Bioethics and the Body: Moral Formation in the Hospital

by

Michael Brett McCarty

Date: 4/23/2018

Approved:

Luke Brubaker, Supervisor

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Mary McClintock Fulkerson

Stanley Hauerwas

Gerald McKenny

Dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Theology in the Divinity School of Duke University

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ABSTRACT

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Abstract

This dissertation explores the formational power of healthcare as revealed in the modern hospital, offering a constructive theological and moral response to two interrelated questions. First, how should the work of healthcare be described? Answering this question requires careful attention to distinct formations of patients and practitioners undergirded by tacit theological assumptions. Second, what moral responses are fitting for these descriptions of the work of healthcare? In contrast to the standard prescriptive approach in modern bioethics, the moral concerns and sources present in contexts of action must be articulated in order to enable prudential moral guidance. Through engaging the relationship between moral description and prescription in the modern hospital, this dissertation argues that the practice of healthcare should be ordered within an overarching moral and theological vision of hospitable bodily care.

In dialogue with writings in phenomenology, ethnography, and history, the dissertation excavates the theological, philosophical, and political assumptions that undergird different accounts of the work of healthcare in the hospital. Within this institution, bodily disruption is imagined and engaged in distinct ways, which form how patients and practitioners speak, perceive, and act. This formation is examined in three paradigmatic medical sites within the modern hospital: the surgical ward, the Intensive Care Unit, and the labor and delivery ward. Within them, the patient’s body is imagined and engaged as enemy, object, and friend. These medical imaginaries are made possible by the development within the modern hospital of distinct arrangements of discourses, practices, and practitioners, each undergirded by particular normative schema.
By articulating the moral sources and conflicts within the modern hospital, the project illuminates the moral theories of three prominent Christian bioethicists: James Childress, H. Tristram Engelhardt, Jr., and Stanley Hauerwas. I argue that Childress offers a just-war inspired bioethics fitting for conflictual encounters, and that Engelhardt’s position, as developed by Jeffrey Bishop, ultimately counsels separation in light of the objectification of the body that occurs in the modern hospital. In his writings, Hauerwas offers an account of care befitting the institution’s roots in practices of hospitality. By developing this moral vision through the work of Luke Bretherton, the dissertation articulates a postsecular approach to bioethics, one that seeks to work within and across robust moral communities to foster the conditions and possibilities of hospitable bodily care.

The project argues that the dominant modes of imagining and engaging the patient’s body in the modern hospital—as enemy and object—do not have to be fundamental. Instead, a constructive normative vision of hospitable bodily care can order the practice of healthcare within the modern hospital. The theological underpinnings of this overarching moral framework are provided through understanding the encounter between patient and practitioner as a Christologically charged event, as depicted in Matthew 25 and the work of St. Basil. This is developed further through a pneumatological account of healthcare. The project concludes by arguing for a theological construal of the practice of healthcare as a means of participating in the Spirit’s work of befriending flesh. Through acts of hospitable bodily care, patients and practitioners are formed into the image of Christ through the power of the Spirit.
For Dana

In Memory of Allen Verhey (1945-2014)
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Introduction

I.1 Learning to Ask the Questions

Over ten years ago, in the middle of a gross anatomy lab I stopped my tour guide and friend to ask, “Why do you call dead people cadavers?” While I did not know it then, I was talking to my future wife about a question that sits near the heart of this project in bioethics. This moment came a few months into my relationship with Dana, who had recently begun her Doctor of Physical Therapy (DPT) program, and her first semester was consumed by a gross anatomy course that she and her classmates took alongside first-year medical students. One afternoon, Dana took me to the gross anatomy lab, excited to show me the space where she spent much of her time. We walked around the lab peering at the various dissection that were in progress, but where she saw intricate displays of the beautiful complexity of the human body, I saw rows and rows of dead people. Why did we imagine these bodies so differently?

Throughout that fall, it became evident to me that the world of the gross anatomy lab was transforming how Dana talked about and perceived the body. As she moved through her dissections, she gained new ways of describing and handling the body. She was just as likely to “palpate” my hand, discerning the different bones and ligaments hidden under my skin, as she was to hold it during a movie. Dana was part of a formation that I knew little about, but it was obviously a powerful experience.

Fast forward a few years. Dana, now my wife, was starting work as a pediatric physical therapist in Duke Hospital’s Neonatal Intensive Care Unit (NICU) while I was entering my second year of my Masters of Divinity program. As newlyweds, we wanted to share with each other all the details of our day. We quickly realized that my coursework on the finer
points of Calvin and Kierkegaard’s thought did not make for the best table talk, and so we rightly focused in on her work in the hospital. Through our conversations, it became clear to me that Dana was undergoing another intense process of formation, one that rivaled the gross anatomy lab in its power.

As Dana worked to care for the fragile bodies of prematurely born babies, her life was intertwined with the lives of her patients and their families. She would care for an infant for months, seeking to recreate the developmental conditions of the womb in the midst of a dizzying array of technology and surgeries that never seemed to end. Over that time Dana would watch over this newborn life, delighting in developments and lamenting struggles. She would develop intense relationships with many of the parents, sharing in their joy and grief, and she would also come home deeply frustrated by apathetic parents who seemed to care little for their child.

As Dana’s life was marked by intense moral commitments to hospitable bodily care, it became evident that there was little language available to her to describe this work in moral terms. The same seemed to be true of her colleagues when I talked with them at social events. How could such an intensely moral practice have so few linguistic resources at hand to frame the inherently moral nature of the work? Could these moral commitments be sustained without ways to talk about them and communities of support? And in the midst of the technologies of the NICU and a litany of surgical procedures, how could a commitment to hospitable bodily care be maintained?

This project is an effort to take seriously the formational power of healthcare as revealed in the modern hospital. Dana’s experiences in the gross anatomy lab and the NICU are not anomalies; instead, they reveal that medical practitioners undergo intense processes
of moral formation that generate conflicts within the pressures and demands of their institutional contexts. Some of the symptoms of that pressure are on display in skyrocketing rates of burnout for medical practitioners in the modern hospital. This crisis uncovers the reality that many practitioners find their work unfulfilling. And yet responses to the crisis also are revealing; superficial solutions like resiliency and mindfulness demonstrate the thinness of the moral resources at hand. Others, sensing that the hospital can offer no substantive responses to these issues, advocate retreat from the institution, and in their search for holistic care they turn to fields like alternative medicine. Given that healthcare consumes the worlds of patients and practitioners alike, not to mention nearly 18% of the American economy, what counsel can we give?

I.2 Questions, Key Terms, and Aims

The present study offers a constructive moral response to two interrelated questions that lie at the root of these symptomatic issues. First, how should we describe the work of healthcare? This is no easy question; it requires careful attention to distinct formations

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undergirded by tacit theological assumptions. And second, given differing descriptions of the work of healthcare, what moral responses are fitting? If healthcare is like the gross anatomy lab, then certain moral responses may be warranted; if it is like therapy in the NICU, then other responses will be justified. Can we order these competing descriptions and prescriptions toward a single end, and if so, how? At its heart, then, this project is concerned with the relationship between moral description and prescription in modern bioethics.

Pursuing the relationship between moral description and prescription in modern healthcare is unavoidably theological work. The practices and institutions of modern healthcare have deep theological roots, and the very field of bioethics was founded by Christian theologians. By clarifying the theological, philosophical, and political assumptions that undergird different accounts of the work of healthcare, we will be in a position to evaluate the moral theories offered by influential Christian bioethicists and discern their fittingness for particular medical imaginaries. By articulating these theological underpinnings of healthcare, we will be in a position to discern the conditions and possibilities for faithful Christian moral agency in modern healthcare.

At this point, clarifying the use of a few key terms is in order. This project focuses on the work of formation found within the modern hospital. When this project uses the term “hospital” it refers to an institution that is devoted to inpatient healthcare, involved in the training of medical practitioners, and open to all, at least through the emergency room. This institution sets the standard for much of modern healthcare, both through its training of early career medical practitioners and also in its standards of excellence for medical care. Within the modern hospital, we will consider the surgical ward, the ICU, and the labor and delivery ward as three paradigmatic medical sites. The term “site” refers to an arrangement
of practices, discourses, and practitioners deeply connected to recognizably distinct medical imaginaries. The term “medical imaginary” refers to a distinct mode of imagining and engaging the human body within modern healthcare. It is a specified form of what Charles Taylor refers to more generally as a social imaginary, which he defines as “the ways people imagine their social existence, how they fit together with others, how things go on between them and their fellows, the expectations that are normally met, and the deeper normative notions and images that underlie these expectation.” Because a social imaginary embodies a moral vision about the way life should be in normative assumptions that are often tacit rather than explicit, work must be done in order to articulate these normative assumptions. The same is true for a medical imaginary, both in how it forms the existence of medical practitioners within the modern hospital and in how it is often tacit and in need of articulation. Therefore, within the modern hospital there are several paradigmatic medical sites, and within each medical site we can work to discern a distinct medical imaginary.

The aims of this project are three-fold: (1) critical and descriptive, (2) hermeneutical and normative, and (3) constructive and theological. The first critical, descriptive aim of the project is to articulate the theological and moral imaginaries at work within the modern hospital. Rather than providing an exhaustive overview of the hospital, it does so through

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4 Charles Taylor, *Modern Social Imaginaries* (Durham, NC: Duke University Press, 2004), 23. For Taylor, a social imaginary is a much broader and more loosely defined phenomenon than a particular social theory; it is formed through a complex interplay of human practices and the ideas that both are made intelligible by these practices and are created through those same. I combine Taylor’s hermeneutical approach with Foucault’s attention to practices, following Gerald McKenny, *To Relieve the Human Condition: Bioethics, Technology, and the Body* (Albany, NY: State University of New York Press, 1997), 228, n. 4.

examining three paradigmatic medical sites. Within the surgical ward, the ICU, and the labor and delivery ward, distinct patterns of formation are at work, each with its own moral and theological imagination. Because no single, simple account of healthcare is capable of describing these three sites, a critical examination of each medical site is necessary, drawing from the work of phenomenology, ethnography, history, and critical theory. This descriptive work reveals medical imaginaries that make profound moral and theological claims on patients and practitioners alike. In these paradigmatic medical sites, the patient’s body is encountered through frameworks of controlled hostility, medicalized objectification, and hospitable care. The three medical imaginaries discerned within the surgical ward, the ICU, and the labor and delivery ward imagine and engage the patient’s body as an enemy, object, and friend. The critical, descriptive aim of this project immediately lends itself to a second aim.

The second aim of this project is hermeneutical and normative, on at least two levels. First, each medical imaginary provides a hermeneutical lens through which moral sources and conflicts can be articulated and placed into conversation with particular moral theories. By identifying the moral sources and conflicts at work within particular medical sites, this hermeneutical approach assists the normative work of discerning fitting moral responses. It does so by placing the work of James Childress, H. Tristram Engelhardt, Jr., and Stanley Hauerwas in critical dialogue with the problems illuminated by the hermeneutical lens of particular medical imaginaries that construe the patient’s body as enemy, object, and friend. Second, the project’s hermeneutical and normative aim applies to the institution of the hospital as a whole. The three distinct medical imaginaries within the modern hospital articulate fundamental moral concerns within the institution, and this overarching
hermeneutical lens enables normative judgments about how action throughout the hospital should be ordered.

This brings us to the project’s third aim, which is constructive and theological. These three medical imaginaries are not simply offered as a triptych of moral formation in the modern hospital. Instead, the witness of these three medical imaginaries is constitutive of the argument of this project, for it makes possible judgments about Christian faithfulness. If the hospital is an institution in which the body is imagined and engaged as enemy, object, and friend, then Christians should construe the practice of healthcare as fundamentally a means by which we can participate in the Spirit’s work of befriending the body as part of the body of Christ. Therefore, this project aims to offer a pneumatological and Christological account of the work of healthcare.

This project’s descriptive, normative, and theological aims are woven together throughout the work, building upon each other to understand the modern hospital as a site of moral and theological formation and to argue for a particular Christian account of the practice of healthcare. In this way, the project serves as a work in both bioethics and Christian ethics, and to those two fields we now turn.

1.3 Contexts: Bioethics and Christian Ethics

As a work in bioethics, this project operates in a field that has its origins in a series of controversies over the body. One set of controversies concern the horrible injustices inflicted upon vulnerable bodies through medical research, ranging from Nazi Germany to Tuskegee, AL. Another set considers disputes over new technologies such as dialysis and in vitro fertilization, and whether or not it is permissible to use these on the body, and, if so, how. Finally, a set of controversies endures over bodily interventions at the beginning and
end of life, from embryonic stem cell research and abortion to organs transplanted from brain-dead donors and physician-assisted suicide. In all these controversies, the body is central, both in how it is imagined and how it is engaged.

In the earliest days of bioethics, theologians had something to say in response to these public controversies, though they certainly did not speak with one voice. Theologians like Paul Ramsey and Joseph Fletcher debated these bodily interventions in the public sphere, and theologically-trained thinkers filled the ranks of the first bioethics institutes. Daniel Callahan, one of the founders of The Hastings Center, reflected on the role of theology in this period, saying, “When I first became interested in bioethics in the mid-1960s, the only resources were theological or those drawn from the traditions of medicine, themselves heavily shaped by religion.” By passing on the wisdom of the body contained within their traditions, these religious thinkers played a fundamental role in creating what is now known as bioethics.

Allen Verhey describes this period of theological retrieval as “the renaissance” of bioethics, and he claims that it was followed by an “enlightenment” during which all overtly theological claims in bioethics were stripped away. The eclipse of religious reasoning in mainstream bioethics is a generally agreed upon phenomenon, though the reasons given

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8 Verhey, Reading the Bible in the Strange World of Medicine, 13-19.
John Evans argues that the loss of theological voices was the result of a debate over moral ends coming to a conclusion. This was not because of any definitive intellectual resolution, but because of the emerging hegemony of Beauchamp and Childress’s approach to bioethics, principlism, which ultimately provided the ends by which everyone else argued. As the principles of respect for autonomy, beneficence, nonmaleficence, and justice became established as the dominant discourse, both the role of theology and the place of the body retreated from bioethics.

According to Verhey, however, discontents with secularism have resulted in a desire for something like an “awakening” in bioethics, and with it more attention to the substantive moral and theological commitments found within religious traditions and communities. Likewise, Evans argues that “we have to have a debate about what our ends should be,” and he claims that theologians are uniquely positioned to contribute to this debate within the sphere of “cultural bioethics.” Theologians are not alone in contributing to such an “awakening” in bioethics, as morally rich work has come from medical anthropology,

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10 According to Evans, the dominance of principlism came first in research and public policy ethics, where the government had jurisdiction and proceeded to endorse principlism as the system of abstract knowledge that would govern work in this new field of bioethics. Principilism quickly extended its reach to clinical ethics. Evans, The History and Future of Bioethics, 3-72.


12 Evans, The History and Future of Bioethics, 155, 160-161.
In these fields the body has once again been foregrounded for moral reflection.

