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Might Only Theology Save Medicine? Some Ideas from Ramsey

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Abstract

In *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying*, Jeffrey Bishop argues that contemporary medicine has (among other things) reduced the patient from a 'subject' to an 'object'. He extends this charge to all corners of contemporary medicine. But in his book's concluding chapter, 'Anticipating Life', he turns toward a constructive proposal, asking, in closing, '[m]ight it not be that only theology can save medicine?' Toward answering Bishop's query, I turn to the thought of Paul Ramsey. Ramsey is helpful because, in thinking through and responding to contemporary moral dilemmas, he begins with his theological commitments and thereby may avoid the reductive tendencies that Bishop argues affect contemporary medicine. Specifically, Ramsey's account of the 'patient as person', I will argue, delimits what the medical endeavor may do and might offer resources to help save medicine.

Keywords

Bishop, consent, end-of-life care, medical ethics, physician-patient interaction, Ramsey

Today, when diverse people draw the same warm blanket of ‘allowing to die’ or ‘death with dignity’ close up around their shoulders against the dread of that cold night, their various feet are showing. Exposed beneath our growing agreement to that ‘philosophy of death and dying’ may be significantly different ‘philosophies of life’; and in the present age that agreement may reveal that these interpretations of human life are increasingly mundane, naturalistic, anti-humanistic when measured against any genuinely ‘humanistic’ esteem for the individual human being.

These ‘philosophical’ ingredients of any view of death and dying I want to make prominent by speaking of ‘The Indignity of “Death with Dignity”’. Whatever practical agreement there may be, or ‘guidelines’ proposed to govern contemporary choice or practice, these are bound to be dehumanizing unless at the same time we bring to bear great summit points and sources of insight in mankind’s understanding of mankind (be it Christian or other religious humanism, or religiously-dependent but not explicitly religious humanism, or, if it is possible, a true humanism that is neither systematically nor historically dependent on any religious outlook).

— Paul Ramsey, ‘The Indignity of “Death with Dignity”’[1]

Introduction

Jeffrey Bishop dedicates much of his book, *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying*,[2] to criticizing contemporary medicine. For him, contemporary medicine has (among other things) reduced the patient from a ‘subject’ to an ‘object’. ‘[M]edicine, insofar as it seeks to be scientific’, he writes, ‘studies animal function by stopping it. The function of the body-machine is lifted out of the messiness of human purpose and meaning; meaning and purpose become part of the cultural attribution placed on the mechanism. Meaning and purpose are post ad hoc additions to the mechanism’ (91). Bishop extends this charge to all corners of contemporary medicine, including experimentation, organ transplantation, palliative care and end-of-life decision-making. But in his book’s concluding chapter, ‘Anticipating Life’, Bishop gestures toward a constructive proposal, one that addresses and then offers an alternative to the reductive tendencies that affect contemporary medicine. Most physicians possess, he writes, ‘a

desire to touch the lives of those suffering' (286–87). To develop a constructive proposal, then, '[w]e need to pause and to engage in the practice of thinking about the beginning of compassion, response, and responsibility. Medicine's hope might exist in desire for the other' (287). In the medical context what does 'desire for the other' entail? And what may inform such a desire? In order to respond to these queries, Bishop suggests drawing from the practices of religious communities. He writes:

> [i]t might be that we can learn once again from the places at the margins of contemporary life, at the margins created by liberalism and biopolitics. It might be that we can learn once again not from history—a static past—but from living traditions. It just might be that the practices of religious communities marginalized in modernity and laughed at as unscientific are the source of a humane medicine. Perhaps there, in living traditions informed by a different understanding of space and time, where location and story provide meaningful contexts to offer once again hospitality to the dying as both *cura coporis* and *cura animae*, we will find a unity of material, function, form, and purpose (313).

Thus, he asks in closing: '[m]ight it not be that only theology can save medicine?' (ibid.).[3]

To think about and develop a modest response to Bishop's query, I will turn to Paul Ramsey. I believe that Ramsey is helpful because, in thinking through and responding to contemporary moral dilemmas, he begins with his theological commitments.[4] Thus, Ramsey's views may help confront the reductive tendencies that Bishop holds affect contemporary medicine.[5] Specifically, Ramsey's account of the 'patient as person', I will argue, delimits what the contemporary medical endeavor may do and may offer resources to help save medicine. In the second section, I will appreciate Bishop's positive claims, reconstructing his arguments from the concluding chapter of his book. Then, in the third section, I will turn to Ramsey's *The Patient as Person* and 'The Indignity of "Death with Dignity"', where he brings Christian ethics to bear on contemporary medical ethics, especially the relationship between the physician and

patient.

Bishop's Critical and Constructive Views

Before turning to his constructive proposal, Bishop notes that his aim has predominantly been critical. He writes: '[m]y point up to now is that the social apparatus of medicine molds and shapes, indeed, subjects students to the normative stance of a biopolitical regime, in which the health of the body politic becomes the object of medicine's inquiry and its domain of management. Death becomes medicine's domain' (285). According to Bishop's narrative, Claude Bernard's nineteenth-century research on the dead body became the standard for how physicians attend to the living. Bishop notes that, for Bernard, the corpse is the 'epistemologically normative body' (23) alongside which the reductive tendencies that permeate contemporary medicine arose. But for Bishop, most physicians do not enter medicine in order to conquer death but rather from a desire to help those affected by illness. How might this picture—in which medicine is focused on the dead, and physicians on the living—be corrected?

