professional responsibility is far from static. They have developed a sense of what they are called on to be and to do in response to their ongoing experience—to the fatal mistake they made (or almost made), to the parent who responds badly to their comments or questions, to the child who responds positively to their optimism and compassionate gesture. Their sense of professional duty is very much a "work in progress," for it is nurtured in the context of their work itself. They have learned about the virtues of medical practice through practice itself, by being present with parents in the face of tragedy and discovering what one can offer them, by being with children in an examining room and learning how to listen attentively. That, after all, is what we meant earlier by referring to compassion, humility, and hope as goods "internal to the practice" of medicine; the practice itself calls forth these moral traits. On this interpretation, their religious sensibilities are but one element, and not necessarily the most important one, in a complex mix of influences that shape their attitudes and choices.

Perhaps that accounts for the difficulty virtually every one of these physicians had in answering questions about how they acquired their sense of moral responsibility. While they could all point to various factors, they were strikingly vague about the source of their professional ethics. I suspect that this vagueness reflects not lack of self-awareness but genuine uncertainty about their own moral development as physicians. So many experiences, professional and otherwise, have come into play that they can hardly be expected to identify which have been decisive.[23]

While we can choose to interpret the data before us as evidence of the influence of religion on professional life, the converse is equally plausible. That is, medical practice itself may have tutored their sense of religiosity. The work of

healing, and the experiences of power and powerlessness that that work entails, may have instilled a sense of what the Jewish theologian Abraham Joshua Heschel called "radical amazement" and identified as the most fundamental of religious experiences.[24] In this sense, medical practice is a religious calling for these doctors, not because they bring a religious mission to their work, but because their work calls forth in them heightened religious sensitivity. Perhaps, too, this accounts for the difficulty they had in relating their Jewish practice—ritual observance, synagogue attendance, etc.—to their professional lives. The latter has become an independent locus of spiritual meaning, a place where their awareness of the religious dimensions of life is nurtured as much as (for some, even more than) through the explicitly religious activities they perform.

While these interviews are suggestive, they are decidedly inconclusive. The role of religious belief in the professional lives of these physicians is extremely difficult to sort out with precision. We have ample evidence here that their sense of professional responsibility extends far beyond the matters they address within the limited scope of their professional expertise. Their sense that it is their moral duty as professionals to be compassionate, humble, and hopeful—as well as the particular ways in which these virtues manifest themselves—suggests that they do not rely solely on their particular professional expertise as physicians. But whether this more expansive sense of moral responsibility can be attributed to their religious views is far from certain.

If the causal connections between the religious and moral dimensions of medical practice cannot be drawn with certainty, other conclusions can be. Plainly, these physicians do think of their professional work in a religious context. The religious sensitivities that they express cannot be denied, and this fact in itself has important implications that point in a number of directions.

First, studies of professional ethics have largely overlooked certain dimensions of medical practice, insofar as they have defined the scope of professional ethics as the minimal standards of behavior that must be maintained in order to uphold the moral integrity of the profession. In the case of physicians, such standards include the duty of confidentiality, the duty to provide the best quality of professional service possible, and the duty to protect public health, among others. Failure to fulfill any of these duties would constitute "unprofessional" behavior and, in severe cases, might warrant disciplinary action by appropriate authorities. Yet, as these interviews amply attest, there is a great deal more to the moral life of professionals than merely remaining within the bounds of professional conduct.

Each patient encounter potentially provides opportunities to practice the virtues of compassion, humility, and hope. Because each professional encounter is also a human encounter, physicians always have the option of bringing to it the full depth of their humanity. That will entail stepping outside the bounds imposed by their role, taking into consideration factors that lie outside the scope of their medical expertise, including the psychological and spiritual needs of the patient and family. In doing so, they will transform the moral significance of this encounter, for it will no longer be a strictly professional interaction between a "doctor" and a "patient" but an opportunity to help the "patient as person" and, in some measure, to be "physician as person." Indeed, one of the striking commonalities among the physicians interviewed here is their refusal in varying degrees to acknowledge a sharp distinction between the professional and the personal. Accordingly, their moral duties as professionals and their moral duties as human beings concerned about others cannot be sharply differentiated. To be a morally sensitive physician and a morally insensitive person is, for them, an oxymoron. Although, as we observed above, we cannot attribute this perspective definitively to their religious values, we can note that, religious or not, this way of thinking about the moral life of the physician is almost wholly lacking in the standard literature on professional ethics.[25]

