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THE LUCE LECTURES ON RELIGION AND THE SOCIAL CRISIS

Morality in Plague Time: AIDS in Theological Perspective

Lecture 2: Obligations — Caring for the Sick

Gilbert Meilaender

At some threshold, hard to define, we will conclude that it is unreasonable to expect people in general to sacrifice themselves and those to whom they have close personal ties to the general good.[1]

In one of the short stories in which he plays a part, a fictional physician whose name you will immediately recognize, is called to the bedside of a dear friend who is dying of a little known, but highly infections disease. Not realizing how dreadfully contagious is his friend's illness, the doctor steps toward the bed.

"Stand back! Stand right back!" said he with the sharp imperiousness which I had associated only with moments of crisis . . . ."

Taken aback, the physician assumes his friend is delirious, but that impression is immediately corrected. "I know what is the matter with me . . . . It is infallibly deadly, and it is horribly contagious."

To which Dr. Watson replies: "Good heavens, Holmes! Do you suppose that such a consideration weighs with me for an instant? It would not affect me in the case of a stranger. Do you imagine it would prevent me from doing my duty to so old a friend?"[2]

Against this wonderful evocation of the meaning of the physician's calling, enunciated, we should note, by one who is himself a physician and not by an outsider deliberating about the obligations of physicians, let us place another paragraph from another work of fiction. In Defoe's *Journal of the Plague Year,* the saddler who narrates the story writes briefly of events after the plague had begun to abate and many who had fled returned to their homes.

> Great was the reproach thrown on those physicians who left their patients during the sickness, and now they came to town again nobody cared to employ them. They were called deserters, and frequently bills were set up upon their doors and written, "Here is a doctor to be let," so that several of those physicians were fain for a while to sit still and look about them, or at least remove their

dwellings and set up in new places and among new acquaintance. The like was the case with the clergy, whom the people were indeed very abusive to, writing verses and scandalous reflections upon them, setting upon the church door, "Here is a pulpit to be let," or sometimes, "to be sold," which was worse . . . . The Dissenters reproaching those ministers of the Church with going away and deserting their charge, abandoning the people in their danger, and when they had most need of comfort, and the like, this we could by no means approve, for all men have not the same faith and the same courage, and the Scripture commands us to judge the most favourably and according to charity.

A plague is a formidable enemy, and is armed with terrors that every man is not sufficiently fortified to resist or prepared to stand the shock against . . . . And we should have considered that such a time as this of 1665 is not to be paralleled in history, and that it is not the stoutest courage that will always support men in such cases . . . . I recommend it to the charity of all good people to look back and reflect duly upon the terrors of the time, and whoever does so will see that it is not an ordinary strength that could support it. It was not like appearing in the head of an army or charging a body of horse in the field, but it was charging Death itself on his pale horse; to stay was indeed to die, and it could be esteemed nothing less . . . ."[3]

Is this not a little closer to what must be said by a third party, an outsider seeking to consider what Dr. Watson and his colleagues ought to do when pursuit of their calling means considerable personal risk? What Dr. Watson quite readily says to Holmes might have been unseemly if spoken to the good doctor by Mrs. Hudson. And yet, as the citizens of London had some sense of the obligations of physicians, even an outsider can gain some understanding of a calling not his own. It is in that spirit that I turn to consider the obligations of caregivers to patients with AIDS (or patients who are HIV+). But, keeping in mind my own calling, I shall begin elsewhere.

Near the end of St. Augustine's life, as North Africa was threatened in the early 5th century by barbarian attacks, an African bishop, Honoratus, had written Augustine, asking whether it might be permissible for a priest to flee in order to escape the threat.[4] We do not have that letter, but it appears from Augustine's reply that Honoratus must have appealed to a number of possible scriptural warrants. He seems to have quoted Jesus' words to the Twelve in Matthew 10:23: "When they persecute you in one town, flee to the next." As precedent, he also appealed to an escape by St. Paul from Damascus, when Paul was let down over the city wall in a basket at night in order to escape those who were plotting to kill him (Acts 9:25; 2 Cor. 11:33). And Honoratus may even have appealed to the example of Jesus Who, as an infant, escaped into Egypt, fleeing from Herod. Why, he wanted to know, could not a priest of the Church do likewise?