For Bishop, the solution seems to turn on properly understanding one's body, and therefore on the ways in which physicians (and others involved) approach caring. On his view, contemporary medicine tends toward a reductive (and therefore problematic) either/or. On the one hand, there exists the tendency to see the body merely as tool that, when affected by illness, becomes broken and stands in need of repair. Thus, medical technologies are aimed at conquering illness and death, thereby doing violence to the individual person. Call this the 'Mechanical Thesis'. 'Biopsychosocialspiritual medicine', on the other hand, attempts to master death through psychology and social science—it 'measures all things and is the measure of all things' (228). While there may have been merits to this model, when it was rooted in Christian hospice care, it has now been reduced to effectiveness and efficiency, including the hospital chaplain who has 'taken on the values of the institutions of health care within the larger socio- politics of Western society' (246). Call this the 'Efficient Care Thesis'.

To avoid these reductive tendencies, Bishop argues, contemporary medicine needs to rethink how it conceptualizes the human body. For example, he writes: 'we do

not possess a body so much as we *are* bodies engaged in practical projects. All projects have histories—a given past set of experiences—which are instantiated in the present moment, moving toward some given *telos*. The body is literally molded and shaped by its experiences' (288). On his view, contemporary medicine focuses only on the generalizations necessary for scientific knowledge, thereby 'setting aside meaning and purpose' (290). In service of the Mechanical Thesis, contemporary medicine disregards that the human person is directed toward some end, seeing instead only a broken tool that stands in need of repair.

Because one's personal projects move from the embodied self to the world around one, he adds, 'the body is the given of projects and purposes, until it can no longer participate in these projects and purposes' (291). Moreover, it is when one's body loses the ability to do something that it becomes an object to oneself—that is, 'when the project and purposes are no longer possible' (ibid.). The effects of the body's inability to pursue some ends aren't solely mechanical. The inability to pursue some end instead causes distress to the individual person and also highlights that the projects one pursues are only possible because they are embodied. On Bishop's view, such distress does not seem to be delimited to the psychical but also affects one spatially and temporally. What are affected by illness, he writes, are not only one's sense of 'place and past, present and future' but also the particularity of one's own body, including the ways in which it is uniquely embodied (292). To emphasize the salience of embodiment, Bishop argues that contemporary medicine needs to move from static views about life and death to dynamic views about living and dying. He writes:

> for it is the body that is living and dying and, along with it, its history, capacities, potencies, projects, and purposes; these are being lost. In terms of the embodied living of a particular person, the body is indistinguishable from these features, and the person's projects only become distinguishable and separated from the body insofar as that body is failing or dying. Finally, a person's embodied projects are themselves ordered according to what has been given to him or her in embodied history (292).

Thinking about the body on these terms emphasizes that it is only through embodiment— that is, through the body itself—that one is able to pursue one's projects. To borrow from and amend a famous term,[6] one may call the body a 'basic good'—that is, a good without which one would not be able to pursue other goods. Following this definition, one may surmise that the body enjoys both fixity and priority in medicine. Without the body, one would not be able to pursue any goods; without a healthy body, the goods one is able to pursue are limited. To avoid reducing attentiveness to the body to the Mechanical Thesis, however, Bishop offers a cautionary note: 'when mere functional life becomes a priority, one is further alienated, not only from the body but also from the entire history and purpose of her embodied projects' (292).

In a lengthy passage, Bishop highlights the extent to which health and sickness affect how one perceives the gift that is healthy life. Moreover, in explicating this idea, he reiterates the need to think about embodiment in terms of living and dying rather than life and death. He explains:

> In health, then, we forget the embodied gift that health is. In disease and illness, we remember the gift that health was. In disease and illness, we hope for what health might be able to achieve in embodied life. Moreover, the health that is forgotten in health and remembered and hoped for in disease is particularly embodied, for health—wholeness—is always tied to particularly inhabited projects and purposes and ways of being-in-the-world. So, at one level, in disease one becomes disembodied, alienated from being embodied; or perhaps better, one becomes differently embodied, for even the distress of the perceived disembodied state—the alienation from the body and life—is embodied. One's purposes and projects are literally trapped in the diseased body. Embodied health, which had been gift, and as given is taken for granted and forgotten, comes most fully into relief when it is slipping way. Or rather, for most of us and much of the time, it is only made present when it is slipping away (293).

Living and dying, on his view, affect the individual person's embodied abilities. Therefore, even those persons one might call 'disabled' are in fact whole. Why? For him, the ways in which individual persons are embodied in the world are tethered to their embodied potency. In living and dying, someone who loses one or another capacity may shift his or her projects and purposes. In ability and disability, if someone never had a particular capacity, 'they do not experience loss at all. They will have known no other way of being embodied in the world than the way in which they are embodied in the world' (293).

Given its devotion to the Mechanical Thesis, Bishop writes, contemporary medicine 'can be experienced as cold' (294). Regardless of whether some medical procedure returns functionality to the patient, what contemporary medicine misses are the embodied features of that person: 'capacities, potencies, histories, projects, and purposes' (294). In sum, the Mechanical Thesis instantiates itself in contemporary medicine when physicians view the diseased or otherwise afflicted body as merely a broken tool, ignoring the embodied person who is affected. What this gives rise to, then, is a medicine that is concerned more with conquering death—that is, exercising sovereignty in matters of life and death—than treating the person and what, in living and dying, he or she is losing.

Bishop's arguments against the Mechanical Thesis are only part of his characterization and critique of contemporary medicine. He then turns his attention to the Efficient Care Thesis, which he explicates and then criticizes by discussing Eric Cassell's ideas.[7]

On the ways in which people suffer, Cassell develops a topology of personhood with which Bishop agrees. Bishop writes:

> Persons have pasts, they have lived experience as the origin of personal meaning, and they have families and cultural backgrounds. A person plays roles and has relationships with others. A person has a relationship with himself, and he is a political being. Persons do things and are often unaware of what happens and why it happens to them. They have behaviors, bodies, and secret lives. They have futures, and they

> have a transcendent dimension. Losses in any one of these 'parts' of personhood result in suffering (295).