This dissertation seeks to advance what Verhey refers to as an “awakening” in bioethics, by bringing together renewed theological reflection on the practice of healthcare with sustained attention to the place of the body in bioethics. In order to engage in moral reflection about healthcare, this project takes as its starting point the daily work of imagining and engaging the body in the modern hospital. A fitting moral response for modern healthcare can be given only once this formation has been taken into account. Such formation is deeply theological, as the moral commitments engrained in the practices of healthcare and the institution of the hospital have their roots in theological understandings. Here the project extends literature on the “theological origins of modernity” to the field of healthcare. By making clear that the bodily formation of healthcare is theological work, this project seeks to draw into relief the ways in which the modern hospital is itself constituted by tacit theological discourses that shape the ways that healthcare is imagined and practiced within it. With this backdrop in mind, this project in theological bioethics seeks to display the ways in which the theological and bodily realities of contemporary healthcare must be taken seriously.


This dissertation is also a work in Christian ethics, and as such it reflects the field’s decades-long focus on formation and practices. This focus has its origins, in part, in the “ecclesial turn” in Christian ethics seen in the work of Stanley Hauerwas and others.  

Attention to formation and practices in Christian ethics can also be seen in the field’s more recent “ethnographic turn.” This project shares with these works a commitment to attending to the formational power of bodily practices as a generative site for inquiry in Christian ethics. It does so by considering the kinds of moral formation undergone by medical practitioners in the modern hospital.

At the same time, the dissertation builds off of recent work in Christian ethics that seek to move beyond a false binary that unnecessarily opposes faithfulness to the “church” and work in the “world.” In the writings of Luke Bretherton, Eric Gregory, Jennifer Herdt, Charles Mathewes, and others, we find a shared commitment to Christians doing and describing life in the public sphere in Christian terms. These thinkers have largely written as Christian ethicists in the field of political theology, where they consider how the ordinary work of earthly citizenship can be Christian ascesis. This project develops this trajectory of scholarship within the world of theological bioethics, and it does so by offering an

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18 Mathewes, A Theology of Public Life, 2-3.
understanding of how the ordinary practices of healthcare can be considered as part of Christian discipleship.

Toward this end, we consider the conditions and possibilities for faithful moral agency in the modern hospital, a setting that is both postsecular and post-Christendom. In order to argue that the modern hospital is a postsecular institution, the project will consider how theology has shaped and continues to shape the discourses, practices, and practitioners found within this site, thereby participating in work on “the theological origins of modernity” mentioned above. As a “post-Christendom” institution, the hospital is an institution that has been historically shaped, in part, by Christian commitments, but it is no longer under the authority of Christians seeking to order all of society. Because of this, Christians have the freedom to operate faithfully in a space they no longer presume to control—or so this project will argue.

Finally, this dissertation is indebted to works in feminist and womanist theology and ethics that have foregrounded the often overlooked moral importance of embodied care for others as part of normative theological anthropologies that attend to the complex formations of moral subjects. These projects have particular salience within the world of healthcare, where they join concern for bodily care with attention to the structural contexts within which such practices occur; in other words, historically marginalized subjects do

19 By using the term “postsecular” I follow Luke Bretherton’s description of our contemporary context as “a period in which, for the first time, multiple modernities, each with their respective relationship to religious belief and practice, are overlapping and interacting within the same shared, predominantly urban spaces.” Bretherton, Christianity and Contemporary Politics, 15.
20 By using the term “post-Christendom,” I take the question asked in the title of Stanley Hauerwas’s After Christendom? to be answered in the affirmative, at least in healthcare and the modern hospital. Stanley Hauerwas, After Christendom?: How the Church Is to Behave If Freedom, Justice, and a Christian Nation are Bad Ideas (Nashville: Abingdon Press, 1991, 1999).
21 Two influential examples of the normative edge of feminist and womanist theological anthropologies are Mary McClintock Fulkerson, Changing the Subject: Women’s Discourses and Feminist Theology (Minneapolis: Fortress Press, 1994), and Delores Williams, Sisters in the Wilderness: The Challenge of Womanist God-Talk (Maryknoll, NY: Orbis Books, 1993).
moral work in caring for others, and they are often exploited as they do so. These feminist and womanist normative approaches to healthcare are exemplified in the work of Lisa Cahill, Margaret Farley, and Emilie Townes, among many others. This work deeply informs both the approach to labor and delivery taken in chapter four and the project’s overall constructive turn.

I.4 Scope and Limits

This dissertation operates with a particular scope and clearly defined limits. It does not attempt to offer an exhaustive account of all modes of moral formation found throughout modern healthcare or even in the modern hospital. Instead, it limits its scope to three paradigmatic medical sites within the modern hospital, each of which reveals a distinct medical imaginary that forms medical practitioners to encounter the patient's body in particular ways. Rather than seeking to provide a comprehensive overview of the contemporary state of theological bioethics, we engage the work of three prominent Christian bioethicists who have proven deeply influential through their own writings and the work of their students. Through this composite picture, the project develops a critical window onto the field of Christian bioethics.

The three medical sites considered reveal powerful sets of forces within the modern hospital, and each has played a prominent role in the history of the institution. First, surgery is one of the most lucrative and prestigious fields in healthcare today. Moreover, its incorporation into the hospital led to the institution's rapid growth in the twentieth century and provides an institutional connection to the military hospital. Second the Intensive Care

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Unit (ICU) sits at the heart of many hospitals, representing the pinnacle of scientific medicine, and it is the culmination of a modern form of medicine birthed in the French Revolution. Finally, the hospital’s labor and delivery ward is where the vast majority of Americans spend their first moments in the world, and it provides an institutional connection to the charity hospital which has Christian roots dating back over fifteen hundred years. Each of these sites, therefore, is deeply formative for the lives of medical practitioners and patients, and each reveals a significant trajectory in the historical formation of the modern hospital and healthcare as an inherently moral practice.

Because this project is focused on these three medical sites within the modern hospital, certain questions are outside its scope. For example, questions about outpatient care are not addressed. While those concerns are certainly important, this project centers on inpatient care because the modern teaching hospital sets the standard for much of the rest of healthcare, both in terms of what constitutes excellent care and also through its training of early career medical practitioners. Also, because the project remains focused on the daily practices of how the patient’s body is imagined and engaged in the inpatient context, concerns about the costs of healthcare are not directly addressed. Within the hospital, questions of cost may linger in the background, but they are not the primary focus of the ordinary practices of healthcare. Building off this project, I plan to engage in my next work the moral questions that arise in healthcare’s outpatient and economic contexts.

Likewise, because the dissertation focuses on three prominent Christian bioethicists, certain approaches to theological bioethics are beyond the scope of this project. James Childress, H. Tristram Engelhardt, Jr., and Stanley Hauerwas, represent two prominent Protestant approaches to bioethics and one Orthodox approach. Their writings display the
range of these traditions, and their influence is felt throughout the field of theological bioethics; each of these three thinkers represent distinct moral approaches to Christian existence in a post-Christendom context. The field of Catholic bioethics is largely outside the purview of this project, and this is because Catholic healthcare is, in many ways, a world unto itself. Catholic bioethics has not addressed the post-Christendom questions that occupy this project as directly. There are, however, deep resonances between the work of Hauerwas and the Catholic natural law tradition, especially in regards to bioethics. As Catholic healthcare moves forward it may increasingly require the kind of response this project offers.

1.5 Methodological Outline

Methodologically, this dissertation seeks to set the work of moral theory within the contexts that make moral action intelligible. In the modern hospital, this means that moral responses to healthcare must be considered in light of the arrangements of discourses, practices, and practitioners that create the conditions and possibilities for distinct modes of imagining and engaging the patient’s body. This requires drawing together work in phenomenology, ethnography, history, and critical theory to offer a description of a medical imaginary, and then connecting this descriptive work with a particular prescriptive moral theorist.

The project does not consider which moral theory is right in the abstract and then simply apply it to different contexts. Instead, it presumes that a moral framework is already present in the contexts of action, and it seeks to articulate this moral schema in order to discern which moral response is most fitting for the concerns already present within the site. Such an approach illuminates the moral theory at hand while also providing prudential moral
guidance for each medical imaginary, and it also enables us to recognize the theological underpinnings of the modern hospital.

By placing the surgical ward’s medical imaginary in conversation with James Childress’s work in bioethics, we can better understand Childress’s approach while also offering concrete moral guidance for the work within this site. The same is true for the ICU’s medical imaginary considered alongside H. Tristram Engelhardt, Jr.’s moral theory, and also for the labor and delivery ward’s medical imaginary examined in light of the work of Stanley Hauerwas. This method positions us to argue that accommodationist and separatist bioethical models are surpassed by an approach that enables prudential moral judgments in light of the conditions and possibilities for moral agency within the modern hospital. This methodological approach is fully detailed in chapter one.

I.6 Summary of Argument and Chapters

This dissertation is structured around three central chapters, each of which explicates an influential medical imaginary discerned in the development of a distinct arrangement of discourses, practices, and practitioners within a paradigmatic medical site of the modern hospital. Each of these chapters argues that a particular moral response offered by an influential Christian bioethicist is most fitting for the medical imaginary under examination. These central chapters are framed by an introductory methodological chapter that specifies the nature of the problem this project seeks to address and a conclusion that builds off the fourth chapter to formulate a constructive theological and moral account of the practice of healthcare.

The first chapter argues that contemporary approaches to bioethics fail to address the moral context within which healthcare occurs. In order to do so, work in bioethics must
consider the medical imaginaries that create the conditions and possibilities for certain forms of moral agency. Describing this field of action in healthcare requires interdisciplinary work in phenomenology, ethnography, history, and critical theory. To illuminate the modern hospital as an institution of moral formation, this interdisciplinary descriptive work examines three paradigmatic medical sites, each with its own arrangement of discourses, practices, and practitioners that have developed over time. Because these three medical sites represent distinct histories of healthcare and the hospital, they make possible a foregrounding of the theological, philosophical, and political assumptions that operate under the surface of this institution. This work of theological and moral description, in turn, makes possible the discernment of fitting moral responses.

Through this methodology, the dissertation examines the surgical ward, the ICU, and the labor and delivery ward as three paradigmatic medical sites within which distinct ways of imaging and engaging the body can be discerned. In light of the moral sources and conflicts revealed in these sites, the moral theories of James Childress, H. Tristram Engelhardt, Jr., and Stanley Hauerwas are illuminated and evaluated. The project argues that the dominant modes of imagining and engaging the patient’s body in modern healthcare—primarily as enemy and object—do not have to be fundamental. Rather, a more fundamental commitment to hospitable bodily care can be discerned within healthcare and the hospital. Christian bioethics should seek to order the practice of healthcare within an overarching moral and theological vision of hospitable care, while never being naive about the great power of the medical imaginaries currently presumed to be dominant. This argument is carried through the project’s three central chapters and conclusion.
The second chapter considers how the body is imagined and engaged as an enemy within the modern surgical ward. The moral issues involved in disciplining and controlling the act of cutting are contrasted with the more indiscriminate use of force in the oncology ward, and the work of James Childress is examined as a possibly fitting moral response. The third chapter examines how the body is imagined and engaged as an object within the modern Intensive Care Unit. The moral issues involved in mapping and manipulating the medicalized body are explored through two strands of thought found in the work of H. Tristram Engelhardt, Jr. His individualistic libertarian emphasis on permission is compared with a more communal libertarian option latent in his thought, but more fully developed by Jeffrey Bishop. In both the surgical and the oncology ward, different theological, philosophical, and political conceptions of the body and the work of healthcare lend themselves to distinct moral theories.

The fourth chapter explores how the body is imagined and engaged as an enemy, an object, and as a friend within the labor and delivery ward. In doing so, it summarizes the previous two chapters while also introducing a third medical imaginary centered on hospitable bodily care. Stanley Hauerwas’s work in bioethics is considered in relation to this third medical imaginary, and it is developed further through the work of Luke Bretherton in order to consider the conditions and possibilities of faithful moral agency within the hospital as a morally complex institution. The conclusion offers a theological and moral account of the work of healthcare as a mode of participation of God’s work in the world.

In summary, this project offers an interpretation of the moral formation undergone within the modern hospital in a way that enables original methodological and substantive work in bioethics. It does so through interdisciplinary investigations of three paradigmatic
medical sites and through innovative readings of three seminal Christian bioethicists. This project addresses contemporary concerns in the fields of bioethics and Christian ethics, arguing that both fields must attend to the theological work of bodily formation within contemporary healthcare. Theologically, this work offers a way to test the spirits of modern healthcare by articulating its moral sources. Moreover, it offers an overarching argument that provides the conceptual resources for medical practitioners to understand the ways in which their work in the strange world of medicine participates in the Holy Spirit’s work of befriending flesh. The Spirit is at work forming the body of Christ in both patients and practitioners through ordinary practices of hospitable bodily care.
Chapter 1

Acting, Perceiving, and Speaking in the Modern Hospital: Methodology for a Reconfigured Bioethics

You can only act in the world you can see and you can only see what you have learned to say.

—Stanley Hauerwas, *The Work of Theology*

The body is our general means of having a world.

—Maurice Merleau-Ponty, *Phenomenology of Perception*

1.1 Introduction

Given the intensity of the moral formation that occurs in the modern hospital, a new approach to the work of bioethics is needed. This chapter exposes standard approaches to bioethics as incapable of dealing with the moral realities uncovered in the modern hospital, and offers a new methodology for reconfiguring how bioethics is done. This chapter first reveals the inadequacy of standard bioethics by revisiting the Hippocratic Oath. Following this, it uses work in medical phenomenology and anthropology to demonstrate the kinds of moral concerns that must be attended to by a robust moral consideration of healthcare. The chapter then reviews critical voices from within the field of bioethics that articulate its fundamental problems, and develops a new methodological approach from recent work in Christian ethics.

By bringing together work in medical phenomenology, ethnography, and history, the moral contexts and concerns that frame action in healthcare are illuminated. Such descriptive work is necessary in order to discern fitting moral responses to the worlds of patients and

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practitioners. Furthermore, by describing paradigmatic modes of imagining and engaging the body in the modern hospital, we can argue for a normative ordering of the work of healthcare within an overarching constructive theological account. What are the conditions and possibilities for faithful moral agent within the modern hospital? This chapter offers a methodology that enables this question to be pursued throughout the rest of the project.

