The Case for a Medicinal Ethic

Olivier de Dinechin SJ

What are the effects on moral theology of the arrival of the AIDS virus? In society as a whole, both in individuals and institutions, we could say that this virus has functioned as a 'catalyst', emphasising the reflexes, the ideologies, what is commonly shared and what is unspoken[1]. In the Church as well, the stir has been significant, and we have more than once commented on the episcopal statements which have appeared in all the countries affected[2]. The moral theologians have had to face questions from journalists, from colleagues or in their relationships with the Magisterium.

Besides the strong recommendation to become involved without discrimination in the care of people infected by the virus, a striking phenomenon in this stir is the widely-shared impression—widely shared inside as well as outside the Catholic Church—that a certain kind of moral language is not suitable for those who are in the most direct contact with AIDS: the sick or people who are HIV Positive, their families, those caring for them, those responsible for public health, the scientific researchers and the pastors themselves. This gap was evident even at the international level, at the 4th Conference on AIDs organised by the Vatican, which took place on the 13—15 November 1989. Some of the moral theologians appointed to speak from the platform left speechless the majority of the thousand participants—priests, religious, doctors, directors of institutions—who had assembled from all over the world. The structure of an exclusively normative moral discourse, reasoning by deduction from principles to 'cases' which it is a matter of 'normalising', if possible in a total way, seemed extremely alien to the people who were practically involved. Many of the audience, however good-willed, thought that to follow such conclusions would be certainly immoral.

Rather than confine ourselves to an academic conflict which is not, frankly, a novel one in the history of moral theology and which, for the past fifteen years, has been quite vigorously debated in the U.S.[3], we would like here to sketch the characteristics of an ethic which will better meet the expectations of those whose Christian vocation does not place them on conference rostrums but among people affected by a dreadful disease. It seems to us, in fact, that AIDS calls for what we could name a 'medicinal ethic'.

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An aim and a thought-process

'Medicinal ethic': let us explain these two terms. First of all, *the ethical* here will be distinguished from *the moral,* in line with Paul Ricoeur[4]. An ethic is defined by him as an aim, as the option chosen by a person who wants to live in a good way, having—Ricoeur specifies—a threefold concern: self-respect, consideration for others, and respect for the institution. *The moral,* on the other hand, is the knowledge, the following and the affirming of norms, and it is defined rather by its form, or even by the imposition of principles and rules (for instance, the *Golden Rule,* or the Kantian maxims). The ethical aim calls for the formalising of morals, but this latter is not for it enough. For it is in the real-life situation that the ethical aim is practised, expressing itself in choices and behaviour.

Ethics does not exist without subjects, in other words human beings endowed with desire and conscience. To talk about ethics is to talk about them, their situation, their history and their projects. In the context which concerns us here, we cannot disregard the fact that they are sick persons, and persons dedicated to caring for the sick, and educators; also that their history is related to AIDS.

Therefore to give the adjective 'medicinal' to ethics specifies the aim of both the persons and this branch of ethics. It is wider than what is meant by medical ethics, namely the ethics of the medical man. Its aim is shaped by confrontation with a disease and desire to escape from it. In that way it is distinguished from, for example, ethics with a juridical aim or even an educative aim. An educative ethic focuses on the possible evil not to commit and the good to accomplish, a juridical ethic on the wrong to punish. We do not deny the relevance of these branches of ethics. It seems besides that the magisterial discourse of the Church is rather heavily impregnated with an educative aim, and we will not question whether one can knowingly do without such an aim. But it seems to us that it cannot serve as a substitute for a medicinal ethic, and still less reject it.

In a medicinal ethic, the concern for others takes the form of caring for the person's physical or moral wound, and—as in classical medical ethics—its first rule is not to harm: 'primum non nocere'. The rule of reciprocity—'do not do what you would not like done to you'—reminds everybody of his or her own actual or potential weakness. And because this weakness reveals itself as much moral as physical, the precept 'not to harm' is translatable as 'not to judge', in the sense of 'not to condemn'.

Is that to say such an ethic ignores the institution—in other words, discards the third aspect of the three-fold area of concern defined by Ricoeur? Does it focus solely on the private relation between person and person, neglecting or rejecting the relationship with society in so far as the society institutes the widely normative relationships between persons and groups? The social dimension of the epidemic itself prevents such a withdrawal, of course. But the question immediately arises whether this

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institution maintains with its members a medicinal relationship or a relationship of exclusion and destruction. Concern for the institution leads here to a strong demand regarding the institution itself: that it be a place of life and welcome, that it be, in the basic sense, 'hospitable'.