In offering this description of personhood, Cassell aligns with Bishop's view about embodiment. But Bishop finds problematic the way in which Cassell calls on physicians and other caregivers to respond to the suffering. While rejecting mind/body dualism, Bishop notes, Cassell nonetheless endorses a view according to which 'the human sciences try to get at things that do not exist as material objects': 'they conceptualize, operationalize, test, and redefine in an epistemological circuit' (296). What Bishop charges Cassell with doing is calling on contemporary medicine to 'divide the suffering body from its "spiritual" or nonobjective parts … and further separate the social from the psychological and the spiritual dimensions' (296). In comparison to Bishop's views about embodiment, Cassell endorses a view on which the human body is divided. By doing so, Cassell aligns with other thinkers—Bishop identifies Sherwin Nuland and Paul Churchland (297)—who also (erroneously) distinguish between functionality and meaning. In other words, Cassell is committed to a dualism according to which 'bodies are bodies and persons are persons, and where mechanism and meaning are distinct' (298). Dividing the body into various parts lends itself to the task of efficiently delivering care. The care that is delivered, however, comes at a cost.

For Bishop, there is an alternative view of suffering, one that turns on the way in which illness affects how one is embodied. 'To suffer is to undergo change in one's way of being embodied, in one's embodied intentionality. To suffer is to undergo loss of capacity, potency, history, project, or purpose', he writes, 'all of which are integral to this particular embodied being' (298). On these terms, suffering isn't delimited to what one, in a particular spatiotemporal moment, is and isn't able to do; rather, suffering affects everything that one has, can, or will do. In other words, suffering isn't limited to the functionality of one's body. Instead, suffering affects one's purposes and projects, which are *only* possible through one's embodied self. 'In this sense', Bishop notes, 'matter is not distinct from form or *telos*' (298). Contemporary medicine fails because it makes such distinctions. Bishop claims:

> The technologies of medicine are geared not to purposes and goods but to functionality; the assessments and discourses of medicine are geared not toward individual purpose or meaning but toward some notion of social function and/or the good death that has been captured, or created, in assessments designed for better social functioning. As such, medicine becomes forgetful of the living and embodied telos of this particular body that has called to it for help. It becomes forgetful of being embodied… [M]edicine thereby causes suffering (299).

By focusing only on functionality, contemporary medicine disregards the embodied per- son. In doing so, moreover, physicians distance themselves from the value commitments held by the patient and the patient's family and community. In order to avoid the reductive tendencies found in the Mechanical and Efficient Care Theses, how should contemporary medicine respond to suffering?

The suffering of others, Bishop observes, moves the perceivers of that suffering in different ways. 'Responding to the loss of functionality', he writes, 'is the calling of the physician. She cannot do otherwise and still be a physician' (300). But while such a response isn't wrongheaded it may be inadequate, especially when the physician is confronted with care for the dying. What's problematic about this picture, he notes, is that when 'function is not fully returned, the coldness of modern medicine stands out' (302). The coldness of contemporary medicine stems from the way in which physicians are trained. Bishop explains:

> the doctor's training and education get in the way of perceiving suffering beyond function, for the doctor has been seduced by the efficient and effective manipulation of bodies and psyches as the most important response to suffering. She has become anesthetized to embodied suffering, literally without the sense of a suffering deeper than functional loss of material objects (302–303).

Contemporary medicine is successful when it responds to the body that is losing

its functionality. But it fails because it *only* responds to functionality, disregarding embodiment. What physicians must learn, Bishop argues, is when they are relevant—that is, when they are able to do something to return functionality, when they will cause only harm, and when they must defer to others, for example, family, friends and religious leaders. In other words, '[t]he doctor must learn to be there with the suffering other when she intervenes in a bodily function, and even when she cannot intervene at all' (303).

Given the coldness of medicine, Bishop avers, the physician-patient interaction must include, on the part of the physician, the 'giving of the self'. Such a response isn't delimited to attempting to return functionality to the patient. Instead, it may also include being with the patient—listening, speaking, or remaining in silence with him or her. Moreover, the response, Bishop says,

> may come in the form of no response at all, in the recognition that the doctor cannot be what the other calls her to be. The response may be one of calling on others with skills—as opposed to techniques—that the doctor may not possess (304).

Through the giving of the self, the physician attends to the embodiment of the patient.

Bishop highlights the phenomenology underwriting his argument. He writes:

> [t]he perceiver of suffering perceives the loss and is moved to fill the loss, but in a manner that may or may not alleviate the function of loss. To be moved by the call of another is a different kind of motion than that forced by a social apparatus that compels us to intervene upon the material of the body or body politic (306).

What moves one to perceive and respond to the suffering of another, he adds, turns on being members of a community. 'By virtue of the community', he notes, 'one can learn how properly to offer care because care has already been received' (306).

‘We are moral strangers’, Bishop writes in closing:

> precisely because we believe that in sharing functionality as our common ground, we have overcome the particularity of place and traditions; and it is this that alienates us from one another. The problem is that in focusing on efficient and material causes, medicine alienates the bodies of patients from their capacities, histories, projects, and purposes, which are molded in communities. In other words, bodies have an integrity prior to and independent of the post hoc investment of meaning and value that is added onto living and dying (309).

How should contemporary medicine move beyond focusing merely on functionality toward attending to both functionality and embodiment? Thus Bishop’s closing query about whether only theology can save medicine.

Some Ideas from Ramsey

I now turn to Ramsey’s writings on medical ethics,[8] focusing on his views about physician-patient interaction and highlighting his conception of the ‘patient as person’. Once I have reconstructed his views regarding the patient as person, I turn to his writings specifically about care for the dying, including whether physicians tend toward under- treatment or overtreatment. These writings taken together, I hope to show, may help respond to the Mechanical and Efficient Care Theses, and therefore might offer resources to help save contemporary medicine.