Similarly, among works on professional ethics one finds very few discussions of the intersection between religion and the life of the professional, for most of this work has adopted the vocabulary of secular, philosophical ethics.[26] The possibility that professionals might bring their own religious values to bear on their work, much less that they might regard their professional work as fulfilling a religious purpose, is not mentioned. Judging from the conversations undertaken in this study, that represents a significant lacuna in the literature on professional ethics. Certainly the participants in this study would have difficulty recognizing the moral lives they lead from the theoretical discussions found in most standard textbooks on professional ethics.[27] One can only wonder how differently those books would read if they attended to the richly textured moral experience of the doctors whose reflections are presented here.

A second set of implications follows for those engaged in medical education. Each of the participants in this study acknowledged that he did not acquire this more expansive, holistic sense of his moral responsibilities as physician during his medical training. Moreover, each seemed to feel that it would have been advantageous had that been otherwise. Even now, while the numbers of ethics courses taught in medical schools has increased substantially, the potential role of religion in the moral life of the medical professional seems to have been avoided. Partly, no doubt, this neglect reflects the fact that medical training is largely scientific in character and is assumed to be quite separate from (and perhaps even in tension with) religious life. Despite the long association between religion and healing noted at the outset of this essay, contemporary physicians receive little or no preparation to think about the religious questions that might arise for them or

their patients in the course of their medical practice. Were this preparation to become a routine part of the training of physicians, they would be better able to understand what ails their patients, apart from the physiological conditions that they attend to. In the process, they would very likely become better, more effective healers. Though the evidence here again is inconclusive, they might even become more attuned to the subtler moral dimensions of medical practice.

Finally, this study may have some implications that pertain to the Jewishness of the participants and that flow from certain things they failed to say. In identifying the factors that nurtured their sense of professional ethics, these physicians listed a wide range of influences—family, mentors, and personal experience, among others. Strikingly, they had great difficulty pointing to specific ways in which their Jewishness influenced their medical practice, despite the fact that all of these individuals are strongly committed to Jewish tradition and practice and active in their respective Jewish communities. None drew connections between the most significant Jewish experiences of his life and his choice to enter the medical profession. None indicated that Jewish worship or ritual practice directly affected the way he practices medicine or thinks about healing, or that Judaism helped him answer questions about why innocent children suffer. None spoke of a time when a rabbi's teachings illuminated the moral aspects of his professional life. At most, they noted that compassion and caring for others were Jewish values and that Jewish rituals lend their lives a certain meaning and direction. Even Breningstall, by far the most traditionally religious member of this group, spoke in rather general terms about the enormous value that Judaism places on human life.[28]

Certainly, this silence can be interpreted in more than one way. Perhaps these physicians have difficulty connecting their Jewish lives to their professional lives because they do not experience a deep connection. What happens in the synagogue or in their own homes as they perform Jewish rituals and recite ancient prayers simply does not spill over into their work as physicians. Perhaps quite the opposite is the case—that the connection between their Jewish experience and their experience as physicians is so natural, so unconscious, that they have a hard time articulating it. Or perhaps those connections are felt strongly but understood only vaguely, so that they simply lack the vocabulary to identify the ways in which these related dimensions of their lives intersect.[29]

However one reads the evidence here, I suggest that this disjunct represents a failure, or at least a missed opportunity, for the rabbis and the synagogue communities to which these physicians belong. After all, Judaism has a great deal to say about God's role in healing, the power of prayer, and the duty to offer healing and comfort to the sick, to name but a few of the salient topics from our conversations. For their part, these physicians certainly have a well-developed

sense of the religious meaning of their work. Yet they may need help making or articulating the connections between their religious tradition and their own moral/religious experience as physicians. In any event, listening to them speak so eloquently about the moral and religious dimensions of medical practice, one cannot help but conclude that their Jewish and professional lives could be more fully integrated.[30] If rabbis were attentive to this possibility, they might help their physician congregants enhance their connection to Jewish tradition, and, in the process, they might discover new ways to do the same for other groups of professionals.

