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Any confrontation of physician and patient concerning treatment can be viewed from at least two perspectives — the perspective of the physician and the perspective of the patient. It is hardly necessary to demonstrate such a truism, but it might be worth our while to provide a couple of examples.

Case 1: A 68-year old man was admitted to a hospital after a barium meal had revealed a large carcinoma of his stomach. He had retired from his own medical practice five years earlier, following a severe heart attack. The early symptoms of cancer had been mistakenly thought to be effects of his earlier heart attack. By the time it was diagnosed, the cancer had advanced to his liver and vertebrae. Ten days after a palliative gastrectomy, he collapsed with a massive pulmonary embolism. An emergency embolectomy was done in the ward. When the patient recovered, he asked that, if he had further cardiovascular collapse, no steps should be taken to prolong his life, for the pain of his cancer was more than he would needlessly continue to endure. He even wrote a note to that effect in his case records. Even so, two weeks later, when his heart arrested, he was revived by the hospital's emergency resuscitation team. Four more times his heart stopped that night, and four more times he was resuscitated. He lived, but only to linger in a coma for three weeks. Intravenous nourishment, blood transfusions, and antibiotics were all administered. Preparations were being made to hook him up to an artificial respirator, but he died before such a plan could be realized.[1]

Case 2: An unmarried 26-year-old man, who had always been very athletic, had recently left the military to join his father's successful real estate business. They had gone together to appraise some property and, unknowingly, had parked their cars near a leaking propane gas line. When the young man started the car, he also ignited a severe explosion. The father was killed, and the young man sustained severe burns. During the next nine months, he underwent repeated skin grafting, removal of his right eye and surgical closing of his left eye in an attempt to save it, amputation of parts of his fingers on both hands,

and daily baths in a Hubbard tank to control infection. Althou he persistently stated that he did not want to live, he accepted trea ent until, at the end of nine months, he refused permission for f ther corrective surgery on his hands and insisted on being dischar d in order to go home and die, as he surely would without the dail Hubbard baths. In spite of his protests and agony, the painful bath vere continued. A psychiatric consultant was called in in the h e of having the young man declared legally incompetent, but conve tion with him only convinced the psychiatrist that the young m was legally competent. Indeed, the psychiatrist helped the youn man secure legal counsel to obtain his release by court order if ne sary. The painful treatments continued even as preparations were n le to begin court proceedings.[2]

It is not difficult to multiply examples of this sort of confr ation between physician and patient concerning treatment. A nu er of recent court cases deal with such confrontations.[3] But these t cases are sufficient, I think, to alert us to the differences of the two rspectives and to the fact that our emotive responses tend som nes to support the patient's perspective and claims and sometimes t pport the physician's perspective and judgment. I propose in this p er not to "solve" these cases but to examine the perspectives of pa nt and physician and to suggest what difference being Christian n and should make to them.

I. The Perspective of Physicians

In the Hippocratic treatise "The Art," the physician's ole was defined as "to do away with the sufferings of the sick, to ssen the violence of their diseases, and to refuse to treat those wh re overmastered by their diseases, realizing that in such cases m dicine is powerless."[4] Indeed, if a patient asks for some remed against impending death, "if," to quote "The Art" again, "a ma demand from an art a power over what does not belong to the art . . ., his ignorance is more allied with madness than to lack of knowledge." Physicians saw the good of health and their powerlessness against death, so they usually abstained from attempting to treat the mortally ill, "those who are overmastered by their diseases." Moreover, in the perspective of these physicians of classical antiquity, to relieve suffering and to lessen the violence of diseases, it was permissible to assist in suicide. The powers of the art included poisons and other techniques to produce a pleasant and painless death.

The famous Hippocratic Oath, of course, stood against such practice: "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect."[5] The oath was written "against the stream," opposing the prevailing perspective and mores. The date of composition and the authorship of the oath are unknown.

Edelstein, the leading interpreter of the code, argues that it was written by a Pythagorean in the 4th century, B.C. At any rate, the Hippocratic Oath was embraced and supported by the Christian Church and gradually shaped the physician's identity and community and, likewise the perspective of physicians who saw not only the good of health and the limits to their powers, but also the respect that was due life itself as a gift of God.[6] The physician's identity and community, therefore, supported and nurtured by the Christian story, prohibited any direct taking of life. There was not yet any recognition of an obligation to treat "those who are overmastered by their diseases," to prolong life. The physician's responsibility toward the dying was simply to tell the patient to "provide for his soul's health, as that of his body was in dangerous condition."[7]

The physician's perspective, however, was to shift again with the development of new powers in the art. Francis Bacon added to the preservation of health and the cure of diseases the prolongation of life, and he said this "third part of medicine" is "new, and deficient; and the most noble of all."[8] Encouraging physicians to this "most noble" end, Bacon essentially rejected the old category of "those overmastered by their diseases' and invited a study of "the cure of diseases which are held incurable . . . since the pronouncing of these diseases incurable gives a legal sanction, as it were, to neglect and inattention, and exempts ignorance from discredit."[9] Bacon's recommendation was, as he said, imaginative for his time, but it gradually shaped the physician's perspective as powerfully as the once innovative oath had. The medical community and identity were enlisted on the side of life, fighting a messy but heroic battle against death. Their courage was their refusal to call any disease incurable; their weapons were forged in study and research; their allies were the university and its laboratories.