Before turning to his writings about medical ethics, consider how Ramsey understands Christian ethics to relate to medical ethics. In prefacing *The Patient as Person*, he writes: ‘[t]his, then, is a book *about ethics*, written by a Christian ethicist. I hold that medical ethics is consonant with the ethics of a wider human community’, with medical ethics being ‘only a particular case of the latter’.[9] ‘The moral requirements governing the relations of physicians to patients and research to subjects’, he adds, ‘are only a special case of the moral requirements governing any relations between man and

man'.[10] For any and all relations, though, there is 'the ethical question': '[w] hat is the meaning of the faithfulness of one human being to another in every one of these relations?'[11] He also comments on his commitments to moral and religious premises:

> I hold with Karl Barth that covenant-fidelity is the inner meaning and purpose of our creation as human beings, while the whole of creation is the external basis and condition of the possibility of covenant. This means that the conscious acceptance of covenant responsibilities is the inner meaning of even the 'natural' or systemic relations into which we are born and of the institutions or roles we enter by choice, while this fabric provides the external framework for human fulfillment in explicit covenants among men. The practice of medicine is one such covenant.[12]

Given his commitments to upholding covenantal responsibilities in general, then, Ramsey aims to think through and explicate what such responsibilities entail in the context of medicine, including 'how to show respect for, protect, preserve, and honor the life of fellow man'.[13]

In prefacing his argument, Ramsey also addresses a concern advanced by his interlocutors: namely that, in approaching moral dilemmas, the theological content of his arguments disappears. I have earlier discussed that Ramsey views medical ethics to be a particular case of ethics more generally. In the specialized case of medical ethics, then, one's general ethical commitments are specified to address the particular problems that medical interactions and research presents. Moreover, he adds that he will 'not be embarrassed to use as an interpretive principle the Biblical norm of *fidelity to covenant*, with the meaning it gives to righteousness between man and man'.[14] But he also notes that 'this is a not a very prominent feature' in his argument 'since it is necessary for an ethicist to go as far as possible into the technical and other particular aspects of the problems he ventures to take up'.[15] While noting his commitments to the covenant responsibilities, he doesn't simultaneously claim that such commitments also entail strict distinctiveness between Christian and non-Christian views: 'in the midst of

any of these urgent human problems, an ethicist finds that he has been joined—whether in agreement or with some disagreement—by men of various persuasions, often quite different ones. There is in actuality a community of moral discourse concerning the claims of persons'.[16]

Following these clarifying notes, how does Ramsey approach problems in medical ethics, and in particular the ones with which Bishop is concerned? The physician, Ramsey writes, 'makes decisions as an expert but also a man among men; and his patient is a human being coming to his birth or to his death, or being rescued from illness or injury in between. Therefore, the doctor who attends the case has reason to be attentive to the patient as person',[17] an idea that speaks to the Mechanical Thesis. Underwriting the relationship between the patient and physician is a more basic relationship, that is, one between members of the covenanted community. What are some features of such a com- munity? 'In order to create and maintain a community of persons', Ramsey writes, 'much more (and more intentionally) than in economic exchange is necessary that each seek not his own good, but the good of his neighbor'.[18] Moreover, '[o]nly an element of concern for the other person for his sake creates a community among men'.[19]

To highlight what motivates the members of such a community, Ramsey links Christian faith and neighbor-love's normative commitments. Ramsey's view about the relationship between faith and love is packaged under the heading 'faith working through love'. According to him, '[f]aith working through love is concerned only to show what love is and to discover the neighbor's needs, not to demonstrate that it itself is faithful'.[20] He further claims: 'Christian love does not *claim* good works; it *gives* them. Christian faith does not seek its own salvation, even salvation by faith, for faith is effective in love which seeks only the neighbor's good'.[21] Insofar as the neighbor exists, then, one is obligated to seek the neighbor's good.

Privileging the person, he notes, does not permit the physician to overstep his or her bounds in the treatment of the patient. Therefore, privileging the person delimits what may be done in the course of treatment. In deontological terms, there exists a priority of the right to the good. There consequently must be, Ramsey says, 'a

determination of the rightness or wrongness of the action and not only of the good to be obtained in medical care or from medical investigation'.[22] To ascertain what is right, the physician is required to get consent from the patient. The consent requirement reflects the 'canon of loyalty' between the physician and patient. For Ramsey, consent isn't reducible to a brute libertarian contract, according to which whatever is consented to may be done. He instead suggests viewing the relationship between the physician and patient—who he calls 'joint-adventurers'—as a partnership.

On Richard B. Miller's reading,[23] the heart of Ramsey's emphasis on informed con- sent is found in the following passage, wherein Ramsey fully explicates what he means by a 'canon of loyalty' in medical practice:

> [a]ny human being is more than a patient or experimental subject; he is a *personal* subject— every bit as much a man as the physician-investigator. Fidelity is between man and man in these procedures. Consent expresses or establishes this relationship, and the requirement of consent sustains it. Fidelity is the bond between consenting man and consenting man in these procedures. The principle of an informed consent is the cardinal *canon of loyalty* joining men together in medical practice and investigation. In this requirement, faithfulness among men—the faithfulness that is normative for all the covenants or moral bonds of life with life—gains specification for the primary relations peculiar to medical practice.[24]

Since it is a partnership between the physician and patient, Ramsey adds, 'consent is a continuing and repeatable requirement'. What's more, the patient must also be in a position to make 'reasonably free and adequately informed consent'.[25] His emphasis on con- sent takes seriously the moral and epistemic claims people make on one another. Ramsey terms these claims 'faithfulness-claims'. 'An informed consent alone', he avers, 'exhibits and establishes medical practice and investigation as a voluntary association of free men in a common cause'.[26]

Ramsey continues to develop (and emphasize the importance of) consent in his discussion of medical experimentation on children. One cannot subject a child to an experimental procedure, he says, 'when there is no possible relation to the child's recovery'.[27] Thus, consent safeguards against a child being reduced to a test site, an epistemological apparatus, that is used to serve medicine's advancement. Moreover, the child that must benefit from an experimental procedure must be the child being subject to that procedure—not some abstract future child.[28] But a child isn't sufficiently formed as an agent such that he or she is able to consent on his or her own. So, it is the child's parents who must consent on the child's behalf. The parents must be in a position to reasonably con- sent to one or another procedure. The child's parents must therefore shoulder particular burdens:

