

Thinking Theologically About Modern Medicine

BONNIE J. MILLER-McLEMORE

ABSTRACT: In the last century the dictates of modern science and technology have gained an unprecedented authority, sometimes heeded with a religious fervor once directed at religious bodies. Meanwhile, on many subjects, mainline Protestantism has withdrawn from the conversation. This is particularly the case when church and academy have tried to think theologically about the highly technical and at times dramatically nontheological problems of physical health. I propose to look at the ways in which this decline from dominance affects 1) mainline attitudes toward healing; 2) Protestant reflections on moral dilemmas in medicine; 3) religious ideals of ministry to the sick and the poor. After attending to the problems in each arena and then noting promising developments, I conclude with suggestions about reviving a vibrant theological witness in medical ethics and health care.

Theology, once esteemed as the queen of the sciences, no longer reigns supreme. And mainline Protestant churches, now deemed "sideline," "oldline," or otherwise,¹ have moved from center to periphery. What happens, then, when those who proclaim religious beliefs turn in sickness and in health to the new candidate for queenship—modern medical science—and its practitioners or the new "priesthood," as some have called them? When church and academy try to think theologically about highly technical problems of health, illness, and healing, they continue to fall short of translating their values and concerns into meaningful, viable premises in the world of medicine and beyond. How can the church think theologically about the complicated practice of modern scientific, technological medicine?

Seminary students struggle with this central question in various courses that I teach in health and medical ethics. Invariably it comes up again and again. Related to this concern is a second, equally difficult query: How might mainline Protestant churches inform public policy in the area of health care? As Michael Novak suggests, mastery of public policy issues requires a talent that most academics and most church members do not relish or even perform well—the "enormous accumulation of detail about particulars and a great

Bonnie J. Miller-McLemore is an Assistant Professor of Religion, Personality, and Culture at Chicago Theological Seminary.

respect for the concrete." For the most part, academic departments and churches alike spend their energies and time regenerating a particular religious tradition, either through reflection or participation. This commitment leaves them little space or interest for the kind of sustained attention demanded for adequate performance in the arena of public policy and health care.²

Most Protestant conversations on the relation between religion and health have understood this question primarily in regard to the impact of the modern science of psychology on religion. Even the nature of this journal, defined by the focus of many of its articles, reflects this trend. In looking at the intersection of religion and health, health has meant, broadly speaking, mental health. The tyranny of secular and sometimes antagonistic social scientific models of health that emerged with Freud and began fundamentally to shape religious ideologies about healing has taken center stage.

The time has come to stretch the dialogue to include another front, that of bodily, physical suffering and cure. Equally powerful metaphors about health come from medicine and current medical practice. With this essay, I wish to prime the pump. We need to look at the ways in which the powerful cultural images of modern medicine have affected and overshadowed religious attitudes toward healing, ethical dilemmas in medicine, and health care distribution. At the same time, we can benefit by noting promising developments and suggestions toward reviving a vibrant theological witness.

Healing and faith

While reading a children's book, *The Miracles of Jesus*, to my small son, the scenes of healing of one ailment after the other began to strike me—women, men, children, poor, and outcast healed from blindness, paralysis, bleeding, and ultimately death. Jesus heals. Jesus commissions the disciples to "go into all the world and . . . lay their hands on the sick" (Mark 16:15,18). Faith healing was a seminal component of early Christianity. What has happened to this ministry of healing?

Among mainline Protestants, the ministry of healing faces real challenges today. According to historians William A. Clebsch and Charles R. Jaekle, of the four pastoral functions in the history of the church—guiding, sustaining, reconciling, and healing—healing has become radically contracted in modern churches. Despite renewed interest in various approaches to wholistic healing in recent years, these remain "isolated from the central understandings of healing that prevail in Western civilization"³ and substantially forgotten or ignored by contemporary liberal Protestantism. Historic activities—anoointing the sick with oil (one of the most prevalent means of healing in the early church), healing through relics, prayers to particular saints, pilgrimages to shrines, the laying on of hands by charismatic persons, exorcism, ritualistic

acts, adjurations, certain prayers, and consecrated potions—all these strike the modern, scientific mindset as quaint, fantastical, even dangerous if taken too seriously. Recent media reports have only magnified the dangers by highlighting the failures of spiritual healing in conservative churches. The deaths of children with diabetes or with bowel obstructions that have led to charges of manslaughter against the parents reflect the difficulties that modern society has in general in determining the exact role of faith in healing.⁴

