

The Linacre Quarterly

Volume 53 | Number 2

Article 9

May 1986

Recovering the Feminine for a Christian Ethic in Medicine

Mary L. Lussier

Follow this and additional works at: <http://epublications.marquette.edu/lnq>

Recommended Citation

Lussier, Mary L. (1986) "Recovering the Feminine for a Christian Ethic in Medicine," *The Linacre Quarterly*: Vol. 53 : No. 2 , Article 9.
Available at: <http://epublications.marquette.edu/lnq/vol53/iss2/9>

Recovering the Feminine for a Christian Ethic in Medicine

Mary L. Lussier, M.D.

Doctor Lussier, a neurologist, is studying in the Interfaculty Program in Medical Ethics at Harvard University and is working as a neurologist on a part-time basis at the Boston Evening Medical Center. She received her medical degree from Northwestern in 1981.

The theme for development in this paper is that there are two philosophical approaches to teaching and practicing medicine, each of which emphasizes apparently opposing, yet ultimately complementary priorities. As Jonsen describes it, the field of medicine is dominated by the paradox of the two most basic principles of morality — self-interest and altruism.¹ As Carol Gilligan explains, the former is more promoted in a male ethic, and the latter in the female ethical system.² The exposition here will be reflective and somewhat personal in that I will begin with a brief summary of the conflicts I perceived and struggled with during my residency. Then I will give a synopsis of Gilligan's thesis regarding male and female moral development and integrate this with the experience of residency and with philosophy of medicine in general. Through this, I hope to show that there is room, and in fact a need, for both approaches integrated in medicine. Then I will conclude with examples of ways in which female ethics in particular, and Christian ethics in general, can be applied fruitfully in medicine.

To begin with my residency period, it would be fair to describe it as both "the best of times and the worst of times," in that a great deal of personal growth took place, but not without the expense of pain and confusion. In retrospect, I am better able to characterize the conflicts which arose. Basically, I had been aware of my value system being in conflict with that of the medical field in general and my supervisors in particular. Their criticisms of me were essentially behavioral, in that they emphasized that I should be more "aggressive" (to use their term), autonomous, self-assured and authoritarian. From their standpoint I had some deficiencies in these areas, which over time I was better able to fill. Personally, however, these were not areas that I felt were problematic. From my perspective, my greatest self-criticism was that I was deficient in empathy and compassion. This view was not shared by my supervisors, who felt that at times I had too much concern for the patients. Thus we looked at the same behavior but arrived at opposite views of deficiencies, because we had opposite goals.

On the broader scale, I could see this conflict in value systems by noting which people and what types of behavior were being reinforced in the medical training system. I saw people being rewarded with prestigious fellowships — people whom I felt lacked responsibility for patients and yet put great effort into academic pursuits. I was vaguely aware of a gender-related aspect to my negative evaluations, in that I noted a predominance of this type of assessment of other women residents. I also noted that women were given approval and assumed to be particularly competent solely on the basis of authoritarian behavior, when nothing else was known about their clinical abilities. Thus this was a time of great personal confusion, since the views I held as a female, and which were developing further in my continuing Christian conversion, were being devalued. While I increasingly felt called to diminish myself and to put others forward, I was being told in the workplace that I should advance myself.

Conflict in Basic Approaches

It has now become clear to me that what was actually occurring was a conflict in the two basic approaches to moral questions, which, as Gilligan explains in her book *In a Different Voice*,³ are each used differently in male and female moral development. In essence, progression in males is seen as moving toward greater autonomy and independence with emphasis on intrapersonal qualities such as intelligence, skill and achievement. Women, however, base their choices on relationships, caring and interdependence. Since men have created the scales by which moral development has been measured, they have emphasized those ideals held by them, and thus women have been found to be lacking. In the same manner, my supervisors felt that behaviorally I had some deficiencies. My different approach to medicine is amplified even further, I believe, by my Christian commitment, which promotes the ideals of humility, inter-

dependence, caring and diminishing of self. Through the process of being challenged to view the world differently, I came to appreciate and assimilate some of the archetypal male approach. In particular I came to define myself more on my own terms, and was less prone to evaluating myself on the fluctuating opinions of others, i.e., I became more autonomous and less subject to approval or disapproval of others. As described in Gilligan, this type of change is seen as maturity in decision-making in females, in that they come to see that caring as an ethic can also be extended to themselves, and in that sense becomes more male-like. On the other hand, maturity in the male is seen as becoming more female-like in that the male comes to see the importance of relationships and interdependence. He expands his view to see that in caring for others, he is also caring for himself, since we are, in fact, in community with each other.⁴ These differing characteristics in males and females are, of course, not exclusive to either sex, but rather this is a description of what predominates in each group in society at present.