An Interesting Response

Augustine's response is both interesting and instructive — especially for us as we think about the obligations of caregivers in risky circumstances. Discussions within the public forum about these obligations have tended

to give voice to two positions. Some, a minority I believe, have contended that it was quite acceptable for physicians (or other health care personnel) to refuse to run the risk of treating AIDS patients. Others have responded by appealing to the obligation of the physician to care for anyone who is ill. We can, I think, learn from the Bishop of Hippo that the moral life is more complicated than either of these views alone.

The fundamental principle laid down by Augustine in responding to Honoratus is simple and straightforward: "There should be no shirking of the duties of our ministry laid upon us by the charity of Christ" (p. 141). At the same time, however, he grants that under some circumstances, a priest might permissibly try to escape. For example, consider the case of St. Paul fleeing Damascus. He was right to do so, Augustine thinks, for his enemies were seeking only him — not Christian clergy generally. Hence, he could rightly escape, thereby preserving himself for future work on behalf of the Church, yet still be certain that Christians left behind would not be deprived of the care they needed. They could get that care from others who were not being sought and, hence, had no need to flee.[5] This exception, though perhaps an interesting one, is not likely to seem very relevant to the problem that concerns us, but consider some of Augustine's other suggestions.

Long before the day of cost-benefit analysis, Augustine examines the contingencies involved. "We should not desert the plain duties of our office, which are certain, for the sake of contingencies which are uncertain" (p. 144). It is right to ask about the degree of risk involved, though, of course, ordinary cost-benefit analysis must blow up in the hands of one who reminds us to reckon into our calculations the fact that God is able, if He so wills, to turn away the evils that threaten us in the performance of our duty! But more important is the principle hinted at in Augustine's treatment of St. Paul's escape and developed explicitly elsewhere in the letter: Flight by a priest is permitted as long as others still remain to provide priestly care for Christians left behind. Indeed, this principle is more important even than the permission to flee that Augustine deduced from the example of St. Paul. Suppose Paul had been the object of attack but, in his absence, no one else would have remained in Damascus to provide priestly care for Christians. Then he must remain, trusting in God to turn away the evil that threatens. Thus Augustine summarizes his basic principle, suitably qualified, in this way:

> Let the servants of Christ, the ministers of His word and of His sacrament, do what He has commanded or permitted. Let them by all means flee from city to city when any one of them is personally sought out by persecutors, so long as the Church is not abandoned by others who are not thus pursued . . . (pp. 142f.).

Honoratus might have been pardoned, however, had he tried one last parting shot. We don't know that he did, but he might have asked Augustine whether he was not expecting too much of our frail humanity — whether he had not enunciated too rigorous a standard for many of us to

attain. After all, compassion for sufferers is, in certain ways, an unreliable motive. Our ability to feel compassion for others who suffer does not necessarily give us the strength needed to stand firm and help them. Rather, it may suggest a sensitivity to suffering easily transmuted into fear for ourselves and our own plight. Helping them, we too may suffer. What then?

Augustine recognizes at several points in his letter that one might be "overpowered" by fear or panic. What we must do then, he counsels, is pray for the charity that is from God — the charity that says, "Who is weak and I am not weak?" (p. 146). If God commands us to stay at our post, we must pray that He will give what He commands, Augustine writes, calling irresistibly to mind one of the famous refrains of Book X of his *Confessions*.[6] This appeal to the grace of God is, of course, not available to us in the public forum where discussions of health care ordinarily take place. But even that fact — that such an appeal is not available — is instructive. It suggests that we should be careful not to set the standard of obligatory behavior too high in contexts where we are unprepared to appeal, as Augustine does here, to the grace of God needed to empower such behavior.