> A parent's decisive concern is for the care and protection of the child, to whom he owes the highest fiduciary loyalty, even when he also appreciates the benefits to come to others from the investigation and might submit his own person to experiment in order to obtain them.[29]

In his comments about experimenting on children, Ramsey highlights that, like all other people, children are recipients of God's love and are therefore irreducibly valuable. Children must always be treated as neighbors—that is, as ends-in-themselves[30]—and never merely as instruments. Like Bishop, Ramsey seems alive to the idea that medicine may tend, especially in experimentation, toward turning children from subjects into objects. But his emphases on consent and fiduciary loyalty aim to foreclose such a move.[31]

In 'On (Only) Caring for the Dying'[32] and, in an article published four years later, 'The Indignity of "Death with Dignity"',[33] Ramsey discusses care for the dying. In the former, Ramsey is concerned with overtreatment and in the latter with undertreatment. The way in which caregivers—physicians and others—attend to the dying is, he writes, 'the oldest medical ethics there is'.[34] There is a concern, however, that attends care for the dying: what are the 'moral limits properly surrounding efforts to save life?'[35] In order to

respond to this concern, Ramsey believes, requires relying not solely on medicine itself but also the patient and the patient's values. There is a relationship among the physician, patient and the available treatments. The patient must be informed whether he or she will get well or will (so far as is known) die. Given that the patient may die, there's a more basic relationship between the physician and patient: '[t]he patient has entered a covenant with the physician for his complete *care*, not for continuing useless efforts to *cure*'.[36]

In instances in which a cure cannot be provided, there is a change in the relationship between the physician and patient. Against the Efficient Care Thesis, the relationship changes to one between two members of the human moral community, that is, between neighbors. The relationship turns from cure to 'how not to die alone'. To care for the dying, Ramsey avers, is a medical-moral imperative, one that is a 'requirement of us all in exhibiting faithfulness to all who bear a human countenance'.[37] Moreover, this imperative may well require the physician to defer to other caregivers—'priests, ministers, rabbis, and every one of us'—whereby the process of dying moves from the hospital and 'back into the home and in the midst of family, neighborhood, and friends'.[38]

Commenting on the seriously and irreversibly ill, Ramsey further highlights the fac- tors relevant for when a physician must defer to others. 'Even when he could succeed', Ramsey writes:

> a doctor may and sometimes should allow his medical judgment to defer to a patient's estimate of the higher importance of worth and the relations for which his life was lived. In doing so the doctor acts more as a man than as a medical expert, acknowledging the preeminence of the human relations in which he stands with these and all other men, rather than solely in his capacity as a scientist or as a healer.[39]

Thus, the physician must have the consent of the patient in order to pursue some course of treatment. Moreover, for the patient, the giving of consent turns on his or her own values, to which the physician must defer. Underwriting this view, Ramsey holds, is

the primitive relationship among people—namely, that all people are, first and foremost, members of the human moral community and not members of the medical enterprise, whether as givers or receivers of care. In the giving of care, which may sometimes include not giving medical care at all, Ramsey emphasizes attentiveness to (borrowing Bishop's term) the embodiment of the patient.

Ramsey also offers two important qualifications regarding the relationship between the physician and patient. The first concerns the nature of the relationship between them. The physician is not, in one instance, solely a physician and, in another, solely a human being. Instead, the physician is both physician and a human being at the same time. Therefore, the physician must honor both his commitments to medicine and to morality. These commitments, Ramsey notes, are distinguishable but not separable. Therefore, Ramsey does not endorse a role morality. What the physician is called to do, then, is to continue trying to find a remedy but, when the occasion demands it, must accord to the patient 'the nobility and opportunity of personally nontherapeutic service of mankind'.[40] The physician thus acknowledges that he or she is obligated to seek a cure but does not desert the patient to die alone when no cure is available. The physician's attention to the patient's suffering, therefore, manifests itself in different ways.

The second qualification concerns care for the dying and whether it is morally permissible to hasten the patient's death. For Ramsey, in instances when a cure is not available, the physician must turn to nontherapeutic care. In these instances, Ramsey writes, 'deeds are done bodily for them which serve solely to manifest that they are not lost from human attention, that they are not alone, that mankind generally and their loved ones take note of their dying and mean to accompany them in accepting this unique instance of the acceptable death of all flesh'.[41] Though unable to give therapeutic care, the relationship between the physician and patient is instead one between neighbors—one which 'will display an indefectible charity that never ceases to go out of business of caring for the dying neighbor'.[42] Such acts of charity and hospitality toward the patient, on Ramsey's view, align with God's will and further demand faithful care from another. Since no one is beyond the ambit of God's love and care, he adds, hastening the patient's death is to be avoided.[43]

In caring for the dying, Ramsey notes, there is nothing dignified about death. For

him, death is an affront to the individual person's value as a human being. But there is a certain nobility and dignity in *caring for* the dying—the caregiver who attends to the dying person is made aware of the uniqueness of that particular person and that the particular uniqueness will end.[44] By noting that the particular person is unique, Ramsey's views about care speak back to the Efficient Care Thesis. Despite the nobility and dignity involved in care for the dying, however, Ramsey believes that ethicists must still struggle with the idea of 'death with dignity'. What is the cause of this struggle? Constructing an ethics of death and dying requires confronting the fact that death itself resists conceptualization.[45] Death limits the lives of all people, Ramsey says, but the way in which it limits life isn't something one can experience—'death is *never* a part of life'.[46] Instead, death is something against which humans live, something whose bearing humans cognize. What death does, he notes, is that it 'teaches us to "number our days"'.[47] While Ramsey believes that death escapes conceptualization, it nonetheless has normative force upon human life. On this point, Ramsey writes, '"Awareness of dying" means awareness of that; and awareness of that constitutes an experience of ultimate indignity in and to the awareness of the self who is dying'.[48]