Thus, in medicine, I see a profession which has been dominated by men and which therefore emphasizes traditionally male values as its goals, and measures performance by that standard. I also believe that maturity comes from an integration of the male and female perspectives, which women who entered medicine have been doing. As I said above, many of the changes I made were growth-promoting, and indeed, being autonomous and decisive and apart from patients is necessary at times in order to reach objective conclusions and to perform certain procedures. We, as females, have been learning some helpful male perspectives, but now for medicine as a field to become more balanced and full, the time has come for it to inculcate more of the female priorities of care and compassion, both within its training functions and its dealing with patients. Just as women in medicine have had to learn that they need not be self-effacing and dependent totally on others for their worth, so also do our male counterparts in medicine need to learn the other side of maturation in that they are not merely autonomous performers of technical skill and knowledge, exercising their expertise on the road to personal achievement. Because teachers in residency training are academicians, there is a greater tendency for them to be people whose value systems favor competition, individual performance and success, since these are the attributes rewarded in this academic system. Since these are the people who "teach" the students, these values are further emphasized and they have perpetuated themselves. The female presence in numbers alone will result in more of a tipping of the scale toward the other ethic, but here I am making a call for a greater awareness of and receptivity to this other perspective for it to be recognized, taught and lived.

Having described these two basic ethical approaches and their expression in my residency experience, I now wish to be more explicit in exploring the implications and modes of application of this ethical system which is more feminine and more broadly Christian in its approach.

Although the present system encourages independence, authority and presumption of inerrancy, a great deal can be gained by cooperation and relatedness, and acknowledgment of our common fallible humanity. I first will deal with how our conceptions of self-identity and self-worth can be seen in this “new” context. Then I will move to how this view of the self involves realizing its finitude and creatureliness. From this realization, a state of acceptance can be attained. I will then develop themes of acceptance in spiritual and psychological frameworks. From this foundation of acceptance, then springs the potential to reach outward in empathy and compassion to others.

Determine Primary Relationship

In initially dealing with our self-conceptions, we must determine what our primary relationship is, since in our “new” system, relationship rather than individuality is key. The responses to this question will vary of course, and here I will speak from my personal Christian perspective.

Traditionally, we as physicians have been basing our worth on prestigious positions, salaries, public recognition or perhaps expressed gratitude of patients. With this outlook, we are mainly being served, rather than serving others. If we base our self-worth on these temporalities, we are sure to fail. These are artificial supports and by their very nature they are transitory and do not reflect our true relationship to God and the world. Our true nature is in our connectedness, in a oneness with one another through Christ, and our relationships to patients and others are based on this. Our essence is that we are creatures of God, and our worth stems from that love relationship with us. This is the only thing that is constant and the only thing worth basing one’s life upon. Only out of this relationship can we be fed, so that we, in turn, can be a source for others. We have to come to accept ourselves as God accepts us — totally imperfect creatures, yet ones to whom He freely gives His all encompassing love. It is not our grades or prestigious appointments or our abilities to memorize biochemical pathways which bring us closer to God. He does not judge us on our academic performance, but rather on our love, which comes to fruition through our relationship with Him, love’s source and essence.

I am not advocating that we not study or not vigorously pursue our careers. These efforts will naturally result from our desire to help others, because acquiring those skills is a pre-requisite to further service. However, I am saying that we should approach these activities as means and not ends. We cannot afford to miss the forest of service for the trees of personal accomplishment. We also must realize that the expertise we acquire and our ability to acquire it are really gifts from God. They are quite contingent, and could easily be lost or could easily never have been bestowed upon us. We need to know that these are not ours to claim.