Almost with relief, religion in Western society in the nineteenth and twentieth centuries turned the obscurities of body and psyche over to medicine and psychiatry. Despite the obvious emphasis on acts of healing in the traditions of the church, mainline church people now experience a peculiar modern embarrassment about the possibility of spiritual healing.⁵ The modern world bears the scars of the wedge that the Enlightenment drove between faith and reason, theology and science, church and health care institutions. We live in a "chopped up" world, with medicine and psychology ruling over the major metaphors of healing, progressively narrowing the domain and authority of congregation and clergy.⁶ Today mainline churches remain confused about their particular religious premises about healing and how to relate these to the modern professions of medicine, pharmacy, and psychiatry. Nor do they know how to relate to former Christian traditions of healing or even to unconventional modes of healing in other societies and in subcultures within our own society. Most consider these forms of healing well beyond the possibility of resurrection or retrieval.

On the one hand, many persons in Protestant congregations, especially among young and middle-aged members, have begun to evidence what I would characterize as a growing sense of questioning and dissatisfaction with the modern medical model. On a broad scale, the movements of wholistic health, hospices, bioethics, centers for the study of health and religion point to this. More narrowly, personal decisions to consider home birth or individual anxieties about "being kept alive on machines" are further indicators of a subtle disenchantment with major motifs of modern medicine. Without a doubt, since the 1970s physicians have suffered a radical loss of confidence.

Yet, on the other hand, laity continue to heed medical advice, sometimes with the kind of deference given religious disciplines in earlier centuries. Despite recent unrest with medicine, the church and minister no longer wield and will probably never regain the same authority in matters of healing as before. Nor, given some of the obvious contributions of scientific medicine, would many mainliners want to return authority for physical health to clergy. But this does not answer the persistent question of the possibility of a viable, equal relationship between two, albeit different, perspectives on health. In final analysis, the religious perspective continues to appear the less viable of the two and ranks far below medical imperatives. Just as a dying parishioner begins to share fears with a minister, fears that may affect the person's overall health in critical ways, the physician hurries in and

abruptly dismisses the minister, saying, "Pardon me, Reverend, I've got work to do."

This kind of societal perception renders the activity of religious healing the most problematic of the pastoral functions. Yet, given the questioning of much of modern medicine and the revitalization of alternative modes of healing, the pastoral function of healing remains the most open to new interpretations and expressions. So, we must ask ourselves, what will some of these new expressions be? How might mainline churches have a hand in shaping public responses and perceptions, both within and without the church?

On one side stands the highly visible, flamboyant faith healing most apparent in television evangelists but not limited to them. A personal and all-powerful God disrupts the laws of nature to affect direct, personal, miraculous acts of healing.⁸ At the other extreme, adherents of medical materialism locate the source of all healing in empirical science, in its investigation of the body as simply physiological matter, and in the practicing physician as a technician of the body.⁹

Caught between these two extremes, many mainline church people resolve the tension between faith and healing by leading separate lives. In one world on Sunday, they praise God for healing powers, acknowledging the truth of this for their lives, at least symbolically; on Monday they return to the racquetball club to promote health through an exercise program or to the outpatient clinic for one more blood test. Although this behavior may appear duplicitous on the surface, it is not. Mainline believers contend that God suffers with us but does not interrupt the natural order with miraculous signs and wonders. God works in and through human activity and institutions. The laboratory, the clinic, the university, the legislature, even the health club, are, as historian Martin E. Marty notes, "arenas of divine activity"¹⁰ but not specific intervention.

This claim seldom satisfactorily answers many questions about the connection between faith and healing.¹¹ In embracing a God active in scientific advances, Protestants face the danger of accommodation to modern culture. Earnestly partaking of the Western rationalistic worldview, mainline believers have become remarkably hesitant to use the language of miracle or spiritual healing even when the unexpected and inexplicable do occur. Protestant chaplains, unsure of what they have to contribute, often sit as token representatives in awkward silence on "interdisciplinary" health care teams where technical language and the medical model still prevail. The minister entering the hospital to visit a parishioner feels like an intruder in the healing process and, as Martin Marty notes, needs reassurance "that it is appropriate to speak of religious faith in clinical settings."¹² Protestants have done away with or forgotten many of the rituals and reminders common to Jewish and Catholic traditions, such as specific prayers of healing, symbols (for example, the Jewish tradition of rending a garment or ribbon at a death or the

Catholic act of saying the rosary), anointment of the sick and dying, and burial and mourning procedures, that recall that caring and curing continue to have significant religious or spiritual dimensions. Sometimes ministers improvise or borrow from more articulate traditions. Even more significantly, laity turn to secular versions of self-cure—Norman Cousins's *The Anatomy of an Illness*, or more recently, Bernie Siegel's *Love, Medicine and Miracles*.¹³ A few turn to charismatic faith healing.