The beginning : infection by the disease

What is characteristic of a medicinal ethic is first of all its source in a special connection with the problem of suffering. In this place and time, illness is neither an academic hypothesis, nor an eventuality to avoid in a still free choice, it *affects* people, their relationships, the situation. It is felt in its gravity, and inexorability. It brings suffering.

AIDS puts people in exactly this plight. Physical illness touches what Xavier Thévenot calls the 'three rocks of reality: basic security, the seriousness of our temporality, and sexual difference.'[5] It weakens the foundations of the awareness of existence, the possibility to place and orientate oneself. The peculiar gravity of AIDS, even in comparison with other mortal illnesses like cancer, raises in an especially acute form the immemorial question'Why?', the problem of the origin of suffering.

This question concerns the link between the present physical suffering and a 'moral' reason for its appearance in the subject: 'Why me? Could I have committed some fault, and, if not, who desires that I should suffer like this, and why?' A moral abyss opens under the 'purely physical' pressure of the suffering. So a 'quite natural' virus provokes a crisis of conscience, of the mind.

Let us not imagine that this stumbling in a whirlwind will diminish when—as is the case with the majority of HIV infections—it is possible to locate 'wrongful acts', or acts considered as wrongful, done by the one infected, any more than it will be diminished by the contrast between the pleasure of a few moments and the suffering to endure in consequence. The logic of retribution leads you maybe to weigh these things up, but it does not bring you to a point of equilibrium offering stability.

In this vacuum, a 'religious' reply is also sought, and the possible faces of God—creator, law-giver, accuser, judge, advocate—come to mind. The universal mythological references surface from the unconscious to represent what cannot be represented of the origin of evil, and to try to close the inside gap. Around the great symbols of blood, sex, life and death, made palpable by AIDS, the religious imagination is put in motion as well. But will it find a point of anchorage?

'The suffering is what one struggles against when one has given up explaining', states Ricoeur[6]. The suffering must not be, it ought to be no more. Stopping asking questions about retribution, I decide to fight it. With the making of such a decision, taken on the edge or in the abyss of the radical question of suffering, the medicinal aim of ethics comes in. It is necessary to heal, to save.

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To heal and to save

To heal of physical illness, to save from moral suffering: this is what we must try to do without waiting for the relationship between the two to be clarified.

Historically, this relationship has never been totally clarified. Dr Henry Ey, studying the origin of medicine[7], noted the confusion between illness and sin present in the ancient cultures, including the culture which is recorded in some parts of the Bible. He also noted how Greek thought and Christianity came to distinguish the two, although approaching the question from different, even opposed, points of view. The naturalist and rationalist thought which little by little appeared among the Greeks emptied the notion of sin; on the one hand it objectified the evil by putting it in juridical terms within the context of the social system, on the other hand it objectified the illness by locating it within the natural harmony of things. Christian thought, in contrast, interiorised the notion of sin in locating sin and law in 'the inner man', and then, drawing on the reply Jesus gave regarding the man born blind (Jn 9: 1—3), it could later on give an almost naturalistic interpretation to physical suffering. A man like Gregory of Nyssa, in the 4th century, will go as far as denouncing the analogy between sin and illness.

The analogy, however, persists: there are so many pages in the gospels in which Christ manifests the *salvation* which he brings through signs (semeia) of *healing*. His disciples will have to bring healing to manifest salvation, and for that they receive authority and power. A medicinal ethic thus does have a natural place in a Christian vision of salvation.

A hospital chaplain, the theologian Louis Perrin, has recently written on the relationship between *to heal* and *to save*[8]. He takes for his basis the spontaneous stories through which the sick themselves express at one and the same time this twofold desire for healing and salvation, and through which they link the desired healing with the sense that they give to their whole existence. From this basis the book plunges straight into the world of symbol, where these two orders of the unique human reality communicate. We are recommended to read the *parables* of healing and salvation which are conveyed in the stories of the sick, as well as in the act of telling such stories to those who are able to hear them, and in the act of listening to them.