This study ends inconclusively, and necessarily so. Just as these results are not statistically significant, and the causal connections between religious identity and moral sensibility cannot be clearly drawn, so too the implications I have drawn are rather sketchy and open-ended. It is in the nature of ethnographic investigations such as this one that they bring into view a bewildering complexity and richness of experience that does not readily yield to logical analysis or neat categorization. Ethnography, like fiction, attends to the stories of people's lives and reveals the moral depth and complexity of their experience. Indeed, that is its primary virtue and the way in which it serves as a corrective to both abstract philosophical as well as statistical and sociological research into professional life. But there is a price to be paid for unearthing the moral ecology of professional life in this way. The stories that are at the heart of any account of human, including professional, experience are always messy and idiosyncratic precisely because they are richly textured and personal. They provide a window into the hearts and minds of individuals who have much to teach us, but they do not offer us a road map for navigating the world that they open up to us. In all, they offer us no firm conclusions about the relationship between religion and ethics in the lives of professionals, not even in the lives of the handful of individuals studied. Instead, their stories help us to see the religious/moral lives of these physicians more fully and, in the light of that vision, to challenge accepted ways of thinking about professional ethics and to raise new questions about the lessons we can draw from their experience.

health care. Selected references, which directly or indirectly inform the discussion in this chapter, include the following: Francis W. Peabody, "The Care of the Patient," *Journal of the American Medical Association* 88 (1927): 877–82; Anthony L. Suchman and Dale A. Matthews, "What Makes the Patient-Doctor Relationship Therapeutic? Exploring the Connexional Dimension of Medical Care," *Annals of Internal Medicine* 108 (1988): 125–30; Howard Brody, *Placebos and the Philosophy of Medicine* (Chicago: University of Chicago Press, 1977) and *The Healer's Power* (New Haven, Conn.. Yale University Press, 1992); and the text and citations in Felicia G. Cohn's thoughtful and well-researched doctoral dissertation, *Dialogue in Medicine: Martin Buber and the Physician-Patient Relationship* (University of Virginia, 1996), 176–216.

4. Brody, *Placebos and the Philosophy of Medicine;* Cohn, *Dialogue in Medicine,* 189–200.
5. Smith and Churchill, *Professional Ethics and Primary Care Medicine,* 5.

Chapter 5: Ethics, Faith, and Healing

1. I wish to thank the Poynter Center for the Study of Ethics and American Institutions at Indiana University, and especially its director, David H. Smith, for enabling me to participate in the collaborative project on Religion, Ethnography, and Professional Life. In addition to all that I learned from the other participants in that project, I gratefully acknowledge the help that I received throughout this project from two consultants. Sheldon Berkowitz, a close friend and a pediatrician, has strong interests in medical ethics and has served for many years on the ethics committee of Minneapolis Children's Medical Center. Laurence Savett, a recently retired internist, has taught courses to undergraduates and to medical students on humanistic values in medicine. Both contributed in significant ways to my conceptualization of the issues addressed here. I also wish to thank the six physicians who gave so generously of their time in responding to my questions. I learned a great deal from each of them and hope that this paper, in addition to representing their views accurately, succeeds in conveying the admiration I have for each of them.
2. Of course, shamans in native cultures in both the Americas and Africa provide evidence of the widespread belief that the power to heal is supernatural in origin.
3. See Numbers 12:1–15.
4. 1 Kings 17:17–24.
5. See John 5:3–9; Matthew 9:27–31; 20:17–19; Mark 10:46–52; Luke 13:10–17, among many such examples. It should be noted that stories of holy men capable of healing circulated in rabbinic literature of the same period. See, for example, the two healing stories of Rabbi Hanina and Rabbi Yohanan; *Babylonian Talmud Berakhot* 5b.