Ramsey also emphasizes that an awareness of dying is uniquely individuating. On the caregiver's role in the dying process, he writes, '[m]embers of the caring community (doctors, nurses, family) are apt to keep closer company with the dying if we acknowledge the loss of all worth by the loss of him in whom inhered all worth in his world'.[49] From here, Ramsey identifies death as a *finis*, not *telos*. One shouldn't therefore reduce human life and death to the same order of natural events. He also cautions against the 'thing-ifying' of death, that is, when people hope for a 'sudden death'. More pointedly, Ramsey believes the sting of death is sin. Death is the enemy of the natural order. But without death, he says,

> we would have no reason to 'number our days' so as to ransom the time allotted us, to receive life as a precious gift, to drink the wine of gladness in toast to every successive present moment. Instead, life would be an endless boredom and boring because endless; there would be no

reason to probe its depths while there is still time.[50]

But death remains, for him, an evil or experienced indignity.

In the face of this evil and indignity, though, one may express '[r]ealistic love for another irreplaceable, noninterchangeable individual human being' through 'car[ing] for another "doomed soul"'.[51] This view follows from a theme present in Ramsey's foundational work in Christian ethics and made more explicit in his medical ethics. That is, by being recipient to God's love, and also being member of the covenant among humans, one is embedded in important interpersonal relationships. Moreover, one is a unique being with an attendant moral status; one is particular and irreplaceable. From this description, Ramsey cautions against two accounts of death. The first account, he says, 'subscribe[s] to an interpretation of "bodily life" that reduces it to an acceptable level of indifference to the person long before his dying'.[52] This account follows Plato's idealized account of Socrates's death.[53] The second account 'subscribe[s] to a philosophy of "human life" that reduces the stature, the worth, and the irreplaceable uniqueness of the individual person (long before his dying) to a level of acceptable transiency or inter- changeability'.[54] But for Ramsey, it is better to bear the indignity of death than to dignify either of these two accounts. Caring for the dying is distinct moral activity. While one may grieve over the dead, this grief turns on an acknowledgement of the uniqueness that inhered in him or her.

Conclusion

Bishop offers a strong characterization regarding contemporary medicine, claiming that it tends toward a reductive either/or. On the one side is what I called the Mechanical Thesis: medical technologies aim at conquering illness and death, viewing the body as a broken tool that stands in need of repair and consequently doing violence to the individual person. On the other side is the Efficient Care Thesis: psychological and social scientific models have, in the place of Christian hospice care, attempted to master death, reducing care to effectiveness and efficiency. Following this strong critical characterization, Bishop suggests that theology might serve as a resource to help save

contemporary medicine.

In response to Bishop, I turned to Ramsey, who relates Christian ethics and medical ethics. More specifically, he draws from ideas about neighbor-love and brings them to bear on informed consent and care for the dying. In each case, Ramsey does not separate what medicine may do and what one is morally obligated to do in thinking about and providing care. While discussing physician-patient interaction, Ramsey motivates his views by emphasizing that the basic relationship between them is one between neighbors, a relationship that is informed and delimited by love. These are ideas that speak to the Mechanical Thesis. Moreover, when confronted with seriously ill or terminal patients, Ramsey emphasizes that physicians must focus on *care* and not solely on *cure*. By focusing on care, physicians recognize that the patient is a unique and irreplaceable member of the human moral community. These are ideas that speak to the Efficient Care Thesis. Thus, Ramsey does not start with the promise of contemporary medicine and then mold his ethics in order to promote any and all medical endeavors. He thus highlights ways in which to resist the reductive tendencies that Bishop believes affect contemporary medicine.

Might only theology save medicine? Perhaps. Some of Ramsey's ideas, I have tried to argue, may help.[55]

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1. 'The Indignity of "Death with Dignity"', in William Werpehowski and Stephen D. Crocco (eds), *The Essential Paul Ramsey* (New Haven, CT: Yale University Press, 1994), p. 224.

2. Jeffrey Bishop, *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* (Notre Dame, IN: University of Notre Dame Press, 2011). Hereafter, references to Bishop's book will appear in-text.

3. Beyond suggesting that a proper response to the reductive tendencies permeating contemporary medicine will wed material, function, form and purpose, Bishop's language is aspirational. Moreover, his language is ambiguous: while highlighting some necessary features, he is not explicit about what sort of theology is sufficient to respond to his charges.

4. For reflections on Ramsey's Christian ethics and his contributions to medical ethics (as well as just war theory), see, e.g., James Johnson and David Smith (eds), *Love and Society: Essays in the*

Ethics of Paul Ramsey (Missoula, MT: Scholars Press, 1974).