In the statement, "The Many Faces of AIDS: A Gospel Response", the U. S. Catholic Conference Administrative Board commented on the question that concerns us here.[7] Its statement received a great deal of media attention because of the controversy surrounding its seeming endorsement of public educational efforts which included information about use of prophylactics as a means for preventing the spread of AIDS. But the statement was far more wide-ranging, including, for example, the following sentences:

> We are greatly concerned that some in the health care professions or working in health care institutions refuse to provide medical or dental care for persons exposed to the AIDS virus or presumed to be "at risk." We call upon all in the health care and support professions to be mindful of their general moral obligation, while following accepted medical standards and procedures, to provide care for all persons, including those exposed to the AIDS virus.[8]

Interestingly, this statement articulates the responsibilities of caregivers without distinguishing obligatory from supererogatory performance, without Augustine's sense that grace might sometimes be needed to empower performance. Whether this is a sufficiently nuanced understanding is precisely the problem we want now to consider.

Thoughts About Obligations

One common way of thinking about the obligations of physicians and other health care personnel is to consider the degree of risk: to weigh the benefits to patients of care against possible costs to caregivers. But all this really does, I think, is encourage us to ask questions which cannot be straightforwardly answered — leaving us, then, simply to follow our

inclinations or intuitions. How great a risk does the physician run in treating AIDS patients? Not very great, we are customarily told. That answer assumes, of course, that the results of about five years of study and experience will hold up in the longer run, and the scientific temperament itself might advise caution about such a judgment. Perhaps the answer may also seem more persuasive to a psychiatrist than to, say, a nephrologist or surgeon. Then, too, the answer does not itself instruct us how to reckon into our calculations the fact that the risk, even if small in degree, is deadly should it become reality. I suppose physicians are more at risk of contracting the common cold than the AIDS virus — which only suggests that degree of risk may not be the most important consideration. I am not persuaded that such approaches are likely to enhance our capacity to discern what a caregiver ought to do, and I turn therefore in a different direction.

The AIDS crisis has stimulated considerable reflection on the nature of the medical profession and the obligations to which professional status gives rise. Indeed, this may be one of the few obviously good results of an otherwise terrible disease. And one point has begun to become clear, or so it seems to me: namely than an ethic which understands the physician/patient bond in purely contractual terms will not be sufficient to undergird a strong sense of physician responsibility. Thus, for example, Abigail Zuger and Steven Miles — themselves physicians — write that we need to move away from a "rights model" or a "contract model" of medical care toward a "virtue-based model."[9] To think of medical care as a right may impose obligations upon society to provide it, but that model is not likely to constrain the freedom of individual physicians to accept or not accept patients whose care may involve some risk. Only in certain circumstances, as for example a physician employed in a public hospital, would this model generate obligations for particular physicians. Similarly, a contract model is likely to obligate only within narrow limits. Physicians need not accept any and all patients, and, just as patients are free to sever the relationship at any time, so also are physicians, "provided the patient is given sufficient opportunity to find another physician."[10]

In Quest of an Ethic

In their search for an ethic that will more strongly require physicians to take considerable risks in serving patients, Zuger and Miles turn to the concept of virtue. Because of their professional commitments, physicians need to develop certain virtues — the behavioral skills which will sustain them in faithfully caring for the sick. Zuger and Miles believe that this conception may better undergird physician responsibilities to care for AIDS patients. Those physicians who "decline to perform . . . are falling short of an excellence in practice implicit in their professional commitment."[11] Zuger and Miles might well have quoted an article which, in fact, they do cite in their notes — Leon Kass's profound and moving

interpretation of the Hippocratic Oath. Kass notes that the oath does not set forth, chiefly, contractual obligations to patients; instead, it articulates an obligation to one's teachers and to the profession. "The physician stands in the world not as one who claims his rights or demands his due; rather he stands gratefully, thankful for the existence of the art of medicine, for the devotion of his teacher, for the community of like-minded healers, and for the privilege of sharing in this noble work."[12] The emphasis, thus, is not on obligations to patients but on commitment to the physician's art and the virtues it requires. If this seems self-serving — if, indeed, it has sometimes in practice been self-serving — Kass is quite right to point out that such a conception may bind a physician far more strongly than any contract would be likely to do. "It obliges always and unconditionally the physician's full performance, regardless of the behavior of the patient or his ability to pay."[13] It obligates, that is, because it commits the physician to the attempt to be or become a person of a certain sort, and it makes integrity central to that ideal of excellence.