6. See Claude Levi-Strauss, *Structural Anthropology* (New York: Basic Books, 1963), especially chapter 10, "The Effectiveness of Symbols." For more recent illustrations of the close connection between religious authority and the power to heal, see Dwight Conquergood and Paga Thao, *I Am a Shaman: A Hmong Life Story with Ethnographic Commentary,* Southeast Asia Refugee Studies, Occasional Papers Number 8 (Minneapolis: Center for Urban and Regional Affairs, 1989) and Anne Fadiman, *The Spirit Catches You and You Fall Down* (New York: Farrar, Straus & Giroux, 1997).
7. Anatole Broyard, *Intoxicated by My Illness,* excerpted in *On Doctoring,* ed. Richard Reynolds and John Stone (New York: Simon & Schuster, 1995), 178.
8. There was nothing scientific or random about the process of selecting physicians to interview. I began by questioning a couple of close physician friends about individuals who might be interested in discussing these issues with me. My initial screening of ten to twelve candidates enabled me to select a half dozen who appeared to have reflected most seriously on the intersection of their personal and professional lives. I settled on three pediatricians in general practice and three pediatric specialists in separate fields. I chose not to interview physicians who now work as administrators rather than clinicians on the assumption that those whose experience was current would offer me the freshest and most detailed answers to my inquiries.
9. I recognize that physicians who work with pediatric patients are often regarded as a self-selected group, perhaps more concerned with humanistic dimensions of medical care and less concerned with professional status and the financial rewards of medicine than those attracted to other areas of medicine. In some respects, the responses of these physicians confirmed those characterizations. Of course, without comparative data, it is not possible to draw conclusions about whether the values of those interviewed for this study were unique, either among those providing pediatric care or among physicians in general.
10. In the end, all those who agreed to participate in this study were male, although it was not my original intent to restrict the study in this way. The group was also somewhat more homogeneous than I intended in terms of professional experience, in that all the participants have been in practice at least fourteen years. I cannot say the extent to which either of these factors may have skewed the responses I received.
11. I met with each physician two or three times for a total of three to five hours. While I have no way of knowing the extent to which they were completely candid with me about frequently sensitive matters, each of them shared with me things that did not reflect positively on their professional lives, a sign of genuine and significant self-disclosure. It should also be noted that each of the participants in this study reviewed an earlier draft of this paper and had an opportunity to suggest additions or corrections. Several of them also participated in a group discussion of the paper, which helped me to clarify their views considerably.

12. I have attempted here to capture as accurately as possible the views and values of the participants in this study as they reported them to me; hence, the substantial quantity of direct quotation, drawn from tape recordings of these interviews. Of course, the organization and conceptualization, as well as the interpretation of this material, is my own.
13. This concept is taken from Alisdair MacIntyre, *After Virtue: A Study in Moral Theory* (Notre Dame, Ind.: University of Notre Dame, 1981).
14. Given the limited nature of this study, I make no claims that these are exhaustive, only that they were most salient in my conversations with this group of physicians about the ways in which they meet the challenges inherent in their practice.
15. Rachel Naomi Remen, *Kitchen Table Wisdom* (New York: Riverhead Books, 1996), 164.
16. This point is made with particular eloquence by Anatole Broyard in his book, *Intoxicated by My Illness*, excerpted in Reynolds and Stone, *On Doctoring*, 178: "To most physicians, my illness is a routine incident in their rounds, while for me it's the crisis of my life. I would feel better if I had a doctor who at least perceived this incongruity."
17. See Ramsey, *Patient as Person* (New Haven: Yale University Press, 1970).
18. In a group conversation with several of the physicians long after the individual interviews had been completed, this distinction between "compassion" as a feeling and "caring" as compassion translated into action received a good deal of attention. Some felt that through medical education one could learn certain techniques (the value of touch, listening skills, etc.) that are indicative of caring, but that compassion is a personal trait that one cannot be taught (at least not in any formal way). Others voiced the belief that caring without compassion was the equivalent of "going through the motions" without real conviction or feeling, and so was disingenuous (and would be recognized as such by patients). Despite these differences, they agreed that when they identified compassion as a virtue of medical practice, they meant to include the willingness and ability to communicate that compassion to patients through actions.
19. Remen, *Kitchen Table Wisdom,* 225.
20. Dr. Sheldon Berkowitz, personal communication, July 22, 1998.
21. I use the term "religious," as scholars of religion often do, to refer to the attitudes of awe and reverence in response to the transcendent dimensions of human life. The physicians themselves, in keeping with contemporary parlance, might refer to these experiences or attitudes as "spiritual," reserving the term "religious" for things connected to organized religious groups and established religious traditions. The difference, in this instance, is strictly semantic.
22. Arthur Kleinman, *The Illness Narratives* (New York: Basic Books, 1988), 210.