Realization of Powerlessness, Fallibility

It is clear that this self-definition necessitates a realization of finitude, powerlessness and fallibility, i.e., elements of creatureliness. Despite these

imperfections and at times because of them, (for as God said, "My power is made perfect in weakness" — 2 Cor. 12), God can work through us. A healthy acceptance of imperfection frees us from the burden of constantly needing to meet an impossible standard. It also then frees us to do the work we intend. For example, we can all cite cases where the doctor pridefully sticks to his/her diagnosis despite developing evidence to the contrary, out of the inability to admit an error. Of course this leads to the detriment of the patient's care. Again we see that our preoccupation with and valuing of the means (i.e., the expertise and clinical acumen) work to the detriment of the end (i.e., the care of patients). Ideals are acceptable and, in fact, laudable, but we have to realize that they are not fully attainable.

Having once recognized our finitude, we then must strive to come to a state of acceptance in these areas where it is true. Particularly difficult areas for us to accept as physicians are those where we are powerless in the face of chronic pain and death. At these times we resist accepting our own impotence and that of the patient in warding off the suffering. We would prefer to deny and fight, than accept. We resist telling a patient that nothing else can be done, and thus we give a futile "treatment" or avoid the patient altogether. At these times, we as physicians (and also as patients) have to come to acceptance of realities in order to deal effectively with situations. We have to deal with our own mortality, so that we can allow others to accept theirs. We become so production-oriented — in that we want tangible results from our work, in that we search for a diagnosis, and treat toward a cure — that if we are not doing these things, we feel we are failures. We sense that if we are not active, then we are not doing or producing anything. What we fail to appreciate is that in another plane of experience, our "just being" with a patient is very productive. We tend to think that if we have not given the patient an answer, for example, to his question of "Why me?" and "Why now?", that we have not helped him. Sometimes, though, people just want us to listen to the question with them. The meaning and value of this kind of exchange is less tangible to us. Yet its lack of quantification does not diminish its helpfulness. We may often be accomplishing great good for a patient without being aware of it, and we should come to accept that at such times our more readily perceived earthly "productivity" will be "down."

Another area which needs acceptance are those personal qualities in ourselves which we find undesirable, i.e., our "shadow sides." As we acknowledge these areas in our make-up, we will become more free — for ourselves and for our patients. For example there is a part of me which does not care about the patient, which cares more that I get home at a reasonable time. There is a part of me which only wants to see patients who can be cured, because otherwise I feel I have failed. There is a part of me which does not want to deal with dying people because I fear the aloneness and lack of control they are experiencing. We have to make peace with ourselves by admitting we are not total altruists, that we are not without needs, insecurities or limitations, that we are not always willing to be compassionate, and to make peace with the fact that we, like our patients, will, in fact, become sick and die. We can come to accept and approve of

our true status as wounded healers, which is what we are.⁵ We have had many opportunities to face these facts about ourselves, and in particular the residency period is a fertile time to realize our relatedness to humanity and to the wounded and suffering in particular. Although, as a resident, he or she is enmeshed in a system which views him or her as self-sufficient, as an island, as one who can survive without time for nurturing relationships, we can realize, by that very experience, that such is not the case. If we admit the truth we can become even painfully aware of our need for interdependence and support. We might then see that neither is the patient an island — that he is more than his disease.

As a Christian, acceptance is fundamental in one's relationship to God, especially at the time of death where it is paramount. Life is, in a sense, a preparation to die, wherein we ultimately accept that we do not control our lives and our destinies. At death and through our daily dyings, we either assent in faith to God, or cling to our autonomy and protest our helplessness.⁶ We, as Christians, need to depart from our false assumptions of autonomy, particularly as they are promoted in the medical field, and of our illusions of power and success. As we do this, we will not only prepare for our own death, but we will be better able to minister to our patients who are only too aware now of their loss of autonomy, made more acute by their illness. We need to face our own powerlessness so that we can truly *be* with our patients when they need us, rather than running from their reminder to us of our finitude.

Realizing our limitations is not something encouraged in medical school and residency programs, probably due to the more male-like emphasis on achievement. In some ways, it would seem obvious through our experience in training, that we as doctors are limited, make mistakes, and that people do die despite our efforts, and, at times, even because of them. I say it is obvious and yet it is denied, since it does not fit our model of our self-image and our perceived role. It is here in this recognition of fallibility and impotence that our feminine and Christian viewpoints of interdependence of people and of shared humanity in community will help us to enter more easily into this common ground of powerlessness, finitude and woundedness with our patients with a greater capability for compassion. Through this acceptance will come our freedom — to *be* ourselves, and to *be with* our patients. We can see this as our common human condition, and thus be less judgmental and more empathic of others.