This turn to the virtues, to an attempt to depict the meaning of professional commitment on the part of physicians or other caregivers, is surely attractive in many ways. Indeed, it is, I think, a turn in the right direction. But as it stands, it is too unqualified. We need to add some complexities that arise when we remember (1) others to whom physicians may have obligations, and (2) that it is not wise to permit the whole of a person's identity to be swallowed up in his or her professional commitment.

Call to mind a picture deeply entrenched in our cultural and religious consciousness: A young knight dressed in armor, carrying lance, sword and helmet, rides his war charger out of Assisi to do battle against a neighboring town in 12th century Italy. He is a brave youth, but, seeing a wretched leper along the road, he spurs his horse to flee the dreadful sight. As he gallops by, however, he seems to recognize Christ in the contorted face of the outcast. Abruptly he stops, dismounts, kisses the leper, gives him alms, seats him on his charger, and leads him to his destination. The virtues St. Francis displays here are not unlike those of the Samaritan in Jesus' well-known story. Heedless of his own concerns or needs, that Samaritan, too, helped a man lying by the roadside. And in telling the story, Jesus makes clear what we owe any human being in need. The story is powerful precisely because it confronts us with a pristinely pure situation of one human being in need and another equipped to bring help. The Samaritan evidently has no children back home whose needs require that he keep some money in his checkbook. But this is not the way life often seems to be for most of us, who may not be called to be St. Francis.

Very often — almost always, surely — we find ourselves committed in different ways to different people, and, therefore, obligated in a number of ways. To describe such circumstances in the language of virtue will not dissipate our problem. The compassion and loyalty a woman physician feels for her patients are not virtues entirely distinct from the compassion

and loyalty she feels for her children. Suppose she is a nephrologist who must dialyze HIV+ patients. Suppose also that she is pregnant. What are her obligations? What would virtues like compassion and loyalty dispose her to do? I, at least, would not be prepared to argue that her professional commitment unremittingly requires her to dialyze those patients. The profession of physician does not swallow up the totality of her life. As Augustine thought, albeit with some reluctance, that a priest might flee so long as another remained behind and the Christian community was not abandoned, one might argue that such a physician, assuming she does not abandon her patients to no care at all, does no wrong and falls short of no excellence the profession of physician *requires*.

This argument should not be pressed too far, however. Such a physician, I have suggested, is bound by other ties as well, not only by the commitments of her profession. She may, for example, consider carefully what she owes her children, or the unborn child she is carrying, when deciding her duties as a nephrologist. Just as physicians have always had to make such judgments in the most elementary of ways — when they parcel out their time between profession and family — so also in these circumstances the physician's selfhood is not swallowed by her professional commitment or, if it is, it ought not be. But at the same time, she dare not forget that her most important legacy to her children may be the image of care-full, self-giving commitment to the needs of others which she imprints upon their memory. We may conclude that turning from a contract-based to a virtue-based model of medical care will not unqualifiedly obligate physicians, even though this model may well capture more successfully the meaning of professional commitment.

Criticism of Recommendation

From a rather different direction, Edmund Pellegrino has criticized the recommendation of Zuger and Miles that we learn to think of the medical profession in terms of its characteristic virtues.[14] If I now proceed to disagree with him as well, I do so with some trepidation, since Pellegrino is a wise physician from whom much can be learned. He is dissatisfied with the argument of Zuger and Miles because — staking so much on the concept of virtues, excellences that should be developed within the profession — it suggests, erroneously he argues, that "altruism is nonobligatory" for physicians. By contrast, he claims that there are three reasons internal to the profession of medicine which distinguish it from some other occupations and make altruism obligatory for physicians.