Developments in medicine and bioethics

Next to the confusion about the church's role in healing stand new biomedical technologies. These technologies have in turn sparked an incredible surge of interest in medical ethics. Initially this surge of interest left the Protestant church by the wayside. Bioethics has a relatively short-lived, primarily American-based, and—significantly for this discussion—secular history.¹⁴ The sources and audiences of the institutes, journals, and books in the field seldom include those within Protestant churches, except secondarily. Protestant religious institutions, bound by their own internal educational priorities and their private status, lagged behind as participants in bioethics discussions. As in many arenas, in conversations about medical ethics religion became “a private consumer product that some people seem to need” but that ought to keep a “civilized distance” from social structures and public policy formation.¹⁵

If the church participated, it did so indirectly. That is, those wearing non-theological hats defined the problems and left little room for theological types of answers. Theologians who entered the discussion failed to do so specifically as theologians. Initially, theological identities and differences were often left aside. According to theologian James M. Gustafson, theologians and ministers alike have the burden of “speaking in a context in which theology is not ‘at home,’ one that demands they render their discourse intelligible to a world become alien.” Theologians lack agreement about what would even make up the subject matter of theology in this whole area; “we know what many of the moral issues are in technology and the life sciences [but] we are not sure what the ‘religious’ or *theological* issues are.”¹⁶

In addition, in free-church traditions the role of the theologian remains “relatively marginal, at least for the decision-making processes of church policies.”¹⁷ Congregations find it difficult to trust theologians. They feel that “seminary professors either do not understand them or deliberately make matters more complex than they need to be.”¹⁸ Often these theological reflections of the academy seem removed from the publics of both society and church. It is “A Marriage Not Made in Heaven,” as reads the title of a rather unfavorable review of *Theology and Bioethics*, a highly theoretical attempt to consider theology's contributions.¹⁹

Yet almost all Protestant ministers have to adjudicate the difficult choices that medical technologies raise and need resources for serious theological consideration of medical issues. But few tend to turn to various doctrines or disciplines of reflection within their particular traditions or to scripture for guidance. More often, ministers rely upon both an intuitional perception of the situation and a general feel for the faith tradition. And they look to secular sources. In the last several decades, when clergy and others struggled with questions about health, illness, and dying, they tended to turn to other disciplines, particularly psychology and its practitioners, for their often sensitive answers and not to theology, scripture, or the church community and its tradition. When persons asked clergy in largely white, mainstream Protestant traditions what they could read that would help them through the difficult moments surrounding dying, death, grief, and bereavement, clergy referred them to books like *On Death and Dying*, Elisabeth Kübler-Ross's well-known book, more often than any religious or ethical text on the subject. As early as 1965 Robert Fulton and Gisbert Geis note the "continuing attrition of the sacred orientation" from deep human existential concerns like death that demand serious theological reflection. Instead, religious institutions attend to the practical essentials of "Religion and Social Work" and "down-to-earth hints": "The advice is not to recommend faith . . . but to establish contact with a family casework agency, a mental health clinic, or similar agencies, all of which can provide 'expert help for the person.'"²⁰ In this way death and illness became not only secular and technical but progressively psychological.²¹ Ministry to the sick and dying struggles to remain "pastoral," "religious," or "spiritual," with liberal clergy "water[ing] down the religious content" of the caring role.²² And persons often fail to see certain medical moments as moral or religious events as well.

High costs and health care distribution

Despite all the issues raised by the question of the nature of healing and medical ethics, high costs and just distribution are fast becoming the most troubling question that confronts religious congregations concerned about issues of health. Modern medical advances cost money. Beyond occasional outrage over the high bill for a hospital stay, many well-situated members of mainline churches may not fully appreciate the magnitude of this problem. Americans spend nearly one billion dollars each day for the privilege of modern health care. The amount "exceeds the gross national product of the continent of Africa."²³ In fact the percentage of the nation's gross national product spent on health care has doubled in the last twenty years. Yet better health does not correlate directly with the amount spent: Britain, for example, spends less, yet their mortality and morbidity rate compares favorably. Can the church count this good stewardship of resources?