It seems to us that this approach, strongly influenced by the human sciences (psychology, structural linguistics), throw light on what we would willingly call 'the horizon' of medicinal ethics. As much in the perception of suffering as in the desire to fight it, a symbolism is present. It is in this horizon that facts and gestures are experienced, that speeches are interpreted and that intentions and consequences are judged. In this way, a medicinal ethic criticises and directs the words and acts of the doctor, the patient, the educationalist, the judge, the friend.

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Human presence

If a medicinal ethic comes into being, is grasped, in the disorientation of suffering, in the decision to heal and to save, if it has for its horizon the symbolism of salvation, then we straightway see that it implies a relationship between persons. There seems at the beginning to be a dissymmetry in this relationship, since it is a relationship between a sick person and a fit one. However, the dissymmetry has already gone because the fit person experiences the shock of the question put by the sick person. There are indeed doctor and patient, saviour and lost, but their meeting has already prompted the ethical decision which will keep them close. Very quickly, listener and speaker have exchanged their roles, and who can say which of the two knows best what is going on between them?

The place of medicinal ethics can only be this presence. The presence of bodies, for the physical closeness allowing the seeing, the listening, the touching, which are almost immediately significant. Also, however, moral or spiritual presence, through the reading of these signs and through the exchange of words, through conversation. Presence marking the present in time, this moment where we reach each other.

The reciprocity in every human presence takes here the form of sympathy in its etymological sense (*syn — pathein*) of compassion. We think of the biblical term for 'mercy', with its connotation of 'bowels' stirred in their depths by what is communicated between the two people of the pain endured, of the disorientating weakness, of the desire to heal. As John-Paul II writes, 'Mercy is the form that love takes in contact with suffering.'[9]

Let us clearly understand that such an attitude has its severe side. As Paul Claudel put it: 'Mercy is not a soft gift of the thing of which we have too much, it is a passion like science. It is a discovery like the knowledge of your face in the depth of the heart that you have made. If all your stars are necessary for me, how much more are all my brethren?'[10] A medicinal ethic, an ethic of mercy, does not lead to a laisser-faire attitude, tolerant by condescension. To remain in this state of presence, not escaping into the shelter of justifications, soon demands a faithfulness beyond reasonable human explanation.

The weight of circumstances, the uncertainty of time

Where life and the choice to live well are at issue, every ethic tackles in the concrete the reality of the circumstances. The medicinal ethic does the same, but takes on besides a specially heavy burden: it cannot hope to dominate the circumstances. It faces situations that are blocked, repetitive, and without a clear termination. It cannot avoid the question of 'the lesser evil' because every word said, every act done, will reactivate part of the evil rooted in the situation itself. Like the doctor who must 'make do' and often be satisfied if he secures not the patient's health but less suffering, a medicinal moral choice only rarely brings perfect purity.

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Ethical dilemma is frequently—if not always—present in such a choice; hence new questions face us. For instance, whether we should permit the sale of syringes to drug-takers. And, even if we do permit the sale and notice a slowing down in the spread of the virus and a certain growth of responsibility among drug-takers, we have not yet finished: what are we to do next?[11]

The resolving of a dilemma being by definition inadequate, clearly time is a specially crucial consideration in medicinal ethics. The times and moments matter a lot. But the presence of suffering colours them in a special way: the past is characterised by its weight of misfortune, the present by urgency in the face of the unbearable, the future by uncertainty. Once again we notice how different this sort of situation is from an educative situation, in which the partners can draw resources and positive references from the past, take on the present at its own rhythm, and envisage a future of progress with reasonable certainty. For people who are HIV Positive this future appears particularly problematic immediately after the diagnosis of the virus: how long, they ask, will that future be, how fit will one be, what—above all—will be the possibilities of choice?

Despite that, a medicinal ethic will remain concerned with improvement: that is to say, first and foremost with not saying words or committing acts which would block the situation, which would indeed make the sufferer regress, but acting rather in ways to reopen the future.

The goad of the moral law

The preceding reflections have already enabled us to have some sense of the moral values, and even the fundamental demands, which control a medicinal ethic: namely, respect of persons, concern that they should rediscover a sensible moral and physical life, true and faithful presence. However, morals contains other norms that we cannot reject nor even relativise under the pretext of the priority of what we have been writing about. Furthermore, these other norms were at work in the ethical dilemmas which we have been discussing. They are notably those of the 'institution' of which Ricoeur speaks, for example the duty of self-preservation—which the drug-taker transgresses—or the network of rules controlling sexuality, dominated in every culture by respect for the differences between the sexes, the difference of generations, the differences of ages and the marriage laws. Neither should we forget the rules of the medical institution, with its forbidding of killing or harming, and the requirement of confidentiality.