The Baconian shift in perspective eventually had three effects on the physician's vision. The physician began to see life as the great good to be preserved and defended along with health and to see death as the great evil to be fought and defeated along with suffering. The physician began to see science as the great ally of medicine, indeed, sometimes to see medicine as a science rather than an art. The effect was a shift of focus from patients to pathologies. I shall refer to this aspect of the physician's perspective as the "medicalization" of care. I will not deny that it has brought great benefits, but it brings certain costs in its train, too. The physician's perspective, insofar as it is allied (and alloyed?) with the technical and scientific perspective on the persons who are his patients, denied their particularity, their exceptionality, in the interest of treating them as the sum total of the physical and chemical mechanisms which operate on them according to scientific laws.[10] The same alliance denies the patient's transcendence in the interest of treating him or his body as manipulable nature, and it eschews *moral* evaluations or instructions in the interest of scientific

diagnosis and prescription.[11] What man is that the physician s uld be mindful of him, his particularity, his transcendence, his oral agency, is thus subtly threatened by the perspective of the phy cian *qua* scientist and technologist.[12] A third effect of the Baconia shift in perspective is the self-conscious refusal to acknowledge any mits to the art. If limits are acknowledged, they are relegated to e ill-defined and shadowy background of a physician's vision.

I do not claim that every physician shares this particular p spective. Some would practice hospitality toward death in some cumstances.[13] Some distinguish themselves not only for their te nical competence but for their humanity toward the persons who a their patients and so become "condign of our biased affection and ol ctive praise."[14] I do claim that to belong to the community of ph cians today, to assume the identity of the physician today, is to ha one's own perspective skewed by this perspective. I do not claim th every physician can only see things from this perspective but rather t it any member of the community of physicians — anyone who assur s that identity — will have his or her own perspective shaped by thi one. I do not claim that every physician will adopt or accept a polic stated by a resident: "As a university teaching service, we tend to tempt resuscitation of all patients, particularly at the beginning of the semester,"[15] only that such a statement and such a policy a under-standable if there is such a perspective operative. I do not cl m that all physicians would resuscitate the 68-year-old cancer vict , only that such action is quite unintelligible apart from such a pers ctive. I do not even claim all would continue the Hubbard bath on e burn victim, only that such a perspective supports such a decision.

II. The Perspective of Patients

The patient's perspective has changed through history as well. For thousands of years, the patient whose disease had "overmastered" him took control of his own dying. With family and friends gathered in the dying person's bedroom, the patient presided in a ritual he had seen enacted many times before. He would forgive and be forgiven, instruct and bless. The patient was, and was expected to be, master of his dying.

In Peter DeVries's *The Vale of Laughter*, Joe Sandwich's father is dying and worries about what his last words will be. He says to Joe one evening, "What if a man goes in the middle of the night and says something there's nobody to hear?" Joe is puzzled and a little irritated by his father's concern, "seing no reasonable motive for it at all except the desire to strut your stuff to the end," but he does care for his father and so, "to cheer him up," he responds, "It might be something completely trite and worthless, and lucky nobody did hear it."[16] Joe's father sees in his death and exceptional moment, one to give his individuality as an urbane unbeliever its definitive form, to "strut his stuff" if not *to* the end, at least *at* the end. But it's an unsupported role. There is no ritual or set of mutual expectations to make it possible. Joe's irritation is a modern one, denying death, and insisting on a dying that does not disrupt the routine too much or embarrass the survivors.

The new role for the patient had its origins, too, I suppose, back when Bacon convinced physicians to pretend there were no incurable diseases. The patient was gradually robbed of the role of the dying and confined to a developing "sick role." The "sick role" was described first by Talcott Parsons as a set of permissions and expectations which society attached to those defined as "sick."[17] The sick were exempted from normal social activities and responsibilities, exempted from blame for their condition, expected to define their own state as undesirable, and obligated to seek competent help and to cooperate in the process of "getting well." Recently, however, many have undertaken to challenge this role-assignment (and the support it gives to treatment simply as an instance of a certain pathology, rather than as a person) as a violation of the patient's autonomy. The patient's consent is required, not only his cooperation in medically indicated treatment. The patient should insist upon being treated as an agent, asserting his rights against the powerful medical perspective, including his right to refuse treatment, even life-saving treatment, and to die. The slogans of "right to die," "death with dignity," and "natural death" all express this new perspective of patients and those who stand to be patients. It is not my claim that all patients share this particular perspective. Indeed, I really think few do. Most patients quite contentedly still play the "sick role." But this new perspective is emerging, and it exerts pressure not only against physicians but upon patients, too. More and more, it is seen not only as the right, but as the role-obligation of the patient to determine the course and limits of medical treatment, to be responsible for one's own dying. Against the great powers of the medical community — both the powers related to their technology and the powers related to their role-relation to the patient — and against the powerlessness of his "sick role," the patient can assert his rights. It is this perspective which makes intelligible the cancer victim's instruction to cease and desist, the burn victim's refusal of treatment, the inconvenienced college professor's assertion of a right to smoke in his room (well, at least twice a day), and sundry other refusals of treatment, whether prudent or tragic or comic.

