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Carleton B. Chapman, the distinguished cardiologist, now chair of History and Philosophy of Medicine at Albert Einstein, writes;

> The concept of a principle of professional ethics focusing on the patient was not to appear fully formed until near our own time, although it was voiced in principle by the pre-exilic prophet Amos well before the Golden Age of Greece. Something like it appears in Luke 12:48 and in Roman writings of the first century A.D.
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> **Carleton B. Chapman**
> ***Physicians, Law, and Ethics***
> **New York: New York University Press, 1984, p. XV-XVI.**

The text from Amos to which Chapman alludes might include:

> They sell the innocent for silver
> and the destitute for a pair of shoes.
> They grind the heads of the poor into the earth (2:6-7)
> Hate evil and love good (5:15)
> Let justice roll like a mighty river (5:24)

The ancient code is also expressed by Luke the physician: "To whom much has been given much will be expected." (12:48)

Today, severe moral challenges confront the medical profession. These challenges call into question the dominant ethic of the profession enhancing its own political and fiscal welfare. They invite the profession to reconsider a most ancient, radical and transcendent ethic. Challenges focusing this reexamination of value include care of the poor, the dying, and persons with AIDS. The essence of the transformation affecting modern medicine, says Chapman,

> . . . is that the medical profession can no longer function primarily for its own benefit; its first obligation is to those who require its services. (xvii)

Today's medical ethics is rehearsing its conceptuality and refreshing its characterology. We are witnessing nothing short of a renaissance of

morality. As we rediscover the principles of beneficence, justice and autonomy, enrich them with their polar antinomies — sacrifice, mercy and solidarity — we need, at the same time, to intensify the related virtues of character; co-adventuring, clemency, empathy, and fidelity. We finally seem to be getting somewhere. The great conflicts in medical ethics today are between the values of duty and utility, provision and profit. Will we seek to exploit human suffering or rise to the excellence of generous service? Now that accountants and attorneys are running the system, a critique of the prevalent ethic and a restoration of a humanistic ethic is absolutely essential.

Crises in contemporary clinical care are forcing this recovery of radical and transcending virtue. Let us consider the challenges of AIDS, poor care and care for the dying as provocative events calling for the renaissance of mercy, justice, and fidelity.

AIDS and Mercy

How shall we respond to this agonizing spectre which has been called everything from the green monkey's last laugh at his keeper's brother to the flaming wrath of God? Let me offer this assertion. When we genuinely care for another person, what Leo Buscaglia calls "hard love", we protect them from harm and mercifully attend them when they are hurt. The ministry of prophylaxis and pity is as ancient as the art of medicine. From the Hebrew hygienic charter, through to the Hippocratic accent on airs, waters, times, and places, on to John Wesley's medical theology which transformed the sewer trap that early Western industrial society had become, into the modern health miracle; in all of these movements of moral conviction, we see the impulse of mercy reflected as prophylaxis and pity. We need a new accent on prophylaxis and prevention. With reference to AIDS we need to care enough for our children and fellow citizens to redemptively influence the cultures of advertising, television, film and education and so retard the ascending style of promiscuity and compulsiveness in sex. We need to reaffirm chaste and faithful love and the integrity of family (Bill Cosby is doing his best). Let's halt our burned-out tirade against chastity and support renewed moral vigor and family vitality through economic, tax and business policies. Most crucially, let us rediscover that reverence for people that leads us to respect and shield them from harm. As Cicero reminds us, we are all the dying, caring for the dying.

The impulse of pity, mercy and forgiveness goes beyond an autonomy ethic which says "live and let live". Mercy doesn't come naturally — the more natural response is "You had it coming"; "You got what you deserve"; "Don't ask me for help"; "Don't get near me!" The whole practice of medicine, it now appears, for at least the rest of the century, will very much be shaped by our experience with AIDS and society's moral response to this agonizing disease. Will we respond in revenge, quarantine and disregard or, like Dr. Rieux, in Camus's *The Plague,* will we remain close in care? The underlying test is one of morality and faith. It is about whether our lives are rooted in grace or in revulsion.

Poor Care and Justice

As the epidemic of AIDS spreads up towards half a million cases devastating our health care budgets in its path and as its face changes from a middle-class homosexual disease to an under-class heterosexual disease we will confront an even more basic ethical challenge — care for the poor.