But these instituted norms all express, at different levels, the moral law such as consciences experience, that inner law undoubtedly difficult to grasp but of which the absence is unthinkable, because it would reduce to nonsense both the individual and society. Whatever are the discussions of moralists on its nature, its content and universal character, its basic authority has to be considered by medicinal ethic, as by every ethic.

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But, and this is the paradox, this ethic will be more frequently open to the negative impact of the moral law. In the disorientated questioning on the origin of suffering, in the infernal logic of retribution, we well see the moral law acting like a goad. This it is which accuses, which enquires, which questions. With St Paul, we confront that accusation which finally proves every human being guilty of sin, and then condemns him to death. This corresponds to the concrete facts. For example, in being forbidden to buy syringes, the young drug-takers not only hear their social exclusion being ratified but also their survival being forbidden and consequently they are hearing their condemnation to death. Coming to grips with this lethal process developing thanks to the moral law is, it seems to us, the most central characteristic of a medicinal ethic. In cases like this, the law has no educational role, and its juridical character invades excessively, even nonsensically, the area of human and social relationships. The deepest relationships, like the one of father and son or of wife and husband, are invaded by a form of breach denying all possibility of a new start. The decision to fight the present suffering leads to conflict with the lethal effects of the law. Is it necessary for a medicinal ethic to fight the law itself? Is there a contradiction between morals and ethics?

To fight the law, denying that it has a value in the given case, that it has value in any case, that it even exists: this has been a temptation for more than one person. But it leads quickly to relativism, then to anarchy, to roads which not only have no exit but are, above all, unreal when you feel you are bearing a weight of guilt which will not go away. Therefore we must find other ways.

To make the story possible: the admission

For some years, numerous moral theologians have discovered the importance of the 'story' in the human being's search for meaning. Life does not 'go without saying'. And this 'saying' certainly is not limited to prescriptive, juridical, and other statements. The story about events has an essential place, both at the individual and collective level. All ethical living includes the hearing of stories, the projection of oneself into these stories, and the active narrating of what we have lived ourselves. The biblical deposit as a whole, including the part called *Torah* (law), which contains both stories and precepts, is a model example and witnesses to this fundamental human fact.

Aware of the importance of speaking and hearing, the medicinal aim turns again to the question of suffering. But this suffering is often such as cannot be put into stories. It continues to be expressed in the indefinite juridical debate, which exhausts itself in searching for a prime cause and is, frankly, nonsense. Sometimes also, the suffering is totally inexpressible. We can see how, for example, with people involved in incest, with the rape of a child or a serious family crisis, the words to speak about it do not come, as if they were barred, and as a result the deep sense of blame goes on growing.

Faithful to our aim, we will seek to restore the possibility to speak, and

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that, for a beginning, by creating the necessary conditions. A respectful presence, hearing, not judging, comes first. It goes together with the availability of pardon.

We use with some hesitation the words of pardon and admission, used too much ritually, hardened too much by juridical use. However, they designate a key process in medicinal ethic: the moral suffering is healed in the admission which leads to pardon. But who can forgive? The Gospel supplies a key answer: the one who is and knows himself forgiven. But how does he know it? In faith which brings about in its turn the desire for pardon and the act of pardon. In moral terms, the law of reciprocity between human beings takes for content, at this moment of the relationship, the admission and the pardon: desire the pardon, admit and receive it, you who forgive; forgive, you who desire the pardon. This is absolutely essential.

In practice, in the real conditions, arrival of the admission and entry into this dialectic of pardon call for time and require real work. It is not just enough to announce the pardon for it to be received. Besides, who can say for himself that he is totally engaged in this process? Every pardon makes history, in the same way as it has a history.

Nevertheless, bit by bit the story takes shape: a less vindictive acknowledgement of the present and past situation, an account with no events tucked out of sight, an account with the facts put in a certain order, in a calmer light in which what is significant and the links between yesterday and today begin to emerge.