Having moved through our issues of self-definition, of realization of creatureliness, and of acceptance, we can now move to the implications for compassion, which is a focal goal in the Christian and caring ethic. The word compassion comes from the Latin meaning "to suffer with," and seen in this way, involves one fully in the condition of being human.⁷ It allows us to put ourselves in the situation of the other and to be there with him or her, to the extent that we are able. The opportunities for this are ample in medicine, yet we are so preoccupied with ourselves that we fail to consider the other person. Our priorities are elsewhere. When we speak to a patient

in the hospital, do we sit down, in order to show that we are giving him or her our attention? Do we knock before entering, to show that we respect his or her privacy? Do we allow him or her to speak freely or do we barrage the patient with our pre-set list of questions? Do we consider how illness affects one's self-image, family, workplace? The ways in which we can improve on these things are endless. The way which deserves the most attention, I think, is the way we listen to patients, and to people in general. The best gift one can give a person is the attention of one's mind and heart. We need to put aside ourselves, our plans and concerns, so that we can give our entire self in concentration to the other. To the extent that that is possible, you can then be with, suffer with, be compassionate to another. It involves realizing that my experience in life encompasses the same range of possibilities as this person is now experiencing. I may not have had it yet and I may never have it, but as a fellow human being, I am capable of experiencing it. Experiencing this connectedness is not, as might be perceived in the male ethic, a loss of identity or autonomy. It is not being "chameleon-like" in that you change yourself, depending on whom you are with. Rather it is entering that common shared space of humanity. This willingness to be with another, along with our recognition of our shadow sides, allows us to be less judgmental and apart. We can see that under other circumstances we too could become addicted to a substance and thus damage our bodies and our lives. We can see that we too could lose our intellectual capacities and be left alone in a nursing home. Thus compassion involves an openness to the totality of human experience and realizing its potential manifestation in us. This empathetic listening allows us to make connection with others in a way which reflects our self-definition as fellow creatures of a loving God.

This outlook is not easily nor fully attained and it will require a lifetime of practice, but it is worth the attempt. The first step is even to set this as a goal. Presently in the medical system, this emphasis on connectedness, creatureliness and compassion is not recognized to the extent that it should be. In order for there to be a greater maturity and depth to the practice and teaching of medicine, there needs to be a greater integration of this caring ethic into the predominant ethic of self-promotion. As these ideals become more interwoven with those already present in the system, they will lead to a fuller breadth of expression and a greater realization of the mature potential of our profession and our lives.

REFERENCES

1. Jonsen, Albert R., "Watching the Doctor," *New England Journal of Medicine* 308 (25), 1983; p. 1532.
2. Gilligan, Carol, *In a Different Voice* (Cambridge: Harvard University Press, 1982).
3. *Ibid.*
4. For one of many authors developing the theme of human community, see James Luther Adams, "The Love of God," *On Being Human Religiously* (Boston: Beacon Press, 1976) pp. 91-101.
5. Nouwen, Henri J. M., *The Wounded Healer* (Garden City: Doubleday, 1979).

6. Rahner, Karl, "On Christian Dying," *Further Theology of the Spiritual Life I*, VII of *Theological Investigations* (London: Darton, Longman & Todd; New York; Herder & Herder, 1971) pp. 285-93.

7. McNeil, Donald P., Douglas A. Morrison, and Henri J. M. Nouwen, *Compassion: A Reflection on the Christian Life* (Garden City: Doubleday, 1983) p. 4.



This publication is available in microform.

University Microfilms
International reproduces this
publication in microform:
microfiche and 16mm or
35mm film. For information
about this publication or any
of the more than 13,000 titles
we offer, complete and mail the coupon to: University
Microfilms International, 300 N. Zeeb Road, Ann Arbor,
MI 48106. Call us toll-free for an immediate response:
800-521-3044. Or call collect in Michigan, Alaska and
Hawaii: 313-761-4700.

Please send information about these titles:

Name _____

Company/Institution _____

Address _____

City _____

State _____ Zip _____

Phone (_____) _____

**University
Microfilms
International**