5. There is lively debate among Ramsey's interlocutors regarding the extent to which Ramsey, in responding to moral dilemmas, privileges his theological commitments. Moreover, the extent to which one finds Ramsey's thought useful may turn on the extent to which one finds Christianity (and Christian theological commitments) continuous or discontinuous with the broader world. For example, Bishop himself, echoing Stanley Hauerwas ('How Christian Ethics Became Medical Ethics', *Christian Bioethics* 1 [1995], pp. 11–28) and Tristram Engelhardt ('The Recent History of Christian Bioethics Critically Assessed', *Christian Bioethics* 20 [2014], pp. 146–67), has a somewhat conflicted view about Ramsey: 'Yet, as Ramsey engaged medical ethics … there can be little doubt that the theological content of his reflection began to diminish. After all, with the exception of the preface to *The Patient as Person*, Ramsey hardly appeals to theological themes' ('False Gods and Facades of the Same: On the Distinctiveness of a Christian Bioethics', *Christian Bioethics* 20 [2014], p. 304). Commenting further on Ramsey and Richard McCormick, Bishop adds: 'McCormick and Ramsey did appeal to the robust metaphysical moral commitments of Christianity, such that they made enemies; yet in attenuating their Christian language, they lost the day to the secularists and scientific progressivists, who aimed at a mid-level and proceduralist ethics' ('False Gods and Facades of the Same', p. 307). Conversely, in their introduction to Ramsey's essay, 'The Indignity of "Death with Dignity"', William Werpehowski and Stephen Crocco write: 'Ramsey, in contrast, argues that the *Christian* vision includes an awareness that death is a deep affront to the individual' (*The Essential Paul Ramsey*, p. 223; emphasis mine). On how he approaches moral dilemmas, Ramsey describes himself as follows: 'I always write as the ethicist I am, namely, a Christian ethicist, and not as some hypothetical com- mon denominator' (*The Essential Paul Ramsey*, p. 237). For further reflection on the relationship among Ramsey, Christianity and medical ethics, see Gerald P. McKenny, 'Whose Tradition? Which Enlightenment? What Content? Engelhardt, Capaldi, and the Future of Christian Bioethics', *Christian Bioethics* 1.1 (1995), pp. 84–96 and Daniel P. Sulmasy, 'In Defense of the Amphibians: A Critical Appraisal of Engelhardt on the Recent History of Christian Bioethics', *Christian Bioethics* 20.2 (2014), pp. 187–95, with Sulmasy defending, in opposition to Engelhardt ('The Recent History of Christian Bioethics Critically Assessed'), Ramsey's commitments. For some further reflections on neighbor-love and its place in (and contributions to) medical ethics, see Richard B. Miller, *Children, Ethics, and Modern Medicine* (Bloomington, IN: Indiana University Press, 2003), pp. 215–19.

6. I borrow and amend this term from Henry Shue, who distinguishes between *basic* human rights and human rights. On his definition, '[w]hen a right is genuinely basic, any attempt to enjoy any other right by sacrificing the basic right would be quite literally self-defeating, cutting the ground from beneath itself'. See Henry Shue, *Basic Rights: Subsistence, Affluence, and US Foreign Policy* (Princeton, NJ: Princeton University Press, 1996), p. 19. Compare Shue's definition to John Finnis's notion of 'basic goods', which is perhaps more familiar to theological ethicists. For Finnis, basic goods are irreducible, self-evident, and 'even unquestionable'; see *Natural Law and Natural Rights* (Oxford: Clarendon Press,

1980), p. 59. For a good to be basic, he holds, means that each and every reasonable person would view the good as an object of human striving (ibid., pp. 83–84). He provides an exhaustive list of the basic goods, with these goods being incommensurable with one another: (1) life, (2) knowledge, (3) play, (4) aesthetic experience, (5) sociability, (6) practical reasonableness, and (7) religion (ibid., pp. 86–89). Cf. John Rawls, *Justice as Fairness: A Restatement*, ed. Erin Kelly (Cambridge, MA: Harvard University Press), pp. 58–59 on primary goods and Martha Nussbaum, *Creating Capabilities: The Human Development Approach* (Cambridge, MA: Harvard University Press, 2011), pp. 33–34 on human capabilities. I prefer Shue to Finnis because, whereas Finnis articulates a list of goods that are the *object* of one's striving, Shue's definition highlights what one necessarily needs *in order to* strive.

7. See Eric Cassell, *The Nature of Suffering and the Goals of Medicine* (Oxford: Oxford University Press, 1991).

8. Ramsey's writings about medical ethics are salient, I believe, not only for his medical ethics in particular but also, owing to the protean nature of his foundational claims about Christian ethics, for the explication of his ethics more generally. On Ramsey's foundational claims, see his *Basic Christian Ethics* (Louisville, KY: Westminster/John Knox Press, 1993). I am elsewhere developing an account wherein I highlight how Ramsey's later writings on just war theory and medical ethics bring analytic clarity to his foundational work. See Bharat Ranganathan, 'Paul Ramsey's Christian Deontology', (in progress). In developing Ramsey's view in the present article, I draw material from 'Paul Ramsey's Christian Deontology'.

9. Paul Ramsey, *The Patient as Person: Explorations in Medical Ethics*, 2nd edn (New Haven, CT: Yale University Press, 2002), p. xliv.

10. Ramsey, *The Patient as Person*, pp. xliv–xlv.

11. Ramsey, *The Patient as Person*, p. xlv.

12. Ramsey, *The Patient as Person*, p. xlv.

13. Ramsey, *The Patient as Person*, p. xlvi.

14. Ramsey, *The Patient as Person*, p. xlv.

15. Ramsey, *The Patient as Person*, p. xlv.

16. Ramsey, *The Patient as Person*, p. xlv. On the distinction between Christian *distinctiveness* and *integrity*, see Nigel Biggar, *Behaving in Public: How to Do Christian Ethics* (Grand Rapids, MI: Eerdmans, 2011), who argues, in contrast to postliberal views, that, insofar as they are shaped by the biblical narrative (i.e. integrity), Christians may analyze and contribute to extra-ecclesial debates and even draw from and be informed by extra-ecclesial sources. On approaching moral dilemmas in the midst of both Christians and non-Christians, consider David Hollenbach's notion of 'intellectual solidarity': 'an orientation of mind that regards differences among traditions as stimuli to intellectual engagement across religious and cultural boundaries. It is an orientation that leads one to view differences positively rather than with a mindset marked by suspicion or fear … Intellectual solidarity arises in this give-and-take of mutual learning among people who see the world differently. It is a disposition based on the hope that we

can actually get somewhere if we decide to listen to what others think a good life looks like and in turn tell them why we see the good life the way we do'. See David Hollenbach, *The Common Good and Christian Ethics* (Cambridge: Cambridge University Press, 2002), p. 138. Promoting intellectual solidarity, Hollenbach adds, turns on a new form of cooperation, one 'that goes beyond coexistence in parallel worlds to conjoint action to which we all contribute … It calls for efforts at mutual understanding that move across the boundaries that tolerance leaves in place. This shows the special salience of the idea of intellectual solidarity today' (ibid., p. 141).