1.2 Bioethics in a New Key

1.2.1 An Ancient Oath in a New Light

The Hippocratic Oath is routinely referred to as an ancient sign that medicine has clear moral commitments, ones that can be listed as timeless moral principles. Such invocations rarely consider the oath in detail. Rather, they often involve general accounts of the oath as the source of principled commitments to help patients while doing them no harm, but pay little attention to the social and political contexts that make the oath morally intelligible. Even a bioethicist as historically sensitive as Albert Jonsen considers the Hippocratic Oath to be “a striking example of deontology” that contains nothing of what he names “politic ethics.” Jonsen’s account of the oath as a collection of timeless moral rules represents the ways in which modern bioethics fails to consider the social, institutional, and political realities that frame much of bioethics. Thus, we begin with reflection on the Hippocratic Oath in order to demonstrate the fruits of a new way of approaching the work of bioethics. If the Hippocratic Oath is in fact an effort to respond to the particular moral

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3 Albert Jonsen, *A Short History of Medical Ethics* (Oxford: Oxford University Press, 2000), pp. 4, 8. Jonsen considers the Hippocratic Oath and the wider Hippocratic corpus of writings to be concerned with deontology and decorum, but no moral reflection on the political and social nature of medicine. Jonsen argues that what he calls “politic ethics” only appears centuries later in more modern work on the morality of medicine, though, as we shall see, that requires a truncated understanding of social and political realities.
challenges faced by medical practitioners at a particular time and place, rather than an ahistorical deontological edict, then perhaps modern work in bioethics also can be understood anew in this way.

The Hippocratic Oath begins by situating the speaker in a religious context, swearing by “Apollo Physician,” his son Asclepius, Asclepius’s children Hygiea and Panaceia, and “all the gods and goddesses as my witnesses.” Contemporary appropriations of the Hippocratic Oath often drop this religious invocation and instead swear by whatever one holds most sacred or by one’s own abilities. The Oath’s opening religious commitments and pledging of fidelity to one’s teacher are often considered to be part of the husk of historical context that must be stripped away in order to uncover a kernel of pure medical morality. Such a treatment of the Hippocratic Oath “fails to examine how ethical problems emerged out of the practices of ancient Greek physician-healers.” Instead, a close reading of the Hippocratic Oath reveals that it is attempting to respond to at least three primary moral problems that proceed from its assumptions about the nature and practice of medicine: first, how to maintain a craft over time; second, how to limit the overreach of medicine’s purview by placing boundaries on its practice; and third, how to appropriately navigate the guest/host relations inherent to the encounter between practitioner and patient. In all of

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4 Ludwig Edelstein, “The Hippocratic Oath: Text, Translation, and Interpretation,” in *Ancient Medicine: Selected Papers of Ludwig Edelstein*, ed. Owsei Temkin and C. Lilian Temkin, trans. C. Lilian Temkin (Baltimore: The Johns Hopkins University Press, 1967), p. 6. Unless otherwise indicated, all other citations of the Hippocratic Oath are from this page and translation. What follows does not depend upon Edelstein’s debated claim that the Hippocratic Oath had its origins in a Pythagorean philosophical sect. Nor does the following discussion depend upon the Hippocratic Oath being sworn by a substantial portion of Greek physicians.

these efforts, the Hippocratic Oath seeks to address the fundamental concern facing physicians and patients: trust.

On its surface, the first section of the Hippocratic Oath seems to take apprenticeship in medicine a bit too seriously. Does becoming a medical practitioner really require adoption into a new family, where your teacher is “equal to my parents,” your teacher’s children are “equal to my brothers,” and your teacher’s “need of money” necessitates that you should “give him a share” of your own? In fact, something like becoming a part of a new family is required, as training in medicine is a process of apprenticeship in which one joins a guild that serves as an alternative kinship structure. There are serious moral obligations that accompany this training in a craft, particularly one with life or death consequences. First, because becoming a master craftsman involves a lengthy commitment by both the apprentice and their teacher, those who receive training must be committed to training the next generation in order for the craft to pass down through time. Second, during the era of Hippocratic medicine, there were no official means of credentialing. In fact, “all that was needed to become a doctor was one’s profession, a statement that one was a healer.” This lack of accountability fostered a medical practice in which “abuse abounded and went...

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6 For more on this aspect of guilds, see Antony Black, From Guild to State: European Political Thought from the Twelfth Century to the Present (London: Transation, 2002), 3-31. My thanks to Luke Bretherton for drawing my attention to the nature of guilds. For more on guilds and other organizations that form parts of “consociational democracy,” see his Resurrecting Democracy.


unpunished.” With this context in mind, the question for the Hippocratics becomes how to create and control access to a medical apprenticeship in an effort to shape practitioners worthy of the public’s trust. Therefore, the first major section of the Hippocratic Oath is not simply a historical relic from a paternalistic past that we have gladly progressed beyond. It is in part an attempt to answer the question of how to transmit this craft in a trustworthy fashion. This requires the formation of people committed to the intrinsic goods of the craft, a formation still necessary for practitioners today.

The Hippocratic Oath moves from the moral issues involved in transmitting the craft of medicine to the ethics of the practice itself. This second section of the oath begins with a concern is to place boundaries on medicine’s purview; practitioners must pledge to work “for the benefit of the sick,” but this constructive injunction is bounded by a promise to keep patients “from harm and injustice.” While contemporary interpreters often point to this passage and a few other texts in the Hippocratic corpus as the early roots of medicine’s commitments to the principles of beneficence and nonmaleficence, such an interpretation is incomplete insofar as it ignores the Hippocratic Oath’s context. Because physicians were itinerant craftsmen, patients had to have ways of distinguishing “the expert from the charlatan.”

By enjoining physicians to healing within the bounds of avoiding harm, the

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10 Summarizing why a medical practitioner would have been attracted to the Oath, Tom Koch explains that “the Hippocratic association engendered public trust in the Hippocratic practitioner: Patients might not know a doctor personally but would know and trust in the community of medicine to which the physician belonged.” Tom Koch, Thieves of Virtue: When Bioethics Stole Medicine (Cambridge, MA: The MIT Press, 2012), 28-29.

11 As Robert Bartz argues, “The Hippocratic writings do not present us so much with overarching ethical principles as with insights gained from grappling with the clinical problems faced and described,” 18.

12 Edelstein, “The Professional Ethics of the Greek Physician,” 323. Edelstein claims that this need is why so much of the Hippocratic corpus attends to what can be described as medical etiquette: how to set up and equip a shop, how a physician should behave at the bedside, including the proper ways to enter a sick room and converse with the patient, etc. He makes the case, though, that this is not just a sly advice on how to attract
Hippocratic Oath marks its adherents as craftsmen devoted primarily to the health of their patients, rather than increasing their income. In order to ensure that physicians are craftsmen instead of profit-maximizing service-providers, the Oath lists several prohibitions:

I will not use give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give a woman an abortive remedy…I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Such a commitment to health marked out proper medical practitioners as those unwilling to say or do anything simply because it may align with their self-interest. This did not go unnoticed. In Plato’s Republic, when Socrates seeks to refute the Sophists, the physician is the first example he gives of someone seeking the good of their practice and not their own gain. Therefore, this section of the Hippocratic Oath displays the commitments of a craft unwilling to pursue ends that stretch beyond the limited internal goods of its practice. This enables physicians to focus on the primary good they are seeking, the health of the patient, while also signaling to society that anyone with these commitments will not attempt to trample on a patient’s health in pursuit of profit. Again, then, by examining its context, we...

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13 This account of physicians as craftsmen follows Alasdair MacIntyre’s description of traditioned practices in After Virtue, 181-203, esp. 187.

can better see and understand the Hippocratic Oath’s concern with promoting a trustworthy craft.

In the second half of this section, the Hippocratic Oath turns its focus from the boundaries and purposes of medicine towards certain social proprieties that should accompany the care of patients. Visits to the homes of the sick should remain free from “all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons.” Furthermore, the physician must keep everything that emerges from visiting a patient in the strictest confidence. These provisions have often been interpreted as promoting a principled ethic for the relationship between a physician and a patient. While this is partly true, such an ahistorical interpretation does not take seriously the dynamics involved in itinerant craftsmen attending to patients in the privacy of their own homes. Entering as strangers, physicians “had to demonstrate through practice and rhetoric that they would approach the concerns of the sick from the position of a friend.”15 The physician’s need to earn the trust of the patient and family was more than just a matter of gaining access; in order to properly diagnose the patient and provide continuity of care, the trust and support of both the patient and their family was of utmost importance.16 The fundamental concern in this part of the Hippocratic Oath is with how to properly navigate guest/host relations. How should physicians comport themselves as good guests in the home of their host, the patient? To fully understand this section of the oath, we must interpret its emphasis on trust and relationship through its particular social context.

Once we begin to see the Hippocratic Oath in this manner, its original context stands in stark contrast with modern medical practice as it occurs within the hospital. Our

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15 Bartz, 15.
16 Ibid., 17.
own moral situation is made strange to us in a way that prevents the easy importation of
principled abstract concerns for justice, sexual propriety, and confidentiality. Instead,
questions begin to arise as we consider the specific dynamics of modern medical practice:
who is the guest and who is the host when a physician enters a patient’s hospital room?
What social forces are at work in the hospital as an institution that may be kept at bay in an
individual’s home? And, recalling the earlier sections of the Hippocratic Oath, is medicine
today a craft in pursuit of a good or simply service-provision? These sorts of questions have,
of course, been raised by modern bioethicists, but they are much more quickly brought to
the fore when we contrast modern medicine with a situation in which the physician was an
itinerant craftsman navigating complex social relations in the setting of a patient’s home.

1.2.2 Formation in Contemporary Medical Education

In the same way, work in bioethics today must take into account the contexts that
form action in contemporary healthcare. Medical practitioners are shaped through profound
social, political, and institutional processes. Moral reflection on their work must engage with
these realities. We can see that this is the case through Byron Good’s ethnographic
investigations into the formation of Harvard medical students, which begin with a second-
year student admitting, “I feel like I’m changing my brain every day, molding it in a specific
way—a very specific way.”

Good proceeds to argue that this transformation is made
possible by a whole host of “formative processes” that shape “a distinctive form of reality
for those who are learning to be a physician.” Through his ethnographic work, Good
describes the ways that modern medical students are formed to construct the patient’s body

17 Byron J. Good, Medicine, Rationality, and Experience: An Anthropological Perspective (Cambridge: Cambridge
18 Ibid., 66, 67.
according to certain biomedical assumptions. By engaging this account, we can more clearly foreground the concerns necessary for contemporary work in bioethics.

The transformations undergone in medical school are part of “a process of coming to inhabit a new world.” In order to understand how this occurs, Good unites the work of medical anthropology and phenomenology, claiming that “critical studies of practices and the analysis of embodied experience” must be brought together. Good argues that the discourses and practices of medicine “engage and formulate reality in a specifically “medical” way.” “Within the lifeworld of medicine,” Good argues, “the body is newly constituted as a medical body…and the intimacy with that body reflects a distinctive perspective, an organized set of perceptions and emotional responses that emerge with the emergence of the body as a site of medical knowledge.” He categorizes these transformations according to seeing, writing, and speaking, which we will examine in turn.

Good begins with how medical students are trained to see the human body. He notes, as we did in our introduction, that the anatomy lab is one critical site for this formation of perception. Through dissections, students are shaped to perceive the body entirely anew. In conversations with Good, they reflected on the strangeness of this experience. According to one student:

I’ll find myself in conversation….I’ll all of a sudden start to think about, you know, if I took the scalpel and made a cut [on you] right here, what would that look like [he said laughing]….very often that happens. And that’s a frightening thing. You say: why are you thinking that way? You know, you’re sitting here having a discussion with a person who’s alive, and yet you’re thinking about the procedures that you use when you’re doing an autopsy.

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19 Ibid., 70.
20 Ibid., 69. Good argues that this builds off the work of Foucault, but in a way that better incorporates the lived experiences and embodied perceptions of those being examined.
21 Ibid., 71.
22 Ibid., 72.
23 Ibid., 73.
We will engage this anatomical mode of perceiving the living body at length in chapter three. For now, we simply note with Good that this student has undergone significant formation that involves “the reconstruction of the person” according to a distinct perception of reality, a reconstruction akin to “learning a foreign language.” With this in mind, we now turn to Good’s account of how the medical student’s writing and speaking are transformed.

As the medical student moves from the anatomy lab and classroom into the clinic, they are trained to write and speak in ways befitting a physician. Good highlights the role that “write-ups” play in clinical training, as students learn to create written accounts of their encounters with patients. The write-up is “a formative practice, a practice that shapes talk as much as it reflects it, a means of constructing a person as a patient, a document, and a project.” Interviews with medical students reveal this reshaping of how they understand their patients:

You begin to approach the patient now with a write-up in mind, [he said], and so you have all these categories that you need to get filled. Because if you don’t do that, you go in, you interact,…you talk…you go back and you realize that you left out this, this, this and you need to go back. And when you go in with the write-up mentally emblazoned in your mind, you’re thinking in terms of those categories.

Students are judged by residents and attending physicians based upon the quality of their write-ups, and so this practice disciplines their imagination. According to one medical student, “To a large extent, you’re authorized through your writing. That’s sort of what justifies everything else, is you are actually now communicating important information, and

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24 Ibid.
25 Ibid.
26 Ibid.
27 Ibid.
this entitles you to poke and prod…spiritually, verbally, and physically.”

The act of writing shapes both medical practitioners and patients in fundamental ways.

Such disciplinary power is even more overtly on display as students move from writing to speaking about their patients. Case presentations occur in front of an audience of medical practitioners, and “learning what ‘the important stuff’ is and how to present it in a persuasive way is central to becoming a physician.”

Because students’ standing with their supervisors depends upon presenting cases well, they rehearse their presentations, honing the practice constantly in an effort to win approval by properly comporting with an authoritative understanding of medicine. Speaking shapes the medical practitioners and the world in which they inhabit. As Good says, “[P]resenting cases is not merely a way of depicting reality but a way of constructing it. It is one of a set of closely linked formative practices through which disease is organized and responded to in contemporary American teaching hospitals.”

This project follows Good in attending to the formation of the medical practitioner through their construction of the patient’s body.

As Good makes clear, this institutional context is critical. These formative practices occur “in an extraordinary “totalizing” setting.” For physicians-in-training, “their whole lives—their waking lives as well as much of their sleep—are spent in the hospital. They are constantly examined…and observed.” The modern hospital, therefore, is a site of intense formation. Good concludes his examination of this formation by arguing that there are profound “moral and soteriological” elements at work within the hospital, but these registers are often “neglected or obscured by many standard sociological or anthropological

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28 Ibid.
29 Ibid., 79.
30 Ibid., 80.
31 Ibid., 82.
analyses.” Although he does not pursue these elements at length, Good challenges his fellow medical anthropologists to take them much more seriously.

In his examination of medical students’ practices of seeing, writing, and speaking, Good displays some of the ways in which medicine involves intense moral formation within the institution of the hospital. In light of his work, we can offer several preliminary methodological remarks which will guide our own analysis. First, the hospital is a generative site for reflection on the work of healthcare. In it are revealed the formative discourses, practices, and practitioners that shape perception and action within healthcare. Second, work in medical anthropology can be joined with phenomenological accounts of how the world is perceived in order to offer a more thorough account of the forms of agency being fostered within modern healthcare. Third, this work of description needs to be analyzed in light of normative moral and theological commitments. And the reverse is also true, as normative moral and theological approaches must take into account the formations that create the setting within which moral action occurs. Good’s account of the transformations undergone by medical students is in need of moral analysis that goes beyond efforts to expose the “hidden curriculum” in modern healthcare. They raise fundamental issues for contemporary work in bioethics, to which we now turn.