III. Toward a Christian Perspective

The physician's perspective and the patient's perspective determine what is seen and not seen, what is in the foreground and what is in the shadows, what is important and what is marginal. As these perspec-

tives are different, so will be the judgments which are made i erms of them. The one who wants to think and act Christianly abo these matters will want to see things from a Christian perspective. ere is more than one way, however, in which that has been (and y be) attempted.

A. Option One: Canonize One Perspective

One option is simply to canonize either the physician's pe ective or the patient's perspective. Indeed, this is very much what s happened in the two books which seem to me the most instructi on the moral issues surrounding death and dying. Paul Ramsey's *Eth at the Edges of Life* comes very close to canonizing the physician's erspective. According to Ramsey, decisions concerning treatmen or the patient should be "medically indicated." He fears that an em asis on the patient's perspective, on the "patient's right to refuse tr ment," runs the risk of "subjectivism,"[18] "enthrones . . . an arbit y freedom,"[19] and makes a decision "right" simply becaus it was made.[20] Moreover, the patient's perspective tends to reduce e physician's role to "animated tools (Aristotle's definit n of a slave)."[21] Robert Veatch's book *Death, Dying, and the ological Revolution: Our Last Quest for Responsibility*, on the o er hand, quite candidly advocates the patient's perspective, short o adopting its slogans. According to Veatch, decisions concerning tre ment are the patient's to make in his own way and according to his o n lights. The physician's perspective may not be allowed to limit o override the agency of the patient.[22] Not only is the physician's po er limited by the norm of freedom, the physician's perspective and sense of special role requirements are rejected as particularistic special pleading.[23]

Each of these outstanding books articulates and defends the perspective it would canonize with both passion and reason; the fault of each is the failure to see certain things and to see them as important, things which, perhaps, can only be seen and seen as important from the other perspective. Ramsey fails, I think, to see that the physician's judgment about the patient's welfare may not be the same as the patient's judgment. The physician's focus will (understandably) be the welfare of the patient *qua* patient rather than the welfare of the patient *qua* person. The good seen and sought and done by a physician may be medically "good," but not necessarily humanly "good," at least not humanly good as a human person who is the patient would see it and seek it. Moreover, if, as Herman Feifel has shown, physicians as a group have a considerably higher anxiety in the face of death than others,[24] that anxiety (and greater than normal desire to conquer death) may lead them to misinterpret the patient's welfare. Canonizing the physician's perspective is not free from the danger of subjectivism, which Ramsey dutifully fights, for enthroning an arbitrary dominance by the professional (or, at least, what may seem such from the patient's perspective) and rendering a decision "right" simply because it was made by a physician will seem (at least to the patient) to be equally subjective and more arbitrary.

On the other hand, Veatch fails, I think, in his advocacy of patient rights, to have any sympathy with physicians or the perspective of physicians. His dismissal of the special role responsibilities and special moral identity of physicians is just wrong. Parents, pastors, teachers, and, not the least, physicians, do have special responsibilities because they have special roles which affect identity and perspective. Veatch's single-minded advocacy of patient rights threatens to render the medical profession an "animated tool" (to use Ramsey's phrase and Aristotle's) to be contracted by patients. Veatch's perspective, moreover, is so dominated by freedom that he overlooks other values. Not only does he fail to see other values which are constitutive of the medical profession, but also he fails to see — or at least to say — what values a patient might or should utilize to make a free decision.

The attempt to canonize either the physician's perspective or the patient's perspective, then, is doomed to be myopic, and it is not the option we should take if we intend to think Christianly about these matters.

B. Option Two: Adopt an Impartial Perspective

A second option is to adopt neither the physician's nor the patient's perspective, but rather a perspective of impartiality. This option would ostensibly free moral discernment from the arbitrary and contingent character of an agent's beliefs, dispositions, and loyalties, basing discernment and judgment on a moral standard taken to be implicit in practical reason itself or at least in the practice of giving and hearing moral reasons. Kant's "categorical imperative," Firth's "ideal observer," Rawl's "original position" are all promising attempts to provide some such place to stand outside of our involvement in particular communities and apart from our loyalty to particular causes. And a number of Christian ethicists interested in bio-ethics have attempted to stand there.

The strengths of such attempts ought not to be overlooked or underestimated. The practical strength of the attempt is that in a heterogeneous society like ours, where people with diverse cultural and religious histories and communities are forced to live together (and be enriched by their interaction), the stance of impartiality and the standard of equal freedom can provide a basis for conversation between people of different loyalties and for the adjudication of conflicting interests. The moral strength of the attempt is its challenge to

the arbitrary dominance of one perspective or person over ar ther. The theological strength of such an attempt — if care is taken t articulate it — is the acknowledgement that the doctrines of creati n and providence are as morally relevant as redemption and sar ifica-tion.[25] Indeed, such an attempt may be particularly import t for Christians as a check against our own religious pride wh , for example, our confidence in revelation would allow us to dismi cava-lierly arguments based on reason (an *ad hominem* argument n the scale of an *ad humanum* argument) or when our loyalty t God's cause would allow us to "crusade" for it and to coerce estab nment of it.