23. Indeed, Laurence Savett, who served as a consultant on this project, su gested that each of the influences on these physicians (personal experienc role models, the communities to which they belong) was a source of valu for their practice, and, moreover, that each of these factors influenced th others. At different times, different influences might come to the fore, but r one of them is decisive, nor could it be. In that sense, any attempt to isola the "Jewish" influence on these physicians' practice as distinct from the oth factors that play a role in their professional lives is futile from the start.
24. Abraham Joshua Heschel, *God in Search of Man* (New York: Farrar, Strau & Giroux, 1955).
25. One does find this perspective represented in the works, both autobiograph ical and fictional, of physicians themselves, as in Reynolds and Stone, *C Doctoring*.
26. An important exception to this is Margaret E. Mohrmann, *Medicine a Ministry: Reflections on Suffering, Ethics and Hope* (Cleveland: Pilgri Press, 1995). See also her article, "The Practice of the Ministry of Medicine in *Update, Loma Linda University Center for Christian Bioethics* (October 1998): 3.
27. By way of example, see Alan H. Goldman, *The Moral Foundations o Professional Ethics* (Totowa, N.J.: Rowman & Littlefield, 1980), an Michael D. Bayles, *Professional Ethics*, 2d ed. (Belmont, Calif.: Wadsworth 1989).
28. Arguably, had our conversations gone on much longer, these things migh have come up. But questions about "how being Jewish affects the kind o doctor you are" and "has Judaism helped you in any way to deal with th challenges of caring for sick children and their families" evoked only rathe general answers.
29. Some of these physicians indicated that their practice of medicine was indee influenced by their Jewishness, but "not directly." When asked to spell ou what this meant, Kohen noted that his practice is "driven by values that com from my family and those are very clearly Jewish values, but they're home ethnocultural values, not shul [synagogue], scripture-based values." To th extent that this sentiment is shared, it reinforces two important points—tha traditional Jewish texts and beliefs are not a major factor in shaping the val ues of these practitioners, and that, nonetheless, Jewish cultural and socia mores may be an important influence on them.
30. Again, Breningstall may be an exception here. Given his Orthodox Jewish practice, he seems most able to articulate the connections between these aspects of his life: "The whole practice of Judaism . . . becomes a sort o affirming way of life that carries over when things get difficult in medica practice. As I'm involved in Jewish learning or religious practice, variou aspects of religious living, it all seems to make a coherent whole that helps everything else fit together too." And later he commented, "Jewish learning

is clearly the most complicated kind of intellectual discipline in which I've ever been involved. The difficulties in undertaking the study of medicine pale in comparison to studying gemara [Talmud]. Just like medical practice is an encounter with a much greater intelligence, this is also an encounter with a greater intelligence." His integration of religious and medical practice is also evident in his acknowledgment that "saying tehilim [psalms] for someone who is ill [which is a traditional Jewish practice] is as potent a healing endeavor as medical practice."