32 Ibid., 85, 87.

While some focus on “professionalism” as a category for moral responses to the hidden curriculum’s formation, Warren Kinghorn displays the problems with this approach in “Medical Education as Moral Formation: An Aristotelian Account of Medical Professionalism,” *Perspectives in Biology and Medicine* 53, no. 1 (2010): 87-105, and in Warren A Kinghorn, Matthew D McEvoy, Andrew Michel and Michael Balboni,
1.2.3 Diagnosing Bioethics from within the Field

Our above examinations of the Hippocratic Oath and the formation of medical students reveal profound social, political, and institutional processes at work in the world of healthcare. Moral reflection on this world must engage with these realities, and yet much of contemporary bioethics seems averse to doing just this. Instead, it prescribes action in an individualistic mode that is inattentive to the formative contexts of action. Even as the work of bioethics has proceeded in this direction, concerns have been raised by critical voices from within the field. By examining their diagnosis of the field and the therapy they recommend, we will be in a position to offer a preliminary account of how work in the field should be done, an account that coheres with work from within Christian ethics as well.

We begin with medical sociologist Renée Fox and historian Judith Swazey, who have long been critical of standard work in bioethics. In one of their earliest accounts, they argue that the “cultural myopia” of bioethics “is a widespread characteristic of the field of bioethics, one that generally manifests itself in the form of systematic inattention to the social and cultural sources and implications of its own thought.” Fox and Swazey go on to claim that such inattention to social and cultural realities is a result of bioethics “proceeding in a largely deductive manner to impose its mode of reasoning on the phenomenological reality addressed.” Bioethics operates with an assumed and ultimately parochial assumption of what it means to be a moral agent. According to Fox and Swazey, “it is the individual, seen as an autonomous, self-determining entity…that is the starting point and the

foundation stone of American bioethics.” Bioethics has been in the thrall of rationalistic and individualistic approach to the subject. Better approaches to bioethics require better accounts of the agents at work and the contexts within which they operate.

The form that these better approaches might take was hinted at in an early essay in the field. In 1973, one of the pioneers in bioethics, Daniel Callahan, wrote a seminal article in the first issue of *The Hastings Center Report* entitled, “Bioethics as a Discipline.” At the end of the essay, Callahan presents an “impossible and scandalous” contention for the discipline of bioethics:

This [discipline of bioethics] requires, ideally, a number of ingredients as part of the training—which can only be life-long—of the bioethicist: sociological understanding of the medical and biological communities; psychological understanding of the kinds of needs felt by researchers and clinicians, patients and physicians, and the varieties of pressures to which they are subject; historical understanding of the sources of reigning value theories and common practices; requisite scientific training; awareness of and facility with the usual methods of ethical analysis as understood in the philosophical and theological communities—and no less a full awareness of the limitations of those methods when applied to actual cases; and, finally, personal exposure to the kinds of ethical problems which arise in medicine and biology.\(^{37}\)

Callahan responds to this “impossible list of demands” and the outcries of scandalized professional fields with a simple, “Well, so what? That is what the discipline of bioethics requires.”\(^{38}\)

In the decades since Callahan’s gave this charge to the field, various kinds of interdisciplinary work have been done in bioethics, much of it seeking to challenge the narrow view of moral theory criticized by Fox and Swazey. Carl Elliott summarizes the shared concern of these approaches, saying, “Feminists, clinical ethicists, medical

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38 Ibid., 73.
anthropologists, literary scholars, and, perhaps most notably, the new casuists…all have criticized ethical theorists for preferring the thin air of moral theory to the thick, particular contexts in which moral problems are situated.”  

However, Fox and Swazey characterize “alternative approaches, such as feminist, virtue, and narrative ethics and casuistry” as often “extrinsic and “shotgun” reactive.” In other words, interdisciplinary work in bioethics requires methodological precision. Fox and Swazey gesture at what this might look like in their call for a new direction in the field, an approach in which:

[T]he philosophical underpinnings of bioethics would become more supple and porous so that some of the boundaries in which bioethical-philosophical thought is presently enclosed could be traversed in ways that facilitate the integration of social (including economic and political), cultural (including religious), legal, and historical variables, and other disciplines’ ways of thinking about them, into the foundational intellectual structure of the field.

This project seeks to respond to this call in ways that avoid muddied interdisciplinary waters. In doing so, it participates in recent work in Christian ethics responding to similar issues within that field in ways that provide methodological direction for work in bioethics as well. By giving an account of this move in Christian ethics, we will be in a position to articulate this project’s own methodology as it sits within the fields of bioethics and Christian ethics.

1.2.4 Christian Ethics Diagnoses Bioethics

In *The Ethics of Everyday Life*, Christian ethicist Michael Banner offers a critique of moral philosophy in general and bioethics in particular as part of a constructive argument for

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how moral theology should be done. He argues that moral theology has become bewitched by its primary conversation partner, moral philosophy, into assuming that the primary focus for reflection ought to be difficult questions at the limits of moral deliberation. In place of moral philosophy, Banner argues that moral theology should engage primarily with work in social anthropology in order to “explicate an everyday ethics, to describe the moral life as it is shaped by a religious imagination, holding up to view the framework of perceptions, meanings, emotions, concepts, and attitudes that are formed by that imagination in its various realizations.” According to Banner, by engaging with social anthropology instead of moral philosophy, moral theology can offer such a rich and substantive account of the moral life.

In order to justify setting aside contemporary moral philosophy, Banner offers a genealogical argument of contemporary moral philosophy’s ignorance of social anthropology. He traces this ignorance back to Immanuel Kant and John Stuart Mill, who share far more in common than is recognized by most overviews of moral philosophy. Rather than standing on opposite sides of the chasm between deontological and utilitarian moral theories, Banner claims that Kant, Mill, and their contemporary inheritors stand together in “resolutely failing to reckon with the fact that morality must be understood as a social practice.” As Kant stipulates in *Groundwork of the Metaphysic of Morals*, it is:

> a matter of the utmost necessity to work out a pure moral philosophy cleansed of everything that can only be empirical and appropriate to anthropology…When applied to man [philosophy] does not borrow in the slightest from acquaintance with him (in anthropology), but gives him laws *a priori* as a rational being.

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43 Ibid., 18.
Kant's demand that anthropology and ethics be pursued as separate disciplines has had significant ramifications for the field of moral philosophy; Banner goes so far as to claim that with this distinction “Kant invented social anthropology as a discipline distinct from philosophy, just by banishing its subject matter from philosophy.” Banner also shows that Mill's project is similarly grounded in a singular focus on prescriptive claims at the expense of concern for description and with it attention to the embodied contexts of action. Banner then argues that following Kant and Mill, modern moral philosophy continually prefers to be prescriptive with little concern for the actual people, practices, and contexts that constitute the field of moral action.

Banner is, of course, not alone in making this kind of critique in moral philosophy. Among others, Alasdair MacIntyre has developed this line of argument throughout his career, the culmination of which can be seen in his recent work, Ethics in the Conflicts of Modernity. There, MacIntyre argues that “philosophers need to begin with the everyday questions of plain persons,” for the modern form of philosophical work is insulated in numerous ways from “plain persons” and their questions. According to MacIntyre, to a substantial extent:

Philosophical inquiry into and discussion of moral theory is isolated from political and moral practice…. Any conception of moral theory as rooted in and unintelligible apart from the particularities of moral practice is generally ignored. Any notion of moral enquiry as needing to begin from or even include anthropological and historical studies of moral practice is ruled out and with it any identification of

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45 Banner, 20.
46 While he briefly acknowledges a tradition of moral philosophy running through “Aristotle, Hume, and Wittgenstein (and amongst contemporary writers, Raimond Gaita, David Wiggins, and Cora Diamond),” Banner does not engage this tradition at much length, aside from criticizing the work of Alasdair MacIntyre in the same footnote. Moreover, Banner ignores crucial developments in black, Latino/a, feminist, womanist, mujerista, and Asian-American ethics. While widely diverse, these fields of inquiry all share a common commitment to what Banner finds lacking in the approaches to ethics he criticizes: they all analyze and critique the “wider cultural context” within which everyday lives are lived. Banner, 23, n. 43.
contrasts between the moral practices of the culture that we here now inhabit and those of cultures of other times and places.\textsuperscript{48}

In response to the arguments of Banner, MacIntyre, and others, this project begins from the assumption that “anthropological and historical studies of moral practice” are essential for moral philosophy and theology. Moreover, within the hospital itself, several distinct “cultures” can be discerned, and by investigating them we can render intelligible distinct modes of moral practice in this one institution, as we shall see.

This turn to the cultures of healthcare brings us to more pointed critiques of the field of bioethics itself. Bioethics is the specific area of moral philosophy that Banner engages at length, and his criticisms are sweeping. According to Banner, contemporary bioethics “misunderstands and misconstrues the ethical, rather than explicates it.”\textsuperscript{49} Because of the field is “grounded in a bluntly prescriptive moral philosophy,” it is “so removed from social intelligence” that everyday moral practice “remains wholly opaque to it.”\textsuperscript{50} His critique of bioethics resonates deeply with that of Fox and Swazey, as they also share a concern to introduce more textured social description into the work of moral reasoning.

These critiques of bioethics and moral philosophy share a desire to bring further interdisciplinary descriptive work to bear on the moral agent and the scene of action. We can see this in James Mumford’s fundamental claim, which is at the heart of his recent work in Christian ethics, that:

ethics has a stake in description. Some of the most pivotal moral decisions we face, even decisions taken at moments of crisis, hinge upon competing descriptions. How we describe something—some phenomenon in the world, some situation in which

\textsuperscript{48} Ibid., 71-72.
\textsuperscript{49} Banner, 22.
\textsuperscript{50} Ibid.
we find ourselves involved—makes all the difference as to how we decide we are permitted to act.\textsuperscript{51}

Here Mumford succinctly summarizes much of the arguments from Banner, Macintyre, Fox and Swazey, and Callahan. At the level of description, serious moral work is done, and efforts to articulate a moral theory should be done in concert with attention to these local worlds of action. As we shall see, within the modern hospital differences in how the work of healthcare is described lend themselves to distinct forms of moral action.

\textit{1.2.5 Methodological Therapy: Action, Perception, and Speech}

In order to construct a methodological foundation for work in bioethics that satisfies the concerns given above, we take as our starting point a claim made by Stanley Hauerwas. Although Hauerwas is known for his work in Christian ethics, he has been a running conversation partner for key figures in the field of bioethics as well. His work points a way forward for the kind of interdisciplinary approach recommended by Fox and Swazey, Callahan, and Banner. Through developing his work in conversation with Charles Taylor and Michel Foucault, this project will be in a position to offer a constructive methodological proposal for work in bioethics and Christian ethics.

We begin with a claim that gets at the heart of Hauerwas’s moral theory: “You can only act in the world you can see and you can only see what you have learned to say.”\textsuperscript{52} For Hauerwas, moral agency flows from one’s moral vision of the world, which itself is formed over time as one learns to speak the world through particular practices, relationships, communities, contexts, etc. Hauerwas is prone to remind his readers that such a conception


\textsuperscript{52} Hauerwas discusses this claim at length in an essay, “How I Think I Learned to Think Theologically,” found in his recent book \textit{The Work of Theology} (Grand Rapids, MI: William. B. Eerdmans Pub., 2015), 11-31, esp. 27-31. See also his earlier \textit{Vision and Virtue} (Notre Dame, IN: University of Notre Dame Press, 1981).
of moral theory flies in the face of modern assumptions about the autonomous rational individual. In other words, his approach shares much in common with the diagnosis and therapy given above by Banner, MacIntyre, Fox and Swazey, and Callahan.

In attending to the relationship between anthropology and ethics, Hauerwas and others build off of an important strand of contemporary moral theory that draws from the work of Ludwig Wittgenstein and his followers. In her seminal 1958 essay, “Modern Moral Philosophy,” Elizabeth Anscombe writes that moral philosophy “should be laid aside…until we have an adequate philosophy of psychology, in which we are conspicuously lacking.”53 While Anscombe’s argument and what she meant by it has been the subject of no small debate, those influenced by her and her teacher Wittgenstein have continued to search for more faithful renderings of human existence in the service of better moral theory.54 More recently, Cora Diamond has argued that in contrast to limited approaches to moral philosophy, like the ones criticized above, moral philosophy must stake out an expanded domain, one that engages with thought and imagination— with the “texture of being.”55 This trajectory of thought is the backdrop to Hauerwas’s attention to the importance of vision and speech for moral action, and it also means that Banner’s wholesale dismissal of moral philosophy is far too broad.

54 Shortly after Anscombe published her essay, philosopher and novelist Iris Murdoch made a similar claim about the relationship between anthropology and moral philosophy:
We are not isolated free choosers, monarchs of all we survey, but benighted creatures sunk in a reality whose nature we are constantly and overwhelmingly tempted to deform by fantasy. Our current picture of freedom encourages a dream-like facility; whereas what we require is a renewed sense of the difficulty and complexity of the moral life and the opacity of persons. We need more concepts in terms of which to picture the substance of our being; it is through an enriching and deepening of concepts that moral progress takes place.
Before moving further with the methodological implications of Hauerwas’s claim, we must make a small but significant change. For although vision and speech are embodied realities, they can easily become associated with overly clean and intellectualized accounts of human existence. To resist this account, the theme of seeing with our eyes needs to be replaced with that of perceiving with our whole bodies. In light of this, we have revised Hauerwas’s dictum to read, “You can only act in the would you can perceive and you can only perceive what you have learned to say.” In replacing sight with perception, I follow the influential work of Maurice Merleau-Ponty and his claim that “we perceive the world with our bodies.”

Perception involves all the senses, and by attending to its formation we must attend to the work of particular bodies in certain times and spaces. Likewise, speech is both formed and expressed through embodied practices. Therefore, within this project, we will primarily attend to how connections between speech, perception, and action occur in enacted and embodied performances, not in some interiorized space of subjectivity inaccessible to all others.