The best such approach to our problem may be provided James Childress.[26] The impartial standard of equal freedom is erative when he attempts to distinguish allowing to die from killin Charac-teristic of this approach, he, in fact, distinguishes "a right to e" from "a right to be killed." The right to die, he says, is a negati right, a claim to noninterference, while the right to be killed is a pos ve right, a claim to someone's assistance. The right to noninterferenc s consis-tent, indeed, entailed by equal freedom. The right to a stance is inconsistent with equal freedom, indeed a form of arbitr dom-inance, making the physician a tool of the patient's wishes he same impartial perspective is operative when Childress justifi allowing patients who choose to refuse treatment to die simply on grounds that they chose it.[27] For the physician or anyone to rride the patient's decision, they must bear the heavy burden of of which weighs on anyone who would interfere with another's fr om. They must show 1) that the patient's choice was not fully volu ary, either because of ignorance or incompetence; and 2) that the pa ient stands to be harmed if his decision is not overridden; 3) that such harm is disproportionate when weighed against the good of independence and other goods the patient seeks by his decision; 4) that the physician's intervention has a reasonable chance to prevent the harm; 5) that overriding the patient's wishes is a last resort, and 6) that the means of overriding his decision are the least restrictive and insulting possible.

I hope enough has been said about the strengths of such an approach that I will not be misunderstood now if I attempt to point out its weaknesses and adopt another approach. This approach is justi-fiable and important, also for Christians and sometimes especially for Christians, both as the *lingua franca* to speak as an advocate for the relatively powerless or as a check on our own spiritual and moral pride. But it is not without its weaknesses.

Its fundamental weakness is its minimalism. It does not tell us what goods to seek as much as what constraints to exercise in the seeking of them. It tells us not what to do as much as what not to do. Its minimalism shows up in another way. It tends to reduce role-relation-ships, husband/wife, teacher/student, doctor/patient, to contractual

relationships between independent individuals. When such relations fail, of course, it is usually appropriate as a kind of last resort to utilize the language of rights and the impartial standard of equal free-dom in an attempt to minimize the damage and danger to the roles themselves and to the participants in those roles. On the other hand, to utilize such language or to appeal to such a principle is itself an indication that the relation is failing, and to rely exclusively on such language damages and endangers the roles and thus, the persons whose social fabric is woven of them. Finally, its minimalism can be seen in its emphasis on procedural questions, explicitly on the question of who decides. A fuller account of morality would focus as well on substantive questions, on the question of *what* should be decided, and on questions of character and virtue, on the question of what the one who decides should be. The minimalism of this approach does not disqualify it from serving moral discernment, but if its minimalism is forgotten or ignored, the moral life can be distorted from this impar-tial perspective.

Another weakness of this approach is that the stance of impartial rationality requires alienation from ourselves, from our own moral interests and loyalties, from our own histories and communities, in order to adopt the impartial point of view.[28] We are asked — nay, obliged — by this approach to view our own projects and passions as though we were outside objective observers. We are asked by this approach to disown — for the sake of morality — the moral projects and passions which we own as our own and which give us our moral character. Now, to be made to pause occasionally and, for the sake of analysis and judgment, to be asked to view things as impartially as we can, is not only legitimate but salutary, but neither physicians nor patients nor Christians can consistently live their moral lives like that with any integrity.

C. Option Three: Toward a Christian Perspective

The third option for one who would think Christianly about these matters — the one I will pursue in the remainder of this paper — is neither to canonize the physician's perspective or the patient's per-spective, nor to require the disowning of either perspective for the sake of adopting the perspective of impartial rationality. It is rather to adopt a Christian perspective candidly and unapologetically and to ask what difference it can and should make to the Christian physician and his perspective, to the Christian patient and his perspective, and to the community which is called to support and sustain such physicians and patients.

Allow me to enter two caveats at the beginning of the undertaking.

First, it would be presumptuous to claim to articulate *the* Cl istian perspective on even one of the central issues involved in these c(ıfron-tations, say, *the* Christian perspective on death, and foolhar / pre-sumption to attempt to develop *the* Christian perspective not ıly on death but also on life, autonomy, professional roles, technolc y, and dying. That may be the task, finally, but it is and must be a ısk for communal discernment, not the work of a single Christian r ›ralist, however presumptuous he may be. It is a task which will der nd the special skills and contributions of moralists, clergy, physici ıs, and patients, each speaking from their own perspectives and eac willing to see things differently because of the common loyalty to G(. Moral discourse within the Church may not — and often will not — ›roduce answers which will have the force of law. But it can — and s: ıetimes does — bring conflicting interests and perspectives under the dgment and renewal of a common loyalty to God. What is underta en here, then, is not the last word on these issues, but a modest contr ıtion to communal discourse and discernment.

The second caveat concerns the relation of the Chris an community to non-Christians. I do not want to be understood claiming moral superiority for Christians. The history of the Chu h is too blemished by religious hatred, holy killing, sanctified co placency, and pious self-righteousness for that sort of claim. Mo ver, any Christian who remains alert to the call to repent and believe is unlikely to indulge in comparisons between his righteousness and th ighteous-ness of his neighbors. Nor am I even claiming that moral distinctive-ness is essential for the Christian life. It would not surpris me — and it would surely not dismay me — if non-Christian mo lists make points similar to those I will make or if non-Christian persons live lives coherent with them. What I do want to claim is that faithfulness to the God Who raised the crucified Jesus from the dead can and should evoke and sustain certain dispositions and intentions. I do want to claim that Christians are given a peculiar identity to which they may and must be truthful.