First, the very nature of illness makes the sick person especially vulnerable and dependent, forced to place considerable trust in the physician. And, Pellegrino writes, such a medical need in itself "constitutes a moral claim on those equipped to help." This seems to me essentially correct, but inadequate to support Pellegrino's claim that altruism is obligatory for the physician. It indicates that medical need constitutes a

prima facie claim on the physician, but I cannot see that this claim must always be stronger than others. To remain with the example I used earlier, the children of a physician are also in a "uniquely dependent, anxious, vulnerable, and exploitable state" with respect to their parent. Of that state, we might also say what Pellegrino says of the patient's condition: it "in itself constitutes a moral claim on those equipped to help."

The weight of the argument must therefore be borne by the second and third reasons Pellegrino gives — reasons which are very closely connected. He argues that those who enter the medical profession "are automatically parties to a collective covenant" which is not to be interpreted unilaterally by them, and that "this covenant is publicly acknowledged when the physician takes an oath at graduation." These are powerful arguments. Physicians surely owe a considerable debt to the community for the knowledge and skill they have acquired — knowledge and skill for which they will be rewarded with considerable affluence. The cost of their training has been subsidized in certain ways. More important, they are indebted to generations of patients who have offered themselves as subjects for experiments or objects of study in a teaching hospital — or, even, as quasi-experimental subjects in the early years of a physician's practice.[15] It is important, therefore, that physicians not understand their care of the sick in purely philanthropic terms, as if they had not also been needy recipients. Pellegrino is right, I think, to argue that *covenant* characterizes the physician's role better than *contract* and that some measure of altruism is therefore obligatory.

William F. May, whose viewpoint is not unlike Pellegrino's, has noted that grounding obligations of physicians in contract is a way of trying to keep commitments limited — an understandable way, let us hasten to add, since one may well drown in the sea of human need. Physician contractors, May says, "dart in and out of the patient's world of need, . . . guard their own interest, specifying carefully the precise amount of time and service for sale."[16] By contrast, "covenants cut deeper into personal identity . . . . Initiation into a profession means, in effect, that the physician is a healer when healing and when sleeping . . ." (p. 119). This is Pellegrino's point, a powerful one. We should notice, though, that even Pellegrino does not press it quite as far as one might have expected. Referring to the physician's oath, he concludes: "*Some degree* of effacement of self-interest is thus present in every medical oath."[17]

Let us pursue that "some degree." I have suggested that obligations of physicians to patients may be limited by their obligations to others. But, still more, their obligations may be limited simply because professional commitment does not encompass the totality of the physician's person. At some point obligation ceases, and continued service becomes supererogatory. Without thinking of physicians *simply* as contractors we can and should say that. How much can be *required* of physicians? Must one be St. Francis redivivus to enter the profession? May notes that, interpreted in ways not unlike his own and Pellegrino's, "a covenantal ethic would appear

to contribute to a self-consuming, eventually destructive commitment" (p. 183). We are likely to avoid this, he thinks, only if we do not uproot the concept of covenant from its original context — a religious one.

> One cannot fully appreciate the indebtedness of a human being by toting up the varying sacrifices and investments made by others in his or her favor. The sense that one inexhaustibly receives presupposes a more transcendent source of donative activity than the sum of gifts received from others . . . . Thus action which at a human level appears gratuitous, in that a specific gratuity from another human being does not provoke it, still, at its deepest level, as gift, answers to gift (p. 129).

May suggests that such a notion of covenant, grounded in the religious sense of oneself as an inexhaustibly needy recipient of divine grace, may produce "an inner freedom and nonchalance that make a deeper commitment to others possible" (p. 184). It may permit a physician "to function in a 'hardship post,' . . . without being annihilated thereby" (p. 184).