The sheer cost of illness and dying has become a constant source of anxiety and a potential threat to the relationships of persons involved. Next to defense spending, health care has become the largest expenditure in many nations and one of our own nation's largest industries. In place of the inexpensive office call less than a hundred years ago and even the trust in a well-known family doctor of recent years, we now have the complexities of HMOs, PPOs, specialized medicine, third-party health insurance payments, government reimbursement and regulation, the pharmaceutical industry, and so forth.

The high cost of new medical technologies is only one of the causes of the development of a two-tiered delivery system with its seeming "option *against* the poor." In 1983, the government implemented a Prospective Payment System for Medicare and Medicaid (Medicare accounts for 40 percent of the average hospital's revenues). The establishment of "diagnosis-related groups" (DRGs), classifying patients by diagnosis, age, standard length of stay, and necessary procedures, and thus limiting payments to predetermined amounts, dramatically shifts the burden of excess costs to local hospitals, turning initial profit margins to deficits. Unwilling to pick up nonreimbursable costs, many for-profit hospitals turn away populations that cannot pay, develop products for more lucrative markets, and cut back on "expendable" departments, including chaplaincy. Many not-for-profit hospitals have had to adopt some of these tactics or face extinction in the fiercely competitive battle for the dollars spent on health care. For both kinds of medical institutions, departments of religion and health are often the first to go.

Others believe the industrialization of medicine happened inevitably. Until the last two decades medicine had managed like no other profession to "escape from the corporation," based upon the excessive prestige given physicians as the sole arbitrators.²⁴ Now their time has come also.

Whatever the cause, money now drives the American system of health-care provision. Administrators engage in aggressive activities of capital development, merger, investment, and profit simply to remain solvent. By its nature, a competitive system displaces those who cannot pay: No one competes for nonpaying business. Thirty-two to 35 million Americans and their dependents lack health insurance. Those facing reduced access include not simply the unemployed but a high percentage of children, the working poor, and a growing number of people whose insurance provides only minimal coverage.

This pushes Protestant-related hospitals to consider serious questions of priorities and commitments. What are church administrative structures to do in a system of health-care provision driven by money? Some level of complicity seems necessary for sheer survival. Other denominations have sold their hospitals to secular corporations and redirected church monies to entirely different ministries. In either case, the cry of the market forces hospitals, historically committed to care for the downtrodden as part of the mission of the larger church, to place financial concerns and institutional self-interest

above concern for healing patients—especially those patients who cannot pay.

Innovation and creativity: a Protestant response

In the midst of such challenges on the front of religion and health, recent years have witnessed several positive developments in each area. Renewed concern about keeping faith alive in the secular worlds of the clinic and laboratory has arisen in the last quarter of a century. We have witnessed new ferment and efforts at retrieval in the Protestant church and academy, some more successful than others.

Mainline churches seem enthusiastic about enlivening their language and practices to address more meaningfully the intersection and differentiation of religious and other forms of healing. Lutheran theologian and pastor Granger Westberg, for example, has continued to initiate projects in the area of wholistic health care, the parish nurse program being one of the more recent.²⁵ The Park Ridge Center, publishers of *Second Opinion*, emerged within the halls of a Lutheran hospital in response to the need to bring faith back into greater dialogue with issues in health and ethics. The Center initiated a dialogue between the Lutheran tradition and modern health issues in three groups (health care professionals, those with chronic illnesses, and those suffering major losses) in a particular Lutheran church.²⁶ Chicago Theological Seminary, where I teach, recently received a grant from The Robert Wood Johnson Foundation to explore the possibilities of preventive health care and the black church.²⁷ An unprecedented conference occurred most recently at the Carter Center in Atlanta, Georgia, on the role of the churches in American health, bringing together public health officials and religious leaders across the nation.²⁸ All of these efforts bespeak the quiet search in Protestant churches, hospitals, wholistic health care centers, and educational institutions to address the isolation of religious bodies from dominant modes of healing and to create new avenues for increased conversation and participation in healing activity. As a whole, they suggest rich resources upon which congregations might begin to draw.