The tasks undertaken here are to articulate the central Christian affirmation, and to demonstrate that this affirmation enables and requires certain perspectives, dispositions, and intentions which, in turn, enable and require a critical reconstruction of both the physician's perspective and the patient's perspective. Both because such critical reconstruction needs the support and instruction of the Christian community and because even the reconstructed perspectives can and will see things differently and come into conflict, I finally undertake to suggest certain opportunities and obligations of the Christian community in such confrontations.

The Christian community started and continues with the affirmation that God raised the crucified Jesus from the dead. That affirmation was and continues to be not only about an event but about the

purpose of God disclosed in the event as well. And it was and continues to be formally not merely a proposition, but a self-involving utterance equivalent to the acknowledgment that Jesus is Lord.

The affirmation of the resurrection was and continues to be an affirmation of God's cause and purpose. The resurrection is an eschatological event, disclosing the final triumph of God's cause and purpose, but the cause and purpose are protological, present already and always in creation and providence. To call it an eschatological event is to admit that it points ahead to what cannot be seen and to what is not yet fully experienced. The resurrection, after all, is not like the resuscitation of the "clinically dead" or even the revivification of Lazarus. Such are "raised" to die again, but the resurrection of Jesus is an event in our flesh, our world, and our history which transcends the enclosures of our mortality and evil, which establishes something new, but something from which our flesh, our world, and our history have (happily) no escape. It is something new, but the cause and purpose whose final triumph it discloses and establishes is as old as light. To call that cause and purpose protological is to claim that it was the cause and purpose of God from the very beginning, that it is knowable in creation and providence, in revelation and in the Jesus Whom He raised. The resurrection is the disclosure and guarantee of God's cosmic sovereignty over His own creation at the end of time. God intends the flourishing of His creation, its release from its "bondage to decay" (Rom. 8:21), and the final victory over death and evil. God the Creator intends life and its flourishing. In *spite* of death and evil, He raised Jesus to His right hand to accomplish His intention for His creation, and to affirm the resurrection is to affirm even now the cause and purpose of God.

This affirmation of the resurrection and of God's cause and purpose was first made and continues to be made in the midst of life under the sign of the cross, in the midst of the apparent power of sin and death. The truth about our world is dripping with blood; poverty and pain, disease and death — that's the truth about our world. And the resurrection of a crucified one neither blinds Christians to this reality nor makes liars of them. The creation does not yet flourish. People still die, and die sometimes horrible deaths.

In such a world, to affirm the resurrection and the cause of God disclosed in it was, and continues to be, not merely an objective proposition, but a self-involving commitment. If the crucified One is raised, then, as the early Church said, He is Lord, Lord of life and death, Lord of our living and of our dying. If He is Lord, then all of life must be reoriented with Christ at God's right hand; then perspectives must be affected, dispositions and intentions formed and informed by this eschatological event. To affirm the resurrection in a world like this one is to stand in *spite* of death and evil, to hope for and work for life and its flourishing, to align with and identify with

the Crucified One in the expectation of a resurrection like is, to refuse to allow evil to be the last word in our lives or in God's world.

This central affirmation of the Christian faith can and should reorient the perspective of every Christian,[29] including the per ective of both Christian physicians and Christian patients. To sh that belief in the resurrection is to share the willingness to brir every point-of-view under the critical and transforming power of C ist the Lord.

1. The Christian Physician

The physician who is a Christian will recognize life as a gi of God and as the intention of God. He will never intend death, bu on the contrary, will intend life and its flourishing. He will see hi nedical knowledge and technology as gifts of God to serve His caus nd His creatures; he will see his role as a calling. So far, the resurre n faith supports and sustains the physician's perspective. But he w realize that the victory over death is finally a divine victory and n escha-tological victory, not a human one, and surely not a technol cal one. So he will not deny the limits of his art or the truth about r world. His affirmation of the resurrection in a world like this one e bles and requires a critical reconstruction of the physician's persp ive, sus-taining but limiting the intention to preserve life, chal ging the "medicalization" of care by his respect for the integrity o mbodied persons, and truthfully acknowledging the limits of his . In this section, I hope to develop the suggestions contained in th last sen-tence.

The Christian physician will not deny the truth abou ur world. People die, and some die horribly. Moreover, sometime in a world like this one, to preserve life is not to serve God's cause o life *and* its flourishing. The medical service to God's cause of human flourishing is the service to health, and, in a world like this one, is sometimes minimally the restoration or preservation of the capacity for human relationships and/or the relief of pain. To affirm the resurrection is to intend life *and* its flourishing. The Christian physician will not intend death, will not practice hospitality toward it, but when resisting it holds no promise of either the restoration of a capacity for human relationships or the relief of pain, he may allow it its apparent victory, confident of God's final triumph.