Medicine is the profession of advocacy of social justice and care for the sick poor. Today we have given ethical preeminence to entrepreneurial economic interests. As Arnold Relman, editor of the *New England Journal of Medicine* pleads, this is absolutely inimical to the humane practice of medicine. How long can we endure the scandal of 30% of our population uninsured or under-serviced? How long can we stand by and allow the "dumping syndrome" with suburban "for profits", even religious "not for profits", doing wallet biopsies on the sick poor, then bumping them down to charity hospitals? If the argument of economic frugality is made in these days of Wall Street tremors, let us be reminded that we are now paying through the teeth for this injustice in neonatal, chronic care, prisons and welfare costs.

Even more unconscionable is the pattern of medical practice which is coming to dominate the American scene. In today's sociology of medicine, the well-insured are cared for by well-trained, mostly affluent, mostly white doctors. The lower and lower middle classes are herded into the Medicare mills for their 30-second appointments with overtesting and over-medication, all at the hands of foreign-trained medical graduates who look with aggressive envy at their well-to-do colleagues who have it made. While we must respect with gratitude these international colleagues who serve our sick with such generosity, medicine must return to the moral qualities of justice for all, where the poor are not excluded from adequate service and where the impulses of faithfulness, care and benevolence and not profit and efficiency prevail. The justice of which we speak is not simply retributive or distributive justice. It is that transcendental command which is cleansed from all human vengeance and opportunism. It is that merciful justice which drops as gentle rain from heaven.

Dying Care and Fidelity

The final virtue incumbent upon us is that which we confront as we stand up against the ultimate mystery of life. Physicians today face new and awesome responsibility in the face of the death of their patients. No longer passive and innocent, essentially unable to influence the awesome, irresistible power of death, now one senses more latitude and power. And we are absolutely at a loss. We need nothing less than guiding virtue. Let us state the issue in stark candor. In a very perplexing and troubling way persons are dispatched to their destiny and nature's economy is maintained.

We all know the facts: cancer treatment is a cause of cancer. Immunosuppression in organ replacement is a lethal force. Iatrogenesis in

general takes a toll. Mutant viruses and other infections plague us in the sexually transmitted diseases, HIV, even in the rather frightening new childhood mutant organisms — mumps, measles, etc. In all of these interventions, the procession of nature is transgressed and she howls against us. All of these morbidities and mortalities are induced into the human condition by our biomedical interventions.

We suffer now the disorders of advancing civilization. By early next century, some say, our two dominant diseases will be AIDS and Alzheimer's. And what of removing death into hospitals — DRG's — the withdrawal of feeding and hydration, even death induced by physicians — oncologists and anesthesiologists? Today in Holland, the sixth leading cause of death is *euthanasia.* Let me be clear that I'm not blindly condemning these developments. We are entering an age, I believe, when persons will knowingly assent to and participate in their deaths. We may indeed be entering an age when it will be necessary to die not only in the presence of, but by virtue of, medical care. But, if it is the case that we shall die under medical attention rather than by accident, human violence and the force of nature — we will then understand again the primordial meaning of medicine as priesthood and the enduring import of the virtue of kindness or fidelity.

Sympathy, empathy, or compassion are the words we use to describe this most extraordinary human virtue. Here we discover the grace of entering into the life-world of another person in times of extremis or drawing their pain into our own. We are now coadventurers, carrying the burden of pain and choice *with* another, sometimes even *for* another. At these points, all assumptions of solipsistic autonomy fall away. We are literally at the mercy of one another. We are relegated together — tethered in sacred trust. Today's crisis of medicine will either provoke reunion or abdication. One can see tendencies in both directions.

In summary, I have argued that contemporary medicine invites its practitioners to remember and reenact the art as a sacred trust. The challenges of AIDs, of indigent care and dying invite reconsideration of classic transcending virtues. Indeed, my strong thesis contends that the ethical practice of clinical medicine requires of us access to the transcending qualities of mercy, justice and fidelity. If this is the case, medicine may again become a priestly profession, where initiates swear sacred oaths before gods, rather than offer oblations before the deities of arrogance, artifacts, accumulation and self-apotheosis. It may be asking too much to restore holiness to this singular profession. For perhaps medicine, as Alan Bloom might say, is only part of a lost world which has near lost its soul. It may be asking too much — or is it? "To whom much has been entrusted, much will be required."