Acknowledgement of this link between past and present allows the future to be half-open, we note. The saying, 'Rise up and go' can henceforward make sense, even if the one who hears it does not know where he is really going. The saying 'Sin no more' summons him to find how to do that in a new relationship to the moral law, being reinstalled in the desire to live.

Personal accompaniment, social hospitality

We have attempted to some extent to sort out and put into words the most important elements of a medicinal ethic, and notably the relationship of this ethic to moral values, to norms and to the law. We have done it by taking into account the experience, made more difficult by AIDS, of those in the Churches, as well as in the wider society, who are in direct contact with the sufferings of humanity. Two more narrowly defined lines of development should be pursued: the status of an ethic of the relationship between two people, one of whom introduces himself as infected by the illness; secondly, the status of a social ethic of hospitality. As a matter of fact, it would be again a matter of recapturing an experience quite widely shared, and formulating the conditions of sensible human practices.

For the first, the interpersonal accompaniment, we have already noted a few basic requirements: the presence, a reciprocity in talking and listening, a lasting faithfulness. But we would have to define the conditions of a presence without complicity, the manners of practising non-directivity

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according to whatever formal or informal role we happen to be in (doctor, parent, teacher, spiritual counsellor, friend ...), the network of relations to maintain to assure that the one who is listening to somebody else is himself listened to (i.e. the ethical value of the practices of 'supervision'). All these points are touched on in a practical literature often called pastoral or spiritual. The Christian ethic and Catholic moral teaching cannot ignore them or consider them as merely subordinate, but will have to integrate them.

Regarding the social dimension of need for hospitality, it would seem that forbidding the elimination of the bearer or of the person responsible for the suffering—forbidding condemnation to social death—is a less advanced task. The spread of AIDS prompts Church institutions to revive the charism of hospitality in new forms. Without waiting for official initiatives, through non-confessional associations of people who are HIV-infected themselves or who are caring for people sick with AIDS, a process of social healing different from exclusion or bare tolerance is already emerging. It will perhaps make it possible to get away from the opposition between respect for the life of the individual and protection of public health and morality which has dominated until now the social ethical debates on AIDS.

By the multiplicity of its aspects and by its revealing depth, AIDS has put into motion in these last years of the century all sorts of women, men, and institutions. The moral theologians stirred by this disaster and moved by this response must promote a medicinal ethic ... which is nothing other than an ethic of Salvation.

1 Cf. Xavier Thévenot in his interview with Emmanuel Hirsch, *Le sida, rumeurs et faits*, Le Cerf, Paris, 1987.

2 For example, the periodical *Actualité religieuse dans le monde*, March 1987, or Bernard Matray, 'Eglises et sociétés face au sida', *Le Supplément*, no. 170, September 1989.

3 It concerns the quarrel between moralists who describe themselves as 'déontologistes', 'conséquentialistes', 'utilitaristes', 'proportionalistes'. Regarding the prevention of AIDS, see for example the criticism of the problematic of the lesser evil used in the declaration 'The Many Faces of AIDS' published by the United States Bishops' Conference, criticised by Janet E. Smith, 'The Many Faces of AIDS and the Toleration of the Lesser Evil', *International Review*, XII, 1, Spring 1988.

4 Paul Ricoeur, address to a colloquium at the Institut Catholique de Paris, 19 January 1989, referred to in an interview published in *La Croix*, 18 March 1989.

5 Xavier Thévenot, op. cit., p. 179.

6 Paul Ricoeur, 'Le scandale du mal', *Nouveaux Cahiers*, no. 65, Summer 9[illegible]. republished in *Esprit*, July-August 1988.

7 Henri Ey, *Naissance de la médecine*, Masson, 1981, pp. 111—14[illegible].

8 Louis Perrin, *Guérir et sauver*, Le Cerf, 1987.

9 John Paul II, encyclical *Dives in misericordia*, 30.11.1980, passim. We wish such statement would impregnate all Catholic teaching on morals: 'This requirement (of mercy) ... constitutes the essence of the evangelical moral and ethical teaching', writes the Pope.

10 Paul Claudel, *Oeuvre poétique*, 'Cinq grandes odes, cinquième ode', Bibliothèque de la Pléiade, 1967, p. 282.

11 See my article, 'La traverseé du dilemme', *Christus*, no. 134, April 198[illegible].

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