The Christian physician will not deny, either, the limits of his art. The victory over death is not, finally, a technological victory. The limits of the art are not only our indefeasible mortality which, after all, is simply the truth about our world again, but the limits of "medicalization" for proper care of patients and, especially, of dying patients. Stanley Hauerwas calls medicine "a tragic profession" because it reflects the limits of our existence,[30] and not just in our

mortality but "in the conflicting claims upon us, in our necessary faithfulness to parochial but nevertheless overriding obligations, in our self-made disasters and errors, and often in our helplessness."[31] It is not Hauerwas's claim that medicine is more tragic than other aspects of our lives, but that its practice essentially manifests and embodies the tragic nature of our existence. Yet medicine has sometimes denied the truth to dying patients and even to itself, when it has denied that some are "overmastered by their diseases." It was not always so, as we have seen. But since Bacon, the alliance with science and technology and the great successes of modern medicine, the limits of the art have been hidden and the proper sense of the tragic diminished. Without the acknowledgment of the limits of the art and without the appropriate sense of the tragic, the profession is tempted to resist death even when treatment holds no promise of either the possibility of human relationships or the relief of pain. It is tempted to the presumption that the victory over death and evil is a technological victory rather than an eschatological one. Without the acknowledgment of the limits of the art and without the appropriate sense of the tragic, of the "not yet" character of our existence, the profession's capacity and responsibility to care even when it cannot cure may not be sustainable.

The problem is compounded and exacerbated because of the limits of "medicalization" for proper care of patients. With science as ally, treatment has shifted from patients to pathologies, from persons to problems. This shift itself participates in the tragic character of medicine as a profession, at least if it is true that error in medicine is not just the result of scientific ignorance or technological ineptitude, but sometimes the result of the necessary fallibility of attempts to understand particulars — and especially persons with a history — as the sum-total of the physical and chemical mechanisms which operate on them.

However that may be, the Christian physician, by his affirmation of the resurrection of the body, can be and ought to be reminded that the body is not just related to nature, is not just the sum-total of the physical and chemical mechanisms which operate on it, but is intimately related to one's own identity, and that it is by and in the body that we relate to other persons and to God. "I believe in . . . the resurrection of the body" can reorient the physician's perspective toward the body. At least that central affirmation of the Christian faith can illumine parts of the situation of the patient which remain in the shadows when the focus is on pathologies or medical problems. The integrity, the wholeness, or — to use a word (formerly) important in Roman Catholic medical ethics — the "totality" of the patient may not be overlooked or ignored if we believe the body not just to be a machine or a mortal coil to be left behind by some immortal spirit, but essentially part of our identity, and not just as individuals,

but as related to others. The affirmation of the resurrection the body thus grounds and nurtures a concern for and a respect the integrity of patients. Then physicians will hesitate to refer to p ents as "the cardiac arrest in room 512" or "the cancer in room 03." They will happily honor the human want and need to be identi d, to be named, to be an individual rather than a case. More importa y for our purpose, then, decisions concerning the treatment of p ents, including especially the treatment of dying patients, may not alto-gether "medical" decisions. They must be decisions concerned and respectful toward the patient's integrity, his identity, his rela n to others and to God, and toward the "embodiment" of that total .

Such decisions, of course, can only be made in honest conv ation with the patient, if competent, or with friends, family, clerg f the patient is incompetent. In conversation, the physician will disc r the patient's identity and learn what respect for the patient's i egrity may mean. The physician does not participate in this conv sation merely as a servant of the patient's integrity,[33] but as the se nt of Christ the Lord in his special role or vocation of physician. H will be an advocate for life, and if it is a matter of choosing ways of c ng, he will be an advocate neither of denying death nor of practicin hospitality toward death, but, rather, of living the last days in way which embody confidence in God's final triumph in *spite* of death nd suffering. He will reserve the right to disagree with the patient's ecision and to attempt to dissuade him of it.

The "medicalization" of care can be a species of tech ological pride, of the presumption that all problems are, at bottom, technological problems and that technology, given time, will solve them. It is a position which lacks the eschatological realism and the human realism of the community which acknowledges the resurrection in a world where death and evil still apparently reign. That realism insists that human flourishing is threatened most of all by ills which have no technological solution, and indeed, sometimes, this side of the eschaton, no solution at all. This is not a call for a casual anti-technological spirit. It will hardly do to rest content with objections to technology as "playing God." Dominion in this world is given to humanity as a mandate and as a blessing. The question is not whether or not we will play God, but whether or not we will exercise our God-given powers responsibly. Christians can commit the sin of sloth as well as the sin of pride with technology. But the "medicalization" of care tempts contemporary physicians to pride more often than to sloth, and my point is that the affirmation of the resurrection reorients the Christian physician's perspective also to technology and enables and requires him to repent of technological pride. For all its promises and all its accomplishments, technology has yet to deliver us, and will not deliver us, from our finitude or to our flourishing. We may not deny technology, but neither may we deify it. It is not "our faithful savior." It

does not "keep covenant." It is God Who brings a new heaven and a new earth, not technology. The victory over disease and death remains a divine victory, not a technological one. Then it may be possible to lower expectations and demands also of medical technology, once again to admit that sometimes — however sadly or tragically — one is overmastered by this disease, to respond in other than technological ways to these threats to human flourishing, and indeed to limit the careless meddling of technologists in a patient's living of his final days. The technological imperative that "if we can, we must" is a technologic which has no standing in human logic or in the rules of Christian discourse.

The Christian physician will deny neither the truth about our world nor the limits of his art, but neither will he deny the resurrection or withstand the intention of God disclosed in it. He will intend life and its flourishing for his patients, and will not deny death, nor simply accept it, but will resist it up to the limits suggested above. In view of the relation of life to human flourishing in God's intention, the physician may allow death its apparent triumph when resisting it holds neither promise of the restoration of a capacity for human relationships nor hope for the relief of pain. In view of the "embodiment" of the person, he may allow choices concerning ways of living while dying which cohere with and serve a person's integrity. He is neither the servant of technology nor the servant of the patient; he is the servant of a risen Christ.