In order to depict the public worlds within which speech, perception, and action are formed and occur, this project draws from Charles Taylor’s concept of a social imaginary, which he defines as “the ways people imagine their social existence, how they fit together with others, how things go on between them and their fellows, the expectations that are

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56 Merleau-Ponty, Phenomenology of Perception, 213.
57 This is a common theme throughout feminist interpretations of Merleau-Ponty. Although Merleau-Ponty failed adequately to consider the gendered body, he provides conceptual resources for such accounts. For example, Judith Butler argues that, for Merleau-Ponty, “the philosophical effort to understand knowledge on the model of vision has underestimated the importance of tactility….instead vision, language, and touch intertwine with each other.” Judith Butler, “Sexual Difference as a Question of Ethics: Alterities of the Flesh in Irigaray and Merleau-Ponty,” Feminist Interpretations of Merleau-Ponty, eds. Dorothea Olkowski and Gail Weiss (University Park, PA: The Pennsylvania State University Press, 2006), 113.
58 At the same time, we cannot entirely reject the importance of how our self-understandings shape our moral speech and vision, and so play a crucial role in our moral agency. This point will be pursued at length later in this chapter when we discuss phenomenology and its relation to theological anthropology.
normally met, and the deeper normative notions and images that underlie these expectations.”\(^{59}\) A social imaginary is a much broader and more loosely defined phenomenon than a particular social theory; it is formed through a complex interplay of human practices and the ideas that are both made intelligible by and created through such practices. In this understanding of a social imaginary, we go slightly beyond Taylor to combine his hermeneutical approach with that of Michel Foucault, who attends more directly to the formative power of practices. Through engaging the work of Foucault and the work of medical anthropologists and historians influenced by him, this project seeks to attend to how speech and perception are shaped within the social imaginaries of modern medicine a more holistic account of the formation and propagation of social imaginaries in modern medicine.\(^{60}\) As indicated in the introduction, we will adopt the term “medical imaginary” as a specified form of Taylor’s understanding of a social imaginary. In this project, a medical imaginary is a distinct mode of imagining and engaging the human body within healthcare.

A social imaginary embodies a moral vision about the way life should be through normative assumptions that are often tacit rather than explicit. Because of this, work must be done to articulate these normative assumptions. The same is true for a medical imaginary, both in how it forms the speech, perception, and action of medical practitioners and in how


\(^{60}\) In my combination of Taylor and Foucault, I follow Gerald McKenny in *To Relieve the Human Condition*. While arguing for the plausibility of a limited concordance between Taylor and Foucault, McKenny does admit that a crucial difference between them is that “Taylor believes that he can understand the formation of the self without direct reference to practices while Foucault believes that the self is formed by practices and cannot be understood apart from them.” McKenny, *To Relieve the Human Condition*, 228, n. 4. Although McKenny’s critique was published before Taylor’s *Modern Social Imaginaries* (McKenny was primarily engaged with Taylor’s *Sources of the Self*), Taylor’s more recent work still struggles at times to escape this charge, though he recognizes its importance. For Taylor’s response to this line of critique, see his chapter, “The Specter of Idealism,” *Modern Social Imaginaries*, 31-48.
it is often tacit and in need of articulation. Such articulacy makes possible moral renewal, as Taylor argues in *Sources of the Self*:

> If articulacy is to open us, to bring us out of the cramped postures of suppression, this is partly because it will allow us to acknowledge the full range of goods we live by. It is also because it will open us to our moral sources, to release their force in our lives. The cramped formulations of mainstream philosophy already represent denials, the sacrifice of one kind of good in favour of another, but frozen in a logical mould which prevents their ever being put in question. Articulacy is a crucial condition of reconciliation.  

By articulating the moral sources present within our modern medical imaginaries, we can begin to reimagine the modes of speech, perception, and action currently available and so give a conceptual account of the transformation of action.

By bringing moral reflection to bear on the connections between speech, perception, and action, we build off of the work of Banner and Hauerwas in Christian ethics while correcting their excesses. Contra Banner, the work of moral philosophy is not to be dismissed but instead engaged in new ways, both through the Wittgensteinian strand of thought represented by Anscombe and Diamond and also through what Taylor described as the articulation of moral sources as a crucial component of moral renewal. Contra Hauerwas, the scene of moral action must be expanded beyond vision to include a more embodied sense of perception, both through the work of phenomenology and through ethnographic investigations that consider the formative power of discourses and practices for moral action.

By developing this work in Christian ethics in conversation with Taylor and Foucault, we have also begun to address the concerns voiced by Fox and Swazey and Callahan about the field of bioethics. In order to do so fully, we must give a detailed methodological account.

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of how action, perception, and speech are connected within a medical imaginary by drawing from work in phenomenology, ethnography, and history in order to depict the formational contexts for action. This attention to the contexts in which action occurs will enable work in bioethics that can respond to the concerns we raised above in conversation with the Hippocratic Oath and Good’s account of the formation of medical students.

1.3 You Can Only Act in the World You Can Perceive: Phenomenology and Medical Imaginaries

Recall that Good’s work highlighted the hidden processes at work in seemingly standard moments of medical formation. In order to perceive what is actually occurring in modern medicine, we must step back and make the normal slightly strange. To do this, we draw from the philosophical movement known as phenomenology, famous for its foundational rallying cry, “Back to the things themselves!” Phenomenological description of how the body is encountered in modern medicine grants us better access to the modes of perception available within a particular medical imaginary, which frame and make possible particular modes of moral action. By attending to different ways that the body is perceived in the modern hospital, we are able to craft fitting moral responses to the ways of inhabiting and acting in modern medicine.

In order to draw from phenomenology in this way throughout the project, we must begin with a more detailed understanding of several relevant phenomenological concepts. This approach enables attending to the transformations of the patient’s lived body and life-world that occur through formative medical imaginaries, as illuminated through notions of

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double sensations and conversion. After this examination of phenomenology, we will then turn to work in medical anthropology and history to uncover the development of distinct arrangements of discourses, practices, and practitioners that create the conditions and possibilities for these ways of inhabiting modern medicine. With this framework of embodied agency within the modern hospital provided by phenomenology, ethnography, and history, we can then return to more explicit bioethical theory.

1.3.1 Lived Body

In his later writings, Edmund Husserl, phenomenology’s foundational figure, uses two different terms in the German language for the body, distinguishing between the physical body (Körper) and the lived, personal body (Leib). For Husserl, to view the body as Körper is to see from a detached and disembodied third person perspective, to gaze upon the body as a material object. In contrast, to see the body as Leib is to see from a first-person perspective of embodied existence in the world. Writing in French, Maurice Merleau-Ponty develops this insight by investigating the difference between the objective body of science and the one’s own lived body (le corps propre). More than any other major phenomenologist, Merleau-Ponty focused on what it means to take embodiment seriously when we consider ‘the things themselves.’

Earlier, we mentioned Merleau-Ponty’s work on embodiment as the reason for our methodological shift from a focus on sight to attending more broadly to perception.

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63 On these two understandings of the body, Husserl says, “Thus, purely in terms of perception, physical body and living body [Körper und Leib] are essentially different; living body, that is, [understood] as the only one which is actually given [to me as such] in perception: my own living body.” Edmund Husserl, *The Crisis of European Sciences and Transcendental Phenomenology: An Introduction to Phenomenological Philosophy*, trans. David Carr (Evanston, IL: Northwestern University Press, 1970), §28, p. 107, brackets in original. See also §9, p. 50.
Merleau-Ponty provides an overview of the importance of embodied perception in a prospectus on his work that went unpublished during his lifetime, where he writes,

The perceiving mind is an incarnated mind. I have tried, first of all, to re-establish the roots of the mind in its body and in its world, going against doctrines which treat perception as a simple result of the action of external things on our body as well as against those which insist on the autonomy of consciousness. These philosophies commonly forget—in favor of a pure exteriority or of a pure interiority—the insertion of the mind in corporeality, the ambiguous relation which we entertain with our body and, correlative, with perceived things.  

Through Merleau-Ponty’s work and the work of those who have followed him, “the roots of the mind in the body” have been investigated in ways that make possible an account of how perception is formed through public action. Because of this attention to the embodied and contextual roots of our perception, Merleau-Ponty’s approach to phenomenology provides helpful conceptual resources for our efforts at uncovering the social imaginaries present in medicine’s treatments of the body in the modern hospital. In particular, Merleau-Ponty’s refusal of “a pure exteriority” and “a pure interiority” is an effort to move beyond accounts of agency that either are thoroughly determined by external affairs or that depend upon a mysterious inner capacity of autonomous self-governing. Both of these accounts of agency treat the body as “merely an object in the world,” and the only question is whether the body is under the control of outside causal forces or if its levers are being pulled by the mysterious Cartesian ghost in the machine. 

Instead, Merleau-Ponty wants to consider the lived body as

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“on the side of the subject; it is our point of view on the world, the place where the spirit takes on a certain physical and historical situation.”

In other words, to perceive one’s own body as a living body is, in a way, to not perceive “it” at all. The first-person perspective of the lived body is a centered and integrating way of perceiving the world from the vantage-point of embodied existence moving through space and time. As Merleau-Ponty says in his most famous work, *Phenomenology of Perception*, “I am not in space and time, nor do I think space and time; rather I am of space and time; my body fits itself to them and embraces them.” To be “of space and time” means that we have no way of completely stepping outside of our situated and finite perspective in order to perceive ourselves objectively. Instead, “we experience our perception and its horizon “in action” [pratiquement] rather than by “posing” them or explicitly “knowing” them.” The perception of our living body is instantiated through our action in the world, even as it constitutes how we perceive that world. In contrast, to properly perceive your body as an object, you must step out of your skin, so to speak, in order to view it from a third person perspective, one that presumes to be as non-localized and ahistorical as possible.

In order to further explore the relevance of the lived body for this project, we turn to examine two phenomena. First, we examine Merleau-Ponty’s understanding of the phenomenon of “double sensations” as an opening into the intersubjective nature of

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67 Maurice Merleau-Ponty, *Phenomenology of Perception*, p. 141. The translator provides a helpful note on the phrase “I am of space and time,” saying, “Merleau-Ponty writes “je suis à l’espace et au temps,” a phrase that, like être au monde, makes use of the rich meaning of the preposition à. In addition to the translation “I am of space and time,” it could be rendered as “I am toward space and time,” “I am at space and time,” or even “I belong to space and time” (n. 103, p. 525). These different translations of the original phrase point out the ways in which embodiment orients our existence within space and time.
perception. Second, we give an account of the conversion of perception that can occur due to how the phenomenon of bodily disruption is experienced within the formative context of modern medicine. These two notions are intimately connected to phenomenology’s understanding of the “life-world,” which serves as a key conceptual bridges to the rest of this project’s methodology. By attending to intersubjective encounters that entail the conversion of perception, we can give begin to give an account of the worlds of action within the modern hospital, one that requires ethnographic and historical work to fully understand.

1.3.2 Double Sensations

If our lived body is our “point of view on the world,” then what might it mean for us to try to see and touch our body itself as an object, rather than view the world and its objects through our body? Merleau-Ponty recognizes the difficulty of this act of perception, claiming that our lived body is, in a way, unseen and untouchable. “Insofar as it sees or touches the world, my body can neither be seen nor touched. What prevents it from ever being an object or from ever being “completely constituted” is that my body is that by which there are objects. It is neither tangible nor visible insofar as it is what sees and touches.”\(^{69}\) Merleau-Ponty’s “insofar” here is crucial, for through it he acknowledges that that our embodied subjectivity exists on a spectrum ranging from the lived body as the subject of one’s own actions to an objectified body perceived and manipulated by others (including one’s own self, insofar as one can abstract away from one’s embodiment). To explore the extent to

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\(^{69}\) Merleau-Ponty, *Phenomenology of Perception*, 94, emphasis added. As Merleau-Ponty’s translator notes, the phrase “completely constituted” likely comes from Husserl’s *Ideas Pertaining to a Pure Phenomenology and to a Phenomenological Philosophy*, vol. 2, *Studies in the Phenomenology of Constitution*, trans. Richard Rojceqicz and André Schwur (Dordrecht: Kluwer, 2002), where he says, “The same Body which serves me as a means for all my perception obstructs me in the perception of itself and is a remarkably imperfectly constituted thing” (§41, 167).
which one can objectify one’s own body, Merleau-Ponty analyzes the phenomenon of “double sensations,” when the body touches itself.\textsuperscript{70}

Take a moment, if you can, to bring your two hands together. Perhaps the first thing you perceive is your right hand being touched. The feel of another finger being pressed against your skin can be experienced as the tingle of the lightest touch, the force of a finger pressed deeply into your flesh, or something in between. At this moment, your right hand is the subject of your embodied experience, the lived body perceiving itself in relation to another object. It just so happens, however, that this object is also part of your own body. It is your left hand. So begin to consider what it feels like for your left hand to be touching your right. This may be hard to do, given the sensitivity our hands have to being touched. But as you press into and palpate your right hand, you might begin to feel the differences between smooth and callused skin, the warmth from the blood, and bones and ligaments under the surface. Now your left hand is the lived body through which you encounter your right hand as an objectified body. This process can then repeat from the opposite direction, with the left hand recognizing itself as being touched and the right hand experiencing touching the left.

This complicated interplay of two hands alternating between touching and being touched gets at the complex relations between the lived body and the material, objectified body, and it also begins to lay the conceptual framework for intersubjective encounters that refuse to reduce other embodied persons to objects. Merleau-Ponty describes the “double sensation” of the left hand touching the right as follows:

\textsuperscript{70} Here Merleau-Ponty is furthering the work of others before him, including Husserl, who described the phenomenon of “double sensation” in \textit{Ideas}, vol. 2, §36, 152-154.
I can recognize the touched hand as the same hand that is about to be touching; in
this package of bones and muscles that is my right hand for my left hand, I glimpse
momentarily the shell or the incarnation of this other right hand, agile and living, that
I send out toward objects in order to explore them. The body catches itself from the
outside in the process of exercising a knowledge function; it attempts to touch itself
touching, it begins “a sort of reflection,” and this would be enough to distinguish it
from objects. I can certainly say that these latter “touch” my body, but merely when
it is inert, and thus without ever catching it in its exploratory function.71

As “the body catches itself from the outside” and “attempts to touch itself touching,” a
process of reflexivity occurs in which the physical “package of bones and muscles” of the
hand is recognized as a living body. In the phenomenon of “double sensation,” the
recognition of a physical body, an object, as an embodied center of perception, a subject, is
immediately followed by that object becoming the subject. And “immediately followed by”
may imply too much temporal separation: when the left hand touches the right, the act of
perceiving the right hand as a thing that is touching back becomes, with no clear point of
separation, the right hand perceived as touching the left.

In this way, Merleau-Ponty has provided the beginnings of an account of recognition
of other subjects centered on touch. Further elaboration of embodied intersubjective
encounter can be found in the manuscript Merleau-Ponty was working on when he died at
the age of 53, published posthumously as The Visible and the Invisible. When describing the
phenomenon of “double sensation” and the reversibility of touch it entails, he says,

Now why would this generality, which constitutes the unity of my body, not open it
to other bodies? The handshake too is reversible; I can feel myself touched as well as
and at the same time as touching, and surely there does not exist some huge animal
whose organs our bodies would be, as, for each of our bodies, our hands, our eyes
are the organs. Why would not the synergy exist among different organisms, if it is
possible within each? Their landscapes their actions and their passions fit together
exactly… 72

71 Merleau-Ponty, Phenomenology of Perception, 95. In his examination of “double sensations,” Merleau-Ponty is
furthering the work of others before him, including Husserl, who described the phenomenon in Ideas, vol. 2,
§36, pp. 152-154.
72 Merleau-Ponty, The Visible and the Invisible, 142.
We will return to Merleau-Ponty’s conception of the phenomena of double sensations later in this chapter and in the project, as it is both phenomenologically and theologically fruitful. First, however, we further explore the intersubjective nature of what it means to touch and be touched in moments of epistemic vulnerability, particularly in the context of healthcare. Through examining the conversion of perception, we can better illuminate the formative power of medical imaginaries.