In these activities and projects, we see a desire to recreate the congregation as a "community of moral and religious discourse," in James M. Gustafson's words,²⁹ or as a mediating structure among individuals, society, and its symbols of healing.³⁰ We have become increasingly aware of the moral context of caring and curing. When inattentively borrowing from secular disciplines such as medicine or psychology, we now recognize that we appropriate, as Don S. Browning notes, "not only scientific information and therapeutic techniques but various normative visions of human fulfillment which are often neither philosophically sound nor theologically defensible."³¹

Recent revival of interest in the area of practical theology, primarily

among seminary and divinity school faculty, may have implications for reflection on the practice of medicine and health care. Some of the questions facing the church and health care include on a narrower scale similar questions facing the field of practical theology as a whole.³² Recent discussions about practical theology attempt both to remedy the gulf "between academia and ecclesia" and to reassert the public role of theology in society. The definition of practical theology varies depending upon who is speaking. But the overall pattern and direction remain the same. Practical theological action and reflection demand a series of phases: 1) a movement of primary recognition and experiencing of the problem and the important role of the cultural realm, including religion; 2) a movement of deconstruction, confrontation, or analysis that involves critical conversation among religious traditions, or stories, cultural interpretations, and personal experience; and finally 3) a movement of decision and strategy that involves an invitation to renewed praxis and the making of new meaning and value. I would like to suggest that our entire discussion about religious perspectives on health is an exercise in "practical theology." The field of practical theology in Protestant seminaries and divinity schools, I believe, has potential to contribute to the general conversation about caring and curing.

Theologians like Gustafson, William F. May, Stanley Hauerwas, Karen Lebacqz, Lisa Cahill, myself, and others have started to address the question of how ideas about the immaterial—piety, will, virtue, character, covenant—can survive the "empirical gaze" of the modern clinic, as philosopher Michel Foucault calls it. In ethical debates, they have entered into the conversation explicitly wearing religious hats.³³ Gustafson compliments theological ethicist Paul Ramsey for clearly proclaiming his theological convictions about covenant love as the guiding principle of his ethical reflections on medicine. Hauerwas and Gustafson both reclaim the importance of the church itself as moral and religious community shaping character and virtuous actions. Hauerwas calls churches to restore medicine as a moral activity *at the service* of the churches' moral projects rather than the reverse.

In the third and more pressing arena of health care costs, mainline religious institutions have only begun to face the immense issue of health care allocation and the public role of religious values and meanings in economic policy formation. Whether practical or not, Protestant churches have historically seen care of the poor, the outcast, and the underprivileged as part of their witness and mission and, when impractical, tried to alter the oppressive structures that make genuine care unprofitable. Ultimately, as Edmund D. Pellegrino acknowledges, the religious imperative to care for the "casualties of our new competitive ethos"—those marginal persons caught in the gap between private, local, and federal responsibilities who will otherwise go without care—"will demand sacrifices on our part as Christians."³⁴ A Protestant critique of the human situation reminds us of the fallen and tragic character of human existence: As Allen Verhey notes, ". . . we are not gods,

... our mortality is indefeatable, and ... our resources, while considerable, are still finite."³⁵ Protestant piety fosters honesty about life's ambiguities, challenges a medical identity geared solely toward technological cure and cost-containment rather than care, and nurtures hope in God's final triumph and the forgiveness necessary to sustain the consequences of guilt and fate. Protestants also have to ask a deeper question of whether this peculiarly American transformation of health care into business misses crucial aspects of the meaning of health. Is health something that we can buy? Is it something that we can receive, demand, or legislate as a right? The evolution of the corporate model leaves significant dimensions of health unmet. This final issue, therefore, bears critical connections to the issue with which we began, the understanding of the word "health" and role of the ministry of healing.

Minister, theologian, and laity alike have begun to find ways to talk about Protestant beliefs with renewed conviction and relevance. These various efforts demonstrate the potential of retrieving religious resources and initiating concentrated theological reflection on issues in health. Mainline religious institutions need to continue to find ways to bring moral and religious reflections into living reality in the practice of the ministry. They possess religious and ethical values on caring and curing internal to their communities and traditions that they have yet to tap and articulate.

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 35. Verhey, A., "Sanctity and Scarcity: The Makings of Tragedy." In Lammers and Verhey, eds., *op. cit.*, p. 654.