2. The Christian Patient

The patient who is a Christian will also recognize life as a gift of God and as the intention of God disclosed in the resurrection. And he, too, will acknowledge the sad realities of our world this side of God's final triumph and live in it under the sign of the cross. But for him, too, to say "God raised Jesus from the dead" is to say "This Jesus is Lord" and, to quote from the *Heidelberg Catechism*, "My only comfort . . . in life and death is that I am not my own but belong to the faithful Savior." The affirmation that God raised Jesus from the dead should reorient the so-called patient-perspective, too.

The Christian patient may be content neither with the assertion of patient autonomy which some are recommending nor with the passivity of the sick-role. One who acknowledges Jesus (or anyone) as Lord can hardly claim to be autonomous, at least in the sense of being "a law to oneself." The Christian's comfort is that he is *not* his own. The arbitrary freedom to will one thing one moment and another the next is not what the Christian claims for himself. The freedom to resist God's gifts and intentions is not something the Christian would claim for himself. The freedom to serve Christ, the freedom of being under

His reign is the freedom Christians claim, but it is simply not to be identified with a neutral autonomy or liberty. To be free under His reign is to be obliged, to be responsible to Him for our conduct and character even as (or especially as) evil and death assert their powers against his intentions.

Precisely because the Christian is obliged — and, perhaps, especially obliged — in the midst of suffering and death, he cannot accept the passivity which is his virtual identity as a *patient* according to the sick role. He will reject — if he can — the reduction of his person to "patient," to "sufferer," to passive recipient of treatment. He will and must, given his affirmation of the resurrection, bring a disposition to choose life and health to the relationship with his doctor, and must be an active participant in his own care. What he may assert, however, as we have said, is not his autonomy, but his integrity, his identity, his "right," founded not in some neutral autonomy but in the freedom and obligation of Christ's Lordship to "strut his stuff" to the end and at the end, to use Joe Sandwich's phrase. He may seize his own dying as an exceptional opportunity to give his Christian integrity definitive and final form.

His obligation is rather to help, to care, to restore, to reconcile, to overcome evil with good, to "glorify God in your body" (I Cor. 6:20). The law of his being is faith and love. Of course, he is not to welcome death, not to practice hospitality toward it. Christ Himself ought to have the cup removed, but God's cause and His own integrity nevertheless brought Him to it. It is life that is to be celebrated and toasted, not death. And the slogans which express — and shape — the dispositions to death will not be "natural death" or "death with dignity" or "a right to die," curious slogans all for a faith which looks for a kingdom in which "death shall be no more" (Rev. 21:4), which sees death as an indignity,[34] and which chooses life and human flourishing. The slogans which express the Christian patient's perspective are rather to be like Donne's "Death, be not proud" and Paul's "Death is swallowed up in victory" (I Cor. 15:54).

These slogans do not deny death, and surely do not deny the Christian's own death. They do not merely accept death, not even the Christian's own death, but surely not the sad and horrible deaths of the hungry, the innocent, the despised. They call Christians, in life and in death, to serve God's cause, to resist and subvert the reign of death and evil. The martyrs knew it well: their own survival counted less than God's cause, their integrity, and their neighbor's — indeed their enemy's — welfare. Their "comfort" was that they were not their own, but belonged in life and death to their faithful savior, and their comfort was their courage.

In more mundane and commonplace ways, the same courage and integrity, the same self-forgetfulness in concern for the neighbor, can and should mark the character and conduct of the Christian patient.

Our comfort remains our courage to live our lives and die our deaths with Christian integrity. If it merely makes us "comfortable" like an air-conditioned sanctuary or hospital room makes us "comfortable," then it is not the comfort, the *cum-fortis*, the enabling and strengthening, of submission to Christ's kingdom. The Christian's comfort calls him to live his life, even the dying of it, in ways that serve God and help the victims of this sad world's evil, especially those to be grieved or conscience-stricken by his death.

The Christian patient, then, may refuse scarce medical treatment so that another might live. He may refuse that medical treatment which bears no promise of enabling him to be anything besides a continual burden and drain on his family or on its (and society's) resources. He may refuse treatments which render his final minutes or days or years less promising to the tasks of reconciliation and forgiveness and joy with family, friends, and enemies. He may choose treatments which mitigate suffering and pain, even while they risk death. Because Jesus has been raised, he may never simply choose death; but because the One Who was raised walked among us caring and helping, teaching and demonstrating the love of God and neighbor, and was crucified, the Christian patient may weigh other goods against the good of his own survival and may discern that he has duties which override the good of survival, duties which should determine how he lives, also while he is dying. So his life and his dying may be like that of a martyr, "bearing witness" (gk. *martyreo*) to the truth.

3. The Christian Community

Such duties or such an identity may not be *imposed* on patients, even on Christian patients, surely not by physicians, especially physicians who would learn from one patient to help another. Indeed, patient decisions like these should not be quickly supported or even honored by other interested parties, including physician and family. The physician, we have said, must respect the integrity of the patient, but he does not become a servant of the patient; he remains the servant of the risen Christ. The Christian physician will sometimes disagree with the decision of the Christian patient, may attempt to dissuade him, and refuse to be a party to it. It is, I think, another mark of the "not yet" character of our existence that goods, real goods, come into conflict, real conflict. Some conflicts are inevitable because of the plurality of goods involved in the human flourishing God intends. Our problem is less that we are ignorant of God's intentions and more that part of what we know to be God's intention conflicts in this sad world with other goods we know to be part of God's intention.