1.3.3 Conversion of Perception

According to Merleau-Ponty, “the body is our general means of having a world.”73 Because of this, in moments of bodily disruption our bodies and our worlds become strange to us. This could be through something as severe as acute pain that induces vomiting or through something as minor as an uncontrollable eye twitch. The more intense the disruption, the more pressing the demand for interpretation, which can enable a conversion of bodily perception. In order to understand this conversion, we will draw from the phenomenological accounts of the conversion of perception given by Elaine Scarry and Kay Toombs and from the account of conversion that Pierre Hadot gives from the history of philosophy. In doing so, we will be in a position to move more fully into the intersubjective world that Merleau-Ponty began to describe in his description of double sensations.

In The Body in Pain, Elaine Scarry examines the phenomenon of pain and how it makes possible the conversion of the self. Scarry argues that intense pain “destroys a person’s self and world,” for intense pain is “language destroying: as the content of one’s world disintegrates, so the content of one’s language disintegrates; as the self disintegrates, so that

73 Merleau-Ponty, Phenomenology of Perception, 147.
which would express and project the self is robbed of its source and its subject.”  

As self, world, and language dissolve in pain, the subject is left epistemically vulnerable and open to being reworded. Given a new linguistic account of the pain, a converted self can emerge with a transformed perception of the world. In her work, Scarry offers one pathway of conversion as seen in the torture chamber. We will attend to this in chapter two as we consider a medical imaginary that construes the body as enemy. But for now it is simply worth noting that intense pain makes possible a conversion of perception that is dependent on the language offered to the epistemically vulnerable person in pain.

In *The Meaning of Illness*, Kay Toombs offers a phenomenological account of how the experience of bodily disruption becomes perceived as disease. For Toombs, it does not require something as intense as acute pain for the conversion of perception. Instead, insofar as “the lived experience of the body itself becomes the focus of attention,” then “one’s ongoing engagement with the world” is disrupted. Because of this, “the body can no longer be taken for granted and ignored. Rather, the bodily disruption must be attended to and interpreted.”  

At this moment, the subject is epistemically vulnerable to modes of perception offered by others. As we shall see in chapter three, Toombs offers a pathway of processes by which the experience of bodily disruption becomes interpreted according to a biomedical model, which we shall consider in light of a medical imaginary that construes the body as an object.

In their accounts of the conversion of perception, both Scarry and Toombs participate in a type of phenomenological thinking that considers instances of foregrounding the body’s

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experiences for reflection as indicating a problem. Phenomenologist Havi Carel summarizes this tradition of thought when she says,

illness, in contrast [to the transparent healthy body], creates areas of dramatic resistance in the exchange between body and environment….Additionally, the body becomes explicitly thematized as a problem. The tacit taken-for-granted attitude we have towards it (we expect our bodies to perform complex actions, to be pain-free, to allow us to concentrate, and so on) is replaced by an explicit attitude of concern, anxiety, and fear.  

This tradition of phenomenological inquiry conflates our embodied experience of “dramatic resistance” when attempting to inhabit certain environments with our bodies becoming problematic. But this conflation does not need to be the case. Such a move disregards a plethora of other instances in which the body is presented to our consciousness for attention and interpretation. Examples from ordinary life include eating, drinking, physical labor, sex, exercise, and dancing. Several religious traditions include significant religious practices that foreground bodily experience, such as fasting, feasting, and ablution. In minor and major ways, these practices foreground bodily sensations not as inherently problematic, but as potential bridges into an altered way of life. They make possible other kinds of conversion.

Such conversions involve a transformation of our own embodied existence. In everyday life, focusing on the body’s pains and difficulties does not necessarily indicate the presence of a problem: in exercise or the discipline of dance or sports, such pain and difficulty represent new possibilities as the body’s habits are being retrained and its abilities

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77 This strand of phenomenological thought dates back at least to Sartre, and it is from him that Toombs develops it. See also Drew Leder, *The Absent Body* (Chicago: University of Chicago Press, 1990).
78 Kristin Zeiler contrasts the body presenting to our consciousness as a problem (“dys-appearance”) to the body being experienced as “well, easy, or good” (“eu-appearance”). She claims, “Eu-appearance can take place in physical exercise, in sexual pleasure and in some cases of wanted pregnancies,” and draws from Young to explore the latter. See, Kristin Zeiler, “A Phenomenological Analysis of Bodily Self-Awareness in the Experience of Pain and Pleasure: On Dys-appearance and Eu-appearance,” *Medicine, Health Care and Philosophy* 13, no. 4 (2010): 333.
are being extended. In Christian religious life, the practice of fasting draws attention to the
body’s needs, not to label the body as problematic, but rather in an effort to increase
awareness of dependency upon God. Such spiritual discipline takes the moment of physical
discomfort to be an opportunity for the fire of the Holy Spirit to melt down hardened habits
in hopes of rendering a body more free to live the life God is calling into existence. And so
bodily disruption can become the occasion for multiple pathways of conversion.

Conversion can also occur at the interpersonal or structural level; in fact, bodily
conversion is bound up with social and institutional changes. For example, an unsettled sense
of dread and discomfort often accompanies the need for and practice of truth-telling and
reconciliation in relationships. Attending to what our bodies are saying to us about our
contexts is common advice in contemporary counseling. The experience of the body
becoming present to our consciousness may signal the presence of deep structural injustice.
Bodies worn down through exploitation cry out against the unjust labor practices and
economic systems. Religious preachers and prophets attest to this when they cannot bear the
disjunction between divine truth and a broken world. The prophet Jeremiah laments the
bodily anguish that he experiences when, in light of the world that surrounds him, he tries to
hold in the difficult divine message he has been given.

For whenever I speak, I must cry out, I must shout, “Violence and destruction!” For the word of the Lord has become for me a reproach and derision all day long. If I say, “I will not mention him, or speak any more in his name,” then within me there is something like a burning fire shut up in my bones; I am weary with holding it in, and I cannot (Jer. 20: 8-9).

Jeremiah’s experience of bodily disruption has nothing to do with illness; instead, it signals
the presence of profound social injustices and the divine judgment that accompanies them.
Jeremiah is driven to call Israel to repentance and conversion on a societal level.
Therefore, in individual, interpersonal, and structural ways, in both everyday life and religious practice, the body’s opacity does not necessarily point to illness. It may accompany new possibilities or reveal other problems. But what all of these instances share, however, is that the body’s opacity is the condition of possibility for the conversion of a mode of habituated embodiment, the transformation from one way of being in the world into another. Conversion is inherently social; at moments of epistemic vulnerability, we receive modes of perceiving and inhabiting the world from those around us. For this project, this means that we must attend to the contexts within which conversion occurs in modern medicine. Here, again, we see the importance of medical imaginaries for making possible certain modes of action, perception, and speech.

Pierre Hadot’s work on conversion helpfully illuminates this transformation of one’s embodied understanding, framework of meaning, and form of life. Hadot claims that the concept of conversion has two roots in Western thought, traced back to the Greek words ἐπιστροφή and μετανοία that correspond to the Latin conversio, from which we get our modern word “conversion.” Hadot argues that these words capture two deep and distinct meanings: ἐπιστροφή “signifies change of orientation and implies the idea of a return (return to the origin, return to the self)” whereas μετανοία “signifies change of mind, repentance, and implies the idea of a mutation and a rebirth.” Because the concept of conversion contains the ideas of both “return” and “rebirth,” Hadot argues that Western consciousness and conscience are split between desiring a return to a former state on the one hand and seeking the creation of a new reality on the other. In the practice of medicine, these two poles of

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conversion are particularly pressing because of the epistemic vulnerability that marks a person experiencing bodily disruption. For many, healing is considered to be a kind of *epistrophe*, a return to a former state of physiological function. And yet the stories of those who have been healed from a serious illness often refer to the notion that there can be no going back, but instead they must learn to embrace a new normal; *metanoia* is required. As we shall see, this tension between *epistrophe* and *metanoia* operates on both individual and institutional levels.

### 1.3.4 Life-World

With this account of the conversion of perception that can be occur in the lived body, we now turn much more briefly to a second key concept that helps illuminate this process, one originally found in Husserl and then developed throughout the phenomenological tradition: the life-world (*Lebenswelt*). In his later writings, Husserl began “asking after the *how* of the world’s pregivenness” as a new mode of the phenomenological reduction as contrasted with the normal “Cartesian way.” He did this by examining the “life-world” as “the world in which we are always already living and which furnishes the ground for all cognitive performance and all scientific determination.” The life-world, then, provides the framework in which we perceive and act. The conversion of perception described above is in many ways the habituated adoption of a new life-world. Heidegger, Merleau-Ponty, and many others engaging with Husserl’s thought have taken the concept of

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the life-world to move beyond the single individual at the center of Husserl’s thought.\textsuperscript{82} As we saw earlier, Merleau-Ponty’s focus on the embodied nature of perception reveals how perception occurs through temporally and spatially situated action in between oneself and others. Investigations of the “life-world” are efforts at understanding the contours of the time and space in which such action and perception occurs. The “life-world” does not appear as a timeless and transcendent reality, but rather as an embodied and contingent one. The process of historicizing the life-world opens it up to investigation.

Although the “life-world” is not a fully explored concept in Husserl’s own thought, through it phenomenology has proved to be generative for sociologists and anthropologists looking to investigate how we come to assume a certain vision and mode of inhabiting the world. Alfred Schutz worked to bridge the fields through what he called “phenomenological sociology.” His final work, \textit{The Structures of the Life-World}, contains an entire section entitled “The Life-World as the Province of Practice.”\textsuperscript{83} In fact, the concept of the life-world has become so much a part of the parlance of contemporary medical anthropology that a leading figure in the field, Veena Das, co-authored an essay entitled, “How the Body Speaks: {\par

\textsuperscript{82} Although beyond the purview of this project, we can trace a line within phenomenological thought from Husserl’s conception of the life-world to Heidegger’s notion of “Being-in-the-world” (\textit{In-der-Welt-sein}). Merleau-Ponty goes so far to suggest at the beginning of \textit{Phenomenology of Perception} that “all of \textit{Sein und Zeit} emerges from Husserl’s suggestion, and in the end is nothing more than a making explicit of the “\textit{natürlichen Weltbegriff}” [natural concept of the world] or the “\textit{Lebenswelt}” [life-world] that Husserl, toward the end of his life, presented as the fundamental theme of phenomenology.” Merleau-Ponty, \textit{Phenomenology of Perception}, lxx-lxxi.

\textsuperscript{83} Alfred Schutz and Thomas Luckmann, \textit{The Structures of the Life-World}, vol. II, trans. Richard M. Zaner and David J. Parent (Evanston, IL: Northwestern University Press, 1983), 1-97. Several interesting threads are connected through \textit{The Structures of the Life-World}. First, Luckmann was Schutz’s student and finished the book from extensive notes left at Schutz’s death. He later co-authored with Peter Berger the hugely influential book, \textit{The Social Construction of Reality} (New York: Anchor Books, 1966). Second, Richard Zaner, who co-translated Shutz’s \textit{The Structures of the Life-World}, is an important early figure in the phenomenology of health and medicine. Finally, the other translator of the first volume of Schutz’s \textit{The Structures of the Life-World} was Tristram Engelhardt, whose work in bioethics will be a major focus in chapter three of this project.
Illness and the Lifeworld among the Urban Poor,” without making any reference to the origins of the term in phenomenology.  

In Das’s work we can begin to see lines of connection between the Wittgensteinian influences we traced in Hauerwas’s work, and the importance of phenomenology for medical anthropology. Wittgenstein famously said, “And to imagine a language is to imagine a form of life.” Husserl’s conception of the “life-world” and Wittgenstein’s description of “forms of life” both depict a reality in which personal experience and public practices are deeply joined together. Das pursues just this point in an essay entitled “Wittgenstein and Anthropology,” where she writes,

> Now if I am correct that the inner is not like a distinct state that can be projected to the outer world through language in Wittgenstein but rather like something that lines the outer, then language and the world (including the inner world) are learned simultaneously.

Das’s somewhat elliptical claim that the inner world lines the outer points to the deep interrelationship between our private and public selves, mediated through language. Writing with Clara Hans, Das explains this further, saying, “The expression “form of life” helps us see language not as linguistic philosophy does—as about language—but rather as human

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> What, then, does phenomenology mean for sociological ethnography? It means the study, through various participant observation-like methods, of the structures of the life-world, meaning the forms, structures or features that people take as objectively existing in the world as they shape their conduct upon the presumption of their prior, independent existence.


beings’ life in language.” Through the concept of a “form of life,” then, Das is able to show how anthropology investigates our lives in language. In terms of Hauerwas’s dictum, learning to speak is learning the world which we perceive and in which we act.

This Wittgensteinian approach to anthropology emphasizes the public, communal, and embodied nature of language in ways that enable the articulacy of the moral world made possible in the ordinary practices and rhythms of life. It also brings us back Byron Good’s account of the formation of medical students. In his argument for a methodological basis for medical anthropology, Byron Good makes explicit use of the concept of the “life-world” as a link between phenomenological description of embodied experience and anthropological description of the contextual setting in which such experience makes sense and is made possible. According to Good, Husserl’s concept of the life-world and Merleau-Ponty’s development of it sets the stage for the investigation of how “the rhythms and disruptions of experience presume a socially organized lifeworld.” As we saw above, Good displays the richness of this attention to the life-world within the world of medicine through his examination of the transformations of seeing, writing, and speaking that medical students undergo within the hospital, exemplifying how the work of phenomenology lends itself to anthropological investigations of the world in which perception is shaped.

Good himself offers a methodological summary of how phenomenology is linked to the work anthropology, which together make possible robust moral reflection:

In sum, I am suggesting that we can bring method to the cross-cultural investigation of illness experience, method quite different than that suggested by the standard

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88 Good writes, “The self is constituted in relation to a world, and it is not only through direct description of embodied experience by through the description of that lifeworld that we have access to the selves of others.” Good, Medicine, Rationality, and Experience, 123.
89 Ibid.
paradigms of the medical behavioral sciences. The unmaking and making of the world are social as well as perceptual processes that can be systematically investigated. They lead us quickly to phenomenological dimensions of illness experience, as well as to narrative and ritual dimensions of efforts to reconstitute the world unmade. They also reveal the practices and ideologies that encode structures of social relations and power, as these shape the rhythms of illness and therapies, and are thus subject to a critical phenomenology. And they open onto moral questions provoked by suffering.\footnote{Ibid., 134.}

By linking moral reflection, perception, and social practices, Good reinforces the methodological claim this project is developing. From Husserl’s conception of the “life-world” to Wittgenstein’s understanding of “forms of life,” we can see how phenomenology’s attention to embodied perception opens up to an investigation of the temporal and spatial contexts in which we learn and live in language. Good and Das’s anthropological studies have prepared us to give a methodological account of the importance of attending to the social discourses and practices that make possible the worlds within which we act. To this we now turn.