17. Ramsey, *The Patient as Person*, p. xliv.

18. Paul Ramsey, *Basic Christian Ethics* (Louisville, KY: Westminster/John Knox Press, 1993), p. 235.

19. Ramsey, *Basic Christian Ethics*, p. 238.

20. Ramsey, *Basic Christian Ethics*, p. 136.

21. Ramsey, *Basic Christian Ethics*, ibid.

22. Ramsey, *The Patient as Person*, p. 2

23. See Miller, *Children, Ethics, and Modern Medicine*, p. 243.

24. Ramsey, *The Patient as Person*, p. 5; original emphasis.

25. Ramsey, *The Patient as Person*, p. 6.

26. Ramsey, *The Patient as Person*, p. 11. On his view, there is only one exception to expressed consent: when the patient is in extreme danger and cannot explicitly consent, e.g., when the patient is comatose or otherwise unconscious (ibid., p. 7).

27. Ramsey, *The Patient as Person*, p. 12.

28. Ramsey, *The Patient as Person*, p. 13

29. Ramsey, *The Patient as Person*, p. 25.

30. Ramsey, *The Patient as Person*, p. 35.

31. Commenting on Ramsey's arguments against proxy consent, Miller notes, 'Ramsey confuses two norms that need to be distinguished. His core concern has less to do with autonomy— the principal value grounding informed consent—than with beneficence as a basic principle of pediatric care. On this view, parents are ineligible as proxies if their decisions do not promise to benefit their children. Respect for autonomy is secondary to a more fundamental test—namely, patient benefit' (Miller, *Children, Ethics, and Modern Medicine*, p. 244). To my mind, Miller is right to claim that Ramsey confuses autonomy and beneficence. But, if Ramsey's views are read in relation to Bishop's distinction between the patient-as-subject and the patient-as-object, I don't think this confusion is as problematic as Miller holds. Specifically, as Miller himself writes, 'researchers who propose nontherapeutic experimentation commit a moral wrong' (*Children, Ethics, and Modern Medicine*, p. 246), whereby they reduce the patient to an object, that is, an epistemological site, instead of a subject who could potentially benefit from experimentation. '[T]he first line of normative inquiry', Miller emphasizes, 'should target the research proposals of scientific investigators rather than the decisions of parents or guardians' (ibid.). Miller

continues to discuss the moral permissibility of nontherapeutic research, asking: ‘is it possible to allow some nontherapeutic research without sacrificing Ramsey’s core concern, namely, the desire to protect children from being unduly instrumentalized, from being treated as things rather than as persons?’ (ibid.). While I will not discuss further Miller’s ideas on nontherapeutic pediatric research, he does believe that, on the basis of non-utilitarian ‘intergenerational reciprocity’, some limited forms of nontherapeutic pediatric research may be morally permissible. For theoretical and practical reflections on such research, see Miller, *Children, Ethics, and Modern Medicine*, pp. 246–67.

32. Ramsey, *The Patient as Person*, ch. 3.
33. In Werpehowski and Crocco (eds), *The Essential Paul Ramsey*, pp. 223–46.
34. Ramsey, *The Patient as Person*, p. 114.
35. Ramsey, *The Patient as Person*, p. 118.
36. Ramsey, *The Patient as Person*, p. 134; original emphasis.
37. Ramsey, *The Patient as Person*, p. 134.
38. Ramsey, *The Patient as Person*, p. 135.
39. Ramsey, *The Patient as Person*, p. 137.
40. Ramsey, *The Patient as Person*, p. 144.
41. Ramsey, *The Patient as Person*, p. 153.
42. Ramsey, *The Patient as Person*, p. 153.
43. Ramsey does offer a sober qualifying note: ‘[a] patient undergoing deep and prolonged pain, who cannot be relieved by means presently available to use to care for him and make him comfortable, would also be beyond the reach of the other ways in which company may be kept with him and he be attended in his dying—as much so, depending on the degree of his undefeatable agony, as the prolonged comatose patient. For the same reasons, this may be another place to locate an abrogation of the good moral reasons for distinguishing between omission and com- mission in our dealings with the dying’ (Ramsey, *The Patient as Person*, p. 163).
44. See Ramsey, ‘The Indignity of “Death with Dignity”’, pp. 224–25.
45. Cf. Eccl. 9:4-6: ‘But whoever is joined with all the living has hope, for a living dog is better than a dead lion. The living know that they will die, but the dead know nothing; they have no more reward, and even the memory of them is lost. Their love and their hate and their envy have already perished; never again will they have any share in all that happens under the sun.’
46. Ramsey, ‘The Indignity of “Death with Dignity”’, p. 227; original emphasis.
47. Ramsey, ‘The Indignity of “Death with Dignity”’, p. 228.
48. Ramsey, ‘The Indignity of “Death with Dignity”’, p. 229.
49. Ramsey, ‘The Indignity of “Death with Dignity”’, p. 232.
50. Ramsey, ‘The Indignity of “Death with Dignity”’, p. 240.
51. Ramsey, ‘The Indignity of “Death with Dignity”’, p. 242.
52. Ramsey, ‘The Indignity of “Death with Dignity”’, p. 244.

53. For Plato's account of Socrates's death, see *Phaedo*, 115b–118b in Plato, *Five Dialogues: Euthyphro, Apology, Crito, Meno, Phaedo*, 2nd edn, trans. G. M. A. Grube and ed. John M. Cooper (Indianapolis, IN: Hackett, 2002).

54. Ramsey, 'The Indignity of "Death with Dignity"', p. 245.

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