I do not claim the moral competence to resolve such dilemmas; they are, after all, real conflicts of real goods. It is here — if not

before — that procedural solutions are typically applied. the absence of certainty about the right decision, the argument g s, let the doctor make it or let the patient make it. There may finall e no way to avoid such a procedural solution, and if it comes to t as a last resort, then the patient's decision is "trump."[35] In such situation of last resort, the best we can do is the assertion of rights d the calculation of fair conditions for overriding a patient's dec n, as Childress supplies. Only let us not deny that such a solution i tragic one, one marked by the "not yet" character of our existence.

Neither the Christian physician nor the Christian patien hould rush to such a confrontation of power or "rights" as that in w ch one ends up powerful and the other powerless. The check on su a rush to confrontation is the axiom of the kingdom which turn onventional judgments concerning power around: "the last shall b st, and the first last" (Mk. 10:31 and par.; Mk. 9:35,36; Matt. 2 6; Lk. 13:30), and also "the exalted shall be humbled, and t humble exalted" (Matt. 23:12; Lk. 14:11, 18:14). Such axioms, t side of the escaton, take the shape of imperatives.[36] Such axioms oreover, are given concrete and normative expression in the curious wer of a cross. To affirm the resurrection of the one who taught th and died thus is to be disposed, I think, not to exercise power or to ert one's rights in order to render the other powerless in the confro tion, but to reason together, to talk and pray together, and to ask eir Christian communities for advice and discernment.

I am not suggesting that clergy be asked to provide *res nses* or to articulate canon law. I am rather suggesting the impor ce of the Christian community as a community of moral discour nd moral discernment for Christians. It is there the Christian mora radition is borne; it is there the story is told; it is there, "where two or three are gathered in (His) name," that the risen Christ is "in the midst of them" (Mt. 18:20). These decisions ought not to be for Christian patients purely private decisions or for Christian physicians purely professional decisions. They ought to be made with Christian integrity, that is, within the context of the Christian community's common faith and common life.

The Christian community may never abandon care for the sick and dying to the medical profession nor may it abandon the physician to science. It is gifted and called to support both the art of dying and the art of medicine. The Church may honor the role both of the dying and of the physician, and call them to the shape of Christian integrity. The duty to visit the sick is not merely quaint and must not be permitted to become banal. There is also a duty, I think, to provide support groups, at least informally, for physicians. Such practices are good in their own right, but my interest now is that they are instrumentally good, both to make the Christian community available for conversations about such dilemmas and to make the Christian community

more skilled and sensitive as a community of moral discourse and discernment concerning such issues.

The Christian community will support the physician and admonish him to critically reconstruct his perspective, to acknowledge the truth about our world and the limits of its art, and to respect the integrity of the patient. The Christian community will also support the patient and admonish him to critically reconstruct his perspective, to be neither a law to himself nor passive, but to be true to his identity and a grateful steward of God's gifts. The Christian community will support not only physician and patient, but their relationship. Because of the Church's understanding of power from the perspective of standing with the crucified One Who was raised, the Church will resist both the model of philanthropy and the model of contract to construe and support their relationship. The model of philanthropy places all power in the hands of the physician and makes the patient the passive recipient of the good the doctor dispenses. The model of contract places all power in the hands of the patient and renders the physician the hired hand, the animated tool, of the patient. Instead of either philanthropy or contract, the Church will understand and support their relationshp as a special covenant bond. Covenant, of course, binds people together precisely because they are together bound to God, the Covenant-Maker and Covenant-Keeper. The special bond established between physician and patient may not, within the Christian community, be abstracted from the responsiveness of both to God or from the story of God's gifts and intentions, which is to say, in the new covenant from the story of God raising Jesus Who both healed and suffered.[37] Such a model will not enable physician and patient always to agree, but it may enable them always to talk, always to respect, and even to instruct one another concerning Christian integrity in their respective and different roles. It may enable them to avoid the sometimes tragic consequences of hastening to the last resort. It may protect medical care from arbitrary dominance and patient courage from foolish autonomy.

Of course, if the Christian community is to support and sustain such medical care and patient courage, it is terribly important that the Church gets its story straight. There has been and is plenty of death-denial and even hospitality toward death in our theology and in our funerals and in our practice. Moreover, we cannot expect to think with Christian integrity on one issue if we do not get our story straight on many issues, including the reign of death by hunger and violence. I am led, thus, to repeat the caveats with which this section began. First, I am not so presumptuous as to think moral discernment of these issues is a task for which I or any other single person is competent. It is a communal task, the task of a community which lives in integrity out of and toward the resurrection. Second, the Christian community should not be so presumptuous as to think we are morally

better than non-Christians, but we are given a peculiar iden y to which we may and must be truthful. Let it be said in closing t t the first and final responsibility of the Church is to tell the story ut of which and toward which she lives and to invite people to sha their conduct, their character, their living and their dying, to its n tive, to make the story their story.

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