Chapter 6: Organ Transplants

1 Richard Selzer, *Imagine a Woman and Other Tales* (New York: Random House, 1990), 3–28.
2. Ibid., 4.
3. Ibid.
4. Ibid., 6.
5. Ibid., 7
6. Ibid.
7. Ibid., 7–8.
8. Ibid., 8–9.
9. Ibid., 10.
10. Ibid.
11. Ibid., 19.
12. Ibid.
13. Ibid., 20.
14. Ibid., 23.
15. Ibid., 27.
16. Ibid., 28.
17. S. J. Youngner, S. Landefeld, C. J. Coulton et al., "'Brain Death' and Organ Retrieval: A Cross-sectional Survey of Knowledge and Concepts among Health Professionals," *Journal of the American Medical Association* 261 (21 April 1989): 2205–2210.
18. D. Wikler and A. J. Weisbard, "Appropriate Confusion over 'Brain Death,'" *Journal of the American Medical Association* 261 (21 April 1989): 2246.
19. Joseph Fins, "When Brain Death Pulls at the Heart Strings," in *Personal Narratives on Caring for the Dying*, 2d ed. (American Board of Internal Medicine, forthcoming), 21–22.
20. Hans Jonas, "Against the Stream: Comments on the Definition and Redefinition of Death," in *Philosophical Essays: From Ancient Creed to Technological Man* (Englewood Cliffs, N.J.: Prentice-Hall, 1974). Reprinted in *Contemporary Issues in Bioethics*, ed. Tom L. Beauchamp and LeRoy Walters (Encino, Calif.: Dickenson Publishing Co., 1978), 263.
21. Ibid., 264.
22. Ibid., 266.
23. Ibid.

24. Ibid.
25. The image of physician as crusader helps to clarify, I think, why so much of medical ethics and public discourse about medical ethics focuses on the "rights" of patients. It also helps us to understand what is good and what is bad about that focus. It is good because the language of "rights" is the most powerful language we have to constrain and restrain the powerful do-gooder It is bad because it is essentially adversarial—it will not (cannot) nurture or sustain the loyalty and trust that are essential not only to healing but to the effort to procure organs for transplant. Adversarial relationships and distrust are serious barriers to procuring organs for transplant. Legalistic attention to the "rights" of patients and their families will not nurture the necessary trust, and any actions that are seen as compromising the loyalty physicians owe patients and their families will threaten that trust. Medical ethics could contribute to alleviating suspicion by developing alternative ways to talk about these issues. And religious communities have access to other ways of talking about professional obligations, like the image of "covenant" that William F May has used so compellingly.
26. Task Force on Organ Transplantation, *Organ Transplantation: Issues and Recommendations* (Washington, D.C.. U.S. Department of Health and Human Services, 1986), 31
27. The Partnership for Organ Donation, *The American Public's Attitudes toward Organ Donation and Transplantation: Summary Results of a Gallup Survey Prepared for The Partnership for Organ Donation* (Boston: The Partnership for Organ Donation, 1993), 3, 6.
28. Task Force on Organ Transplantation, *Organ Transplantation*, 31.
29. Partnership for Organ Donation, *American Public's Attitudes*, 3, 6.
30. Task Force on Organ Transplantation, *Organ Transplantation*, 31
31. May, *The Patient's Ordeal*, 176–77
32. Gil Meilaender, "Case Studies: The Anencephalic Newborn as Donor," *Hastings Center Report* 16 (April 1986): 23.
33. Alexander Capron, "Anencephalic Donors: Separate the Dead from the Dying," *Hastings Center Report* 17 (February 1987); see also Arthur Caplan, "Fragile Trust," in *Pediatrics, Brain Death, and Organ Transplantation*, ed. H. Kaufman (New York: Plenum Press, 1989), 299–307.
34. Selzer, *Imagine a Woman*, 7
35. Leon Kass, *Toward a More Natural Science* (New York: Free Press, 1985), 277–78.
36. May, *The Patient's Ordeal*, 182–87.
37 Arthur Caplan, "Professional Arrogance and Public Misunderstanding," *Hastings Center Report* 18 (April–May 1988): 34–37
38. Susan Martyn, Richard Wright, and Leo Clark, "Required Request for Organ Donation: Moral, Clinical, and Legal Problems," *Hastings Center Report* 18 (April–May 1988): 27–33.
39. Caplan, "Professional Arrogance," 36.