I have quoted May at such length because I believe he does, in fact, lay bare the background beliefs that must underlie Pellegrino's vision of the physician's role. To the degree that his explication is a perceptive one, however, we may again become reluctant to press too rigorous a notion of physicians' obligations. Zuger and Miles note that, in the face of the Black Death, many medieval cities hired a "plague doctor": "a municipal employee who was given a home, a salary, and citizenship; in return he agreed to 'treat all patients and visit infected places; in as it shall be found to be necessary,' thus relieving his colleagues of this obligation."[18] That is to say, even in a culture more religious and less pluralistic than ours, the morality of plague time seemed to fall back upon contract — upon a sense that certain actions were supererogatory for all who had not explicitly agreed to undertake them.[19] We may put the point this way: The morality of plague time, if that is what we actually face, will inevitably force upon us a two-tiered system of caregivers. One way to structure those tiers is to distinguish between those physicians who have and who have not explicitly contracted to face certain threats. Another way is to encourage the development among some physicians of dedication to service that goes beyond what can be called obligation. We cannot presume that all well-intentioned and sincere physicians know what is, in fact, the ultimate truth: that they are inexhaustibly gifted by a transcendent Giver. And even for those who do so understand themselves, we cannot presume to circumscribe the call of God, as if all were called to be like St. Francis. And we should even be willing to recognize, as Augustine was in a very different context, that one may be overpowered by fear. *We* cannot command courage because, unlike God, we cannot give what we command. We can only seek to instill it, honor those who exemplify it, and when we are in need of it, pray, as Augustine says, for the charity which is from God.[20]

References

1. Nagel, Thomas, *The View From Nowhere* (New York and Oxford: Oxford University Press, 1986), p. 202.

2. Doyle, Sir Arthur Conan, "The Adventure of the Dying Detective," in *The Complete Sherlock Holmes, Vol. II* (Garden City, NY: Doubleday, 1930), p. 933. This passage was first called to my notice in a letter to the editor by Warren Boroson, *New York Times,* Nov. 9, 1987, p. 26.

3. Defoe, Daniel, *A Journal of the Plague Year Written by a Citizen Who Continued All the While in London* (London: J. M. Dent & Sons, 1908). Everyman's Library Edition, pp. 269-272.

4. Letter 228 in Saint Augustine, *Letters, Volume V* (New York: Fathers of the Church, Inc., 1956), pp. 141-151. Citations in the paragraphs that follow will be given by page number in parentheses within the body of the text.

5. I overlook the fact that Paul, as one who claimed to be an apostle, may in fact have occupied a position unlike anyone else in Damascus. Augustine simply assimilates Paul's circumstances to those of a later period in the Church's history, after the development of certain offices. No doubt Honoratus would have agreed.

6. St. Augustine, *Confessions,* translated by Rex Warner (New York: New American Library, 1963), X, 29, 31, 37.

7. *Origins,* 17 (Dec. 24, 1987), pp. 481-489.

8. *Ibid.,* p. 485.

9. Zuger, Abigail, M.D. and Miles, Steven H., M.D., "Physicians, AIDS, and Occupational Risk: Historic Traditions and Ethical Obligations," *Journal of the American Medical Association,* 258 (Oct. 9, 1987), pp. 1926f.

10. *Ibid.,* p. 1927.

11. *Ibid.*

12. Kass, Leon, *Toward a More Natural Science* (New York: Free Press, 1985), p. 242.

13. *Ibid.,* p. 243.

14. Pellegrino, Edmund D., M.D., "Altruism, Self-interest, and Medical Ethics," *Journal of the American Medical Association,* 258 (Oct. 9, 1987), pp. 1939f. Citations of Pellegrino in the paragraphs that follow will be taken from this two page essay.

15. In addition to Pellegrino, cf. William F. May, *The Physician's Covenant* (Philadelphia: The Westminster Press, 1983), pp. 112ff.

16. May, p. 128. Further citations of May will be identified by page number in parentheses within the body of the text.

17. Pellegrino, p. 1939. Italics added.

18. Zuger and Miles, p. 1925.

19. Cf. Nagel, p. 204: "The appearance of supererogation in a morality is a recognition from an impersonal standpoint of the difficulties with which that standpoint has to contend in becoming motivationally effective in the real life of beings of whom it is only one aspect."

20. My thanks to David H. Smith for his comments on an earlier draft of this essay.