\section*{1.4 You Can Only Perceive What You Can Say: Social Formation in Medical Sites}

In moving from perception to speech, we seek to give an account of the necessity of attending to the social formation of distinct modes of imagining and engaging the patient’s body. While phenomenology is capable of giving an account of distinct forms of perception that frame moral action, it is limited in its ability to describe the formative discourses, practices, and practitioners that set the contexts of action. Without attending to institutional arrangements that have developed over time, we are unable to fully illuminate the moral conflicts and sources embedded within the modern hospital. By turning from
phenomenology to ethnography and history, then, we turn to modes of description that enable normative judgments in light of the structures that frame moral encounters in healthcare.

1.4.1 Foucault and the “Conditions of Possibility of Medical Experience”

We begin with the work of Michel Foucault, who began his seminal work, *The Birth of the Clinic*, by claiming, “This book is about space, about language, and about death; it is about the act of seeing, the gaze.”

It is difficult to overstate the influence that Foucault and his work on the clinical gaze have had in the fields of medical anthropology, sociology, and history, and this project builds off of his attention to the sites of the linguistic and perceptual formation. Like Foucault’s, this project seeks to be “both historical and critical, in that it is concerned—outside all prescriptive intent—with determining the conditions of possibility of medical experience in modern times.”

As we shall see, this descriptive work will be taken up with prescriptive efforts in ways that Foucault was averse to doing directly. But for now, we focus on how Foucauldian thought can enable us to speak the worlds within which action occurs in modern healthcare. In this way, we will be in a position to articulate medical imaginaries and their moral sources in ways that can be joined to moral reflection.

Foucault’s focus in *The Birth of the Clinic* on “the conditions of possibility of medical experience” results in attention to the spaces, histories, discourses, and practices that have enabled contemporary modes of perception in healthcare. Gerald McKenny describes the importance of this move in his appreciative engagement with both phenomenology and Foucault as resources for a more robust bioethics, saying, “If Foucault’s account is superior

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92 Ibid., xix.
to that of the phenomenologists, it is due to his recognition of the ways in which subjects are formed by practices that act on the body.”93 Foucault’s attention to these formative practices is historical, as he provides an account of how a particular way of seeing has come into existence over time. In other words, he historicizes what Husserl called the “life-world” in the ways suggested at the end of our examination of phenomenology.

It is telling, therefore, that as we move from phenomenology to history, sociology, and anthropology, that we shift from a discussion of Merleau-Ponty’s *Phenomenology of Perception* to Foucault’s *The Birth of the Clinic*, which is subtitled *An Archaeology of Medical Perception*. Foucault’s earlier work often uses the term “archaeology,” which Jeffrey Bishop describes as taking “a good look around a particular historical moment in order to explain how different aspects of particular histories—of particular times—have different origins but work together to create the present.”94 But with *Discipline and Punish*, Foucault’s middle work shifts to the task of genealogy, which traces the often quotidian and always contingent processes that produce different visions of the world. In a famous essay, “Nietzsche, Genealogy, History,” Foucault expounds on the genealogical task with particular relation to the body. He describes the body as “the inscribed surface of events” and defines the task of genealogy as exposing “a body totally imprinted by history.”95

In this project, I follow Jeffrey Bishop’s reading of Foucault in *The Anticipatory Corpse* to offer a “method of engagement [that] is both genealogical and archaeological; it deals

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93 Gerald McKenny, *To Relieve the Human Condition*, 209. McKenny goes on to say, “The tendency of the phenomenologists to ignore the ways in which the lived body is a product of such practices in favor of an almost exclusive emphasis on what appears to (or withdraws from) cognitive awareness testifies to the continuing hold of the Cartesianism they claim to have superseded.” Our above discussion of phenomenology focused on important strands that largely avoid McKenny’s charge, which remains true for much work in the field.


with medicine’s history (time) and its politics (space).” Such an exploration of “political space and historical time” asks “medicine how its practices came to be.”

In this shift from phenomenology to Foucault’s account of what makes possible medical perception, we seek to attend to the historical development of discursive practices that form the body. Because of this, ethnographic and historical work on healthcare will be foundational in this project’s articulation of the medical imaginaries found within the modern hospital. Following Foucault, the hospital must be considered as a formative institution for our medical imaginaries. Therefore, we now turn to the importance of institutions for this project’s methodology.

1.4.2 Institutions

As Byron Good has shown, the modern research and teaching hospital is a deeply formative institution that houses and shapes foundational modes of action, perception, and speech in modern medicine. In its exploration of moral agency within an institution, this dissertation sits at the nexus of a variety of schools of thought that operate from diverse assumptions about the value of institutions. For some, institutions are a deeply repressive and hostile threat to human freedom and flourishing.

But for others, human flourishing

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96 Bishop, The Anticipatory Corpse, 23.

97 For example, Ivan Illich begins Limits to Medicine: Medical Nemesis: The Expropriation of Health (London: Marion Boyars, 1975, 1995) with the following line: “The medical establishment has become a major threat to health” (3). Illich, whose work has been influential for philosopher Charles Taylor, is at times a bit more nuanced than this: “I have argued that institutions are functional when they promote a delicate balance between what people can do for themselves and what tools at the service of anonymous institutions can do for them.” Tools for Conviviality (London: Marion Boyars, 1973), 84. Michel Foucault’s description of modern institutions is often taken to be a negative normative assessment, though it is unclear just where to trace the lines of Foucault’s normative vision, as his basic reflections on power consider it to be a creative force. At the least, in their reception Illich and Foucault represent a general anti-institutional strand within much scholarship, only hinting at the possibility of redemption of institutions. As Illich says in a series of interviews near the end of his life, “The way I judge and hope to accept modern institutions is not as plain evil but as sinful, as the attempt to provide by human means what only God calling through the beaten-up Jew could give to the Samaritan, the invitation to act in charity.” The Rivers North of the Future: The Testament of Ivan Illich as told to David Cayley (Toronto: Anansi, 2005), 180.
would be impossible without institutional life.\textsuperscript{98} This project avoids sweeping claims about the inherent nature and value of institutional life and instead follows the judgment of anthropologist Mary Douglas, who proposes that “moral philosophy is an impossible enterprise if it does not start with the constraints on institutional thinking.”\textsuperscript{99} In other words, the formative power of institutions for our moral agency, perception, and speech is hard to overestimate, and any serious work in moral philosophy and theology must grapple with present institutional contours and forces. With the importance of this kind of institutional examination in mind, a brief overview of two relevant approaches to institutions is in order.

First, for Foucault, institutions are where power “becomes embodied in techniques, and equips itself with instruments and eventually even violent means of material intervention.”\textsuperscript{100} These disciplinary techniques are instantiated in discursive practices that produce “subjected and practised bodies, ‘docile’ bodies.”\textsuperscript{101} In order to understand the variety of “docile bodies” produced in modernity, Foucault suggests the need for the histories of “different disciplinary institutions, with all their individual differences.”\textsuperscript{102} His discussion of the medical clinic and the modern prison are a move in that direction, but Foucault acknowledges that his fundamental purpose is “to map on a series of examples

\textsuperscript{98} See, for example, Hugh Heclo, \textit{On Thinking Institutionally} (Boulder, CO: Paradigm Publishers, 2008). Heclo provides a helpful summary of contemporary social science scholarship on institutions in his chapter, “From Thinking about Institutions to Thinking Institutionally,” 45-79.


\textsuperscript{102} Ibid., 139.
some of the essential techniques that most easily spread from one to another.”

Significant work in medical history, sociology, and anthropology has followed Foucault’s focus on how bodies are shaped and subjects formed in particular institutional settings, and we will engage that work throughout this project.

This project brings together this Foucauldian line of inquiry with an Aristotelian approach that emphasizes the importance of institutions for sustaining the conditions and possibilities for virtuous practices and human agency. Alasdair MacIntyre describes institutions as primarily concerned with external goods (such as a hospital’s concern for money), but he also says that institutions are the bearers of particular practices concerned with the pursuit of internal goods (such as medicine’s concern for health). “No practices can survive for any length of time unsustained by institutions,” but at the same time “the ideals and creativity of the practice are always vulnerable to the acquisitiveness of the institution.” MacIntyre claims that the virtues enable a practitioner to faithfully practice a craft while resisting “the corrupting power of institutions.” MacIntyre’s focus on the role of the virtues as mediating between practices and institutions points toward the question of human agency as practitioners operate within institutional space. But institutions are not simply “corrupting” on MacIntyre’s account, for the renewal of moral traditions is and will be necessarily institutional. Those committed to such moral renewal, according to MacIntyre, have “commitments to making and sustaining institutions that provide for those practices

103 Ibid. Foucault ends his section on discipline with a rhetorical question that suggests some similar institutions for this kind of inquiry: “Is it surprising that prisons resemble factories, schools, barracks, hospitals, which all resemble prisons?” 228.

104 For a thoughtful constructive engagement with Foucault, MacIntyre, Stoicism, and the contemporary practices of science, see Paul Scherz’s dissertation, “Technology and Subjectivity in the Thought of Alasdair Macintyre and Michel Foucault,” (PhD diss., University of Notre Dame, 2014).

105 Alasdair MacIntyre, After Virtue, 194.

106 Following MacIntyre, Stanley Hauerwas writes, “In my accounts, agency but names our ability to inhabit our character.” Stanley Hauerwas, The Peaceable Kingdom (Notre Dame, IN: University of Notre Dame Press, 1983), 40.
through which common goods are achieved, practices of families, workplaces, school, clinics, theaters, sports, institutions that characteristically, although not always, take the form of cooperative enterprises.”

How, then, might the modern hospital be such an institution enabling moral renewal?

Luke Bretherton develops this possibility in an important way in *Resurrecting Democracy*, which considers broad-based community organizing as making possible the politics of a common life. In reflecting on the life and legacy of Saul Alinsky and his Industrial Areas Foundation (IAF), Bretherton mentions the importance of certain anchor institutions for community organizing in an age when the possibilities for committing to the good of a particular place seem to be continually shrinking. He describes hospitals and universities as “large-scale anchor institutions that connect people and capital to place in relatively stable configurations over time.” Although he recognizes that there may be multiple self-understandings within such institutions, which we turn to in a moment, Bretherton argues that

as vocational institutions rooted in the history of a place there is, at least notionally, a common ethos and covenental commitment to a shared purpose and vision. The commitment to delivering a substantive good such as health or education that sits above and beyond the institution can be used alongside more mundane place-based and convivial interests as a basis on which to organize.

In a development of MacIntyre’s more hopeful take on institutions, Bretherton argues that institutional commitments to host practices devoted to certain substantive goods like health

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107 MacIntyre, *Ethics in the Conflicts of Modernity*, 110. Here he is drawing from the example of the English Distributivists to make a wider point about the possibilities for moral renewal in an economic order structured by capitalism.


or education carry with them a “shared purpose and vision” about the purposes of the institution. These commitments, as expressed through the work of people in a particular place over time, can enable a substantive moral formation capable of resisting a shallow utilitarian calculus.

In his description of anchor institutions, Bretherton acknowledges that such large structures often contain diverse sectors with their own individual interests, values, and visions of the good, saying, “Different sections of the hospital or university are equivalent to different institutions in a coalition.”\textsuperscript{110} This dissertation takes those differences seriously within the modern research and teaching hospital and the practices of healthcare it contains. Simply put, today’s hospital does not operate with a single medical imaginary. Because of this reality, this project seeks to bring together the work of phenomenology, ethnography, and history in order to excavate three distinct medical imaginaries operative within the modern hospital.

Foucault’s account of the rise of the modern clinic traces the ascendancy of one particular medical imaginary, and we shall explore it further in chapter three. But the history of medicine and the space of the hospital do not begin, as Foucault suggests, with the French at the end of the eighteenth century. Western medicine traces its roots back over 2,500 years, and the institution of the hospital has its earliest origins in both the Roman Empire’s military hospital, the \textit{valetudinarium}, and Basil of Caesarea’s combination of medical care with the \textit{xenodocheion} (house of strangers) in the fourth century CE. For our guide to this history, we follow Guenter Risse’s definitive work, \textit{Mending Bodies, Saving Souls: A History of

\textsuperscript{110} Bretherton, \textit{Resurrecting Democracy}, 294.
We engage this history in chapters two and four, depicting alternate medical imaginaries to the Foucauldian medical gaze.

Therefore, this project focuses in on three paradigmatic sites in the modern hospital, with the term “site” referring to an arrangement of practices, discourses, and practitioners deeply connected to recognizably distinct modes of imagining and engaging the human body within modern healthcare. The three sites are the surgical ward, the Intensive Care Unit (ICU), and labor and delivery. Within each we can discern a particular medical imaginary at work assuming the body to be an enemy, an object, or a friend. As we shall see, the first two of these medical imaginaries consider healthcare as states of emergency and exception, while the last remains committed to the bounded ordinariness of bodily care.

By focusing in on these three paradigmatic sites and their accompanying medical imaginaries, surely some of the messy richness and complexity of modern healthcare will be lost. But these paradigmatic sites possess what Hannah Arendt called an “exemplary validity” that assists in moral assessment. In describing the importance of ethnography, Luke Bretherton says, “The key to generating judgments on the basis of phronesis is to identify case studies within which assessment of practices can take place.” These three paradigmatic sites are just such case studies. Bretherton goes on to describe the importance of such an approach in language that recalls our earlier discussion of the importance of public action. As he writes,

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analysis of exemplary case studies enables a movement beyond subjectivity into the arena of publicly adducible reasons or grounds. The intellectual task is to give an account of the conditions and possibilities for judgment, the process of developing grounds for judgment, and the practices said to embody or enact those judgments.\footnote{Bretherton, “Coming to Judgment,” 181. Where Bretherton focuses here on the language and moment of “judgment,” I prefer to step back slightly in order to give a consideration of the operations of practical reason within different medical sites and imaginaries.}

By examining these three paradigmatic sites, this project takes up the task of naming and narrating the moment of moral judgment in the modern hospital, along with its accompanying operations of practical reason.

The work of ethnography and history enables the robust description of paradigmatic medical sites of moral formation. The patient’s body is imagined and engaged in particular ways in light of institutional arrangements that have developed over time. Drawing from the work of Foucault, MacIntyre, and Bretherton, we can say that this ethnographic and historical work makes possible the articulation of the moral conflicts and sources that are at work through distinct modes of perception and action found within the modern hospital. Therefore, by bringing phenomenology, anthropology, and history to bear on paradigmatic sites of action within the modern hospital, robust normative engagement is made possible.

### 1.5 Normative Engagement with Medical Imaginaries

#### 1.5.1 Connecting Description and Prescription

Following critiques of standard bioethics, the descriptive resources offered so far are brought together as a development of methodological trends in Christian ethics concerned with bioethics, as seen in Banner and Hauerwas. The crafting of fitting moral responses is made possible through this work of illuminating the moral concerns and issues within medical sites. As Stuart Hampshire writes, for moral action, “the crux is in the labelling, or...
the decision depends on how we see the situation." By interrogating the “labeling” provided by different medical imaginaries, we can better understand the moral responses fitting for each site.

This project will argue that three different forms of fitting moral response for three distinct medical imaginaries can be discerned within the modern hospital. While this will be examined in detail over the course of the work, we can understand how this connection between description and prescription works by recalling our opening examination of the Hippocratic Oath. The moral injunctions of the oath are fitting moral responses for the practice of a medicine within its own social, institutional, and political context. By seeking to pass along the craft over time, to maintain boundaries in the pursuit of the goods of that craft, and to navigate guest/host relations in the patient’s home, the Hippocratic Oath responds to the pressing moral concerns of the itinerant craftsman physician. As we shall see, different forms of moral response will be fitting for the distinct contexts of action discerned within the modern hospital.

Even though this approach satisfies the concerns of the critics of bioethics, this project is not satisfied with simply providing richer descriptive accounts that can illuminate moral concerns and so enable more fitting moral theories. While such work is important and necessary, it must be paired with a normative theological vision. Therefore, this project seeks to offer an account of how the practices of healthcare might be ordered within a theological understanding of healthcare as craft. Given a theological account of caring for the body, how should we morally consider work within the modern hospital? We will begin unfolding

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114 Stuart Hampshire, “Fallacies in Moral Philosophy” Mind 58.232 (1949): 466-482, 476. Hampshire is referring to a famous passage from Aristotle’s *Nicomachean Ethics* (1109b, 23-24) in which Aristotle admits the difficulty of knowing how well someone has hit the mean in particular situations.
this theological vision in the final section of this chapter, but first we must offer a conceptual account of how distinct medical imaginaries, with their own sets of moral concerns, might be normatively ordered toward an overarching theological vision. To do this, we return to the work of Charles Taylor, as developed by Graham Ward in conversation with feminist standpoint theory.

1.5.2 Ordering Medical Imaginaries

Graham Ward takes up and expands Taylor’s concept of a social imaginary in his Cultural Transformation and Religious Practice by focusing on the way in which agents navigate multiple social imaginaries. Ward’s argument is worth careful attention, as his work enables us to better consider how practitioners can thoughtfully negotiate a complex social institution like modern medicine. Ward draws from the work of feminist scholars on what is known as “standpoint theory,” which holds that a “standpoint is a shared knowledge; an understanding of the world that, in being articulated, is recognized and held to be a better account of the world than others available.”¹¹⁵ For feminist theorists such as Sandra Harding and Nancy Hartsock, standpoints exist on a spectrum of dominance to marginalization. By identifying marginalized standpoints that oppose the dominant mode of conceiving the world, Harding and Hartsock hope to make visible the “production of beliefs from specific locations and the challenges those beliefs pose to a culture’s dominant, naturalized and unquestioned accounts of truth.”¹¹⁶ By illuminating lived patterns of resistance to a dominant standpoint, standpoint theory provides conceptual assistance to the marginalized.

¹¹⁶ Ibid.
Ward goes on to claim that no one person simply inhabits one standpoint; instead, “any subject-position may embrace several standpoints, for several traditions of reflective practice may converge, overlap or stand in tension.” This means that no single standpoint dominates in such a way that all others standpoints are excluded. This claim undercuts those who maintain that subjects within an institution like the hospital are solely captive to one single way of imagining the world and their lives in it. We will have more to say in later chapters about what this means for medical practitioners. For now, we seek to explore the conceptual possibilities these alternate standpoints raise for resistance to dominant medical imaginaries.

According to Ward, in daily decisions, practices, and habits of life, the various standpoints that make up a subject-position are ordered into a normative hierarchy. When describing the relations between some of his own standpoints (being English, socialist, and a priest), Ward says:

Just as personal hierarchies emerge between evaluations and interpretations with respect to the extent to which they determine subsequent actions, so a hierarchy may structure the relations between various standpoint identifications for any one subject. This may be particularly so if one of the standpoints has transcendent significance. A commitment to a religious practice might (though not necessarily) be considered more significant and determine the character of the interpretation of and engagement in other standpoints – being a socialist, for example. This evaluation of one standpoint with respect to others may be enjoined by the traditions of that standpoint.

By acknowledging the possibility that standpoints with “transcendent significance” are well-positioned to interpret, engage, and order other standpoints into the integrity of a single subject-position, Ward describes how a religious moral agent can navigate complex spaces made up of competing practices and imaginaries. This account of agency has important

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117 Ibid., 83.
118 Ibid.
implications for moral theories developed in response to the problems of modern medicine. This dissertation seeks to enable—and, in fact, enjoin—medical practitioners to do the hard work of evaluating and ordering the multiple standpoints that make up the rhythms of each day. We shall examine how such work might be done throughout this project, especially in chapter four and the conclusion.

By focusing in on the standpoint of particular agents, then, Ward is able to mobilize Taylor's conception of a social imaginary for normative cultural engagement that is both critical of contemporary problems and constructively aimed toward hopeful possibilities. But this is not simply a tactical aid for solitary individuals attempting to make the best of the standpoints available to them. Instead, Ward draws from the discussion of standpoint theory in order to better describe and enable broader cultural engagement with multiple social imaginaries. As he writes:

My point is only to demonstrate how our lives inhabit, simultaneously, several different social imaginaries, and our living crosses back and forth through them all….What this means is that social imaginaries are never stable. They are as constantly shifting as time and context. They are continually being negotiated, questioned, recognized, forgotten, dreamed of, and aspired to. Each encounter with what is other to our social imaginaries calls for a reshaping of them all.119

Within the hospital, this means that even though certain medical imaginaries may be dominant, they do not exclude other ways of imagining and inhabiting the world. As Ward explains, it is particularly “at the more local level” where “the dominance of a ‘ruling ideology’ may well find successful forms of resistance.”120 This local level of resistance is not necessarily individualistic; in fact, it is in communities of support that these resistant imaginaries have a better chance of taking hold.

119 Ibid., 134-135.
120 Ibid., 135.
1.5.3 “New Imaginary Significations”

This dissertation will rely upon the more fluid conception of social imaginaries found in Taylor and Ward coupled with a deeper conception of the histories present within modern medical space and practice in an effort to open up conceptual room for new therapeutic possibilities within medicine.

Through Ward’s development of Taylor’s work in conversation with standpoint theory, we can give a better conceptual account of constructive moral work within the modern hospital. Those seeking to resist a dominant medical imaginary can order their work within an overarching normative vision. What might this work look like within the modern hospital? Ward’s description of two forms of constructive cultural engagement is helpful here:

There is then a twofold work for those projects involved in developing transformative practices of hope: the work of generating new imaginary significations and the work of forming institutions that mark such significations.121

As we shall see, there are some who believe that the work of forming new institutions should be the primary (if not exclusive) work of those interested in “developing transformative practices of hope.” In other words, a kind of separatism might be required in order to instantiate an alternate medical imaginary.

Rather than advocating separatism, we will engage Ward’s first task of “generating new imaginary significations” in this dissertation’s constructive work. This work is not done ex nihilo; instead, it is done by excavating the latent moral resources present within the hospital. For example, if a core thread in the history of the hospital is a Christian effort in Cappadocia over sixteen hundred years ago to integrate care offered to those who are sick,

then the work of forming new institutions has already been done, as we shall examine in chapter four. If this theological vision of the hospital is buried within the modern hospital, then this project seeks to uncover it and allow it to transform the imagination of contemporary medical practice.

Another way of describing this constructive work is an effort to give a conceptual account of Alasdair MacIntyre’s hopeful but underdeveloped claim in *After Virtue* that “the tradition of the virtues is regenerated...in everyday life...always through the engagement by plain persons in a variety of practices.” For if medicine is a tradition on MacIntyre’s terms—that is, an “argument extended through time in which certain fundamental agreements are defined and redefined” through internal debate and external critique—then its regeneration occurs through a marginalized aspect of the continuing argument gaining ascendancy in new, creative, and unforeseen ways.

But what, exactly, might it mean to generate “new imaginary significations” in modern medicine? First, medical practices must be amenable to multiple moral descriptions. Following Ward and Taylor, multiple medical imaginaries are carried within particular actions, habits, and daily rhythms that mark the institution of the hospital. We will explore whether or not this is the case within the labor and delivery ward in chapter four. And second, the dominant narratives describing medical practices must be challenged and perhaps replaced by marginalized narratives more amenable to the kinds of moral description and therefore agency promoted by this project. For example, the medical imaginary traced back to fourth century Cappadocia can challenge dominant medical imaginaries and enable the reordering of medical practice within an overarching normative

122 MacIntyre, *After Virtue*, xv.
123 Ibid., 12.
vision, one that seeks to assist patients in befriending their estranged flesh through practices of hospitable bodily care.

Therefore, by uncovering moral concerns and articulating latent moral sources within the institution of the hospital and the practice of healthcare, this project seeks to make possible two kinds of normative engagements. First, fitting moral responses can be crafted in light of the moral concerns and conflicts that mark particular medical imaginaries. The work of phenomenology, ethnography, and history makes possible the illumination of moral formations that entail these concerns and conflicts. In light of criticisms of standard bioethics and recent work in Christian ethics, this reconfigured approach to the work of bioethics provides a constructive way forward for moral theories in healthcare. Second, and more broadly, by articulating the latent moral sources carried within the hospital and the practice of healthcare, an overarching normative vision can order the practice of healthcare according to a marginalized but present medical imaginary, one that is committed to hospitable bodily care. We now conclude by making clear the theological vision that undergirds this project’s normative work.

1.6 Normative Theological Vision

Several theological sources are at work providing this project’s overarching normative vision. First, this project draws from the work of David Kelsey to provide a theological anthropology that situates interdisciplinary scholarship on embodied, public action within the context of God’s relation to creation. Second, the project is guided by a Christological account of intersubjectivity. Third, the project is funded by a pneumatological understanding of the work of healthcare as hospitable bodily care participates in the Spirit’s work of
befriending flesh. What follows is a brief description of these theological sources, which run throughout the project and surface at various points before coming back together in the conclusion.

1.6.1 Theological Anthropology

David Kelsey’s *Eccentric Existence* offers a theological anthropology within the context of three Trinitarian narratives of God relating to all that is not God. Kelsey’s project is one of several recent accounts of the Trinity and theological anthropology that have developed Karl Barth’s Christological focus in a distinctively Trinitarian key. These accounts describe the patterns of Trinitarian relations revealed in the person of Jesus Christ, “the image of the invisible God” (Col. 1:15). From there, they describe ways that human beings are incorporated by the Spirit into the body of Christ, thereby participating in the Son’s inter-Trinitarian relations. Therefore, humanity images the image of God, Jesus Christ, in a way that turns away from an interiorized imaging of God in rational operations without falling into social Trinitarianism’s undifferentiated relations of mutuality.

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Within this broader context, we are particularly interested in how Kelsey focuses on public bodily agency as fundamental to what human beings are, over and against accounts that privilege subjectivity and consciousness. Kelsey does so primarily in his section on God relating creatively through his close reading of Job 10, in which Job describes the ways God formed him in the womb and brought him into the world. Kelsey places the theology of birth he uncovers there in conversation with modern scientific conceptions of human existence and linguistic accounts of human personhood. As creatures, we are addressed by God and in a responsive relationship with God. Kelsey also claims that God relates to human beings indirectly, “through their creaturely proximate contexts, and in particular through us of an ordinary language.” This indirect mode of relation involves “God, as it were, talking living human bodies into being personal.” These direct relations of God create unique human living bodies that exist in dependence and interaction with their material, relational, and social environments and also with their God who created them in and through those same realities. Kelsey’s extended meditation on Job 10 provides theological reasons for not privileging accounts of interiority, subjectivity, rationality, consciousness, etc., as foundational for human existence. In their place, Kelsey’s approach focuses on human beings living as embodied, public agents—existing eccentrically, as it were.

Although his reasons for privileging bodily agency over subjectivity and consciousness are primarily theological, Kelsey also recognizes that this choice is not philosophically self-evident. However, such a choice seems philosophically prudent given that serious philosophical problems do arise from projects that do focus on subjectivity and consciousness as foundational. As Kelsey says,

126 Kelsey, *Eccentric Existence*, 293. For Kelsey’s reading of Job 10, see “To Be and to Have a Living Body: Meditation on Job 10” (242-280) and “Personal Bodies: Meditation on Job 10” (281-308).
it is less clear how a concept of a person as a center of consciousness can be used to develop an account of human persons that systematically includes scientific knowledge about persons as bodied, how and why their living bodies function, and how consciousness is related to their bodies. It is also less clear how a concept of person as center of consciousness can be used to develop an account of human persons, not only as subjects of experiences of personal and nonpersonal others and imaginers of possible actions in the privacy of their subjective interiorities, but as active agents in a public world.\textsuperscript{127}

Kelsey’s focus on human beings as “active agents in a public world” fits nicely within certain contemporary trajectories in philosophical anthropology that we have already examined, such as those of Maurice Merleau-Ponty, Michel Foucault, Charles Taylor, and numerous others who consider human agency as both being constituted by and also working alongside other forces that form our embodied and historically situated existence. Kelsey’s theological anthropology provides a foundation for this project’s assumption that embodiment in particular spaces and times is not a threat to subjectivity but instead the conditions and possibility for the existence of human subjects. Recall that Merleau-Ponty says “the body is our general means of having a world.”\textsuperscript{128} And if our body is our “mediator of a world,” then we must begin to interrogate what kinds of worlds our bodies inhabit, as we did in our account of the connections between phenomenology, anthropology, and history.\textsuperscript{129} Kelsey’s theological account undergirds this project’s focus on our public embodied actions within the modern hospital.

Situated within these theological and philosophical trajectories, then, this project follows Kelsey in concluding that “anthropologically significant proposals that assume that subjectivity, and the consciousness of which it is a center, are the defining features of human

\textsuperscript{127} Kelsey, \textit{Eccentric Existence}, 360. For more on modern philosophical conceptions of personhood and why subjectivity and consciousness are not to be considered foundational, see Kelsey’s chapters “This Kinds of Project This Isn’t” (80-119) and “Basic Unsubstitutable Personal Identity” (357-401).
\textsuperscript{128} Merleau-Ponty, \textit{Phenomenology of Perception}, 147.
\textsuperscript{129} Ibid., 146.
being should be bracketed (not necessarily denied) insofar as they are systematically generated by technical philosophical phenomenology.” And yet “there is no reason that particular insights yielded by technical philosophical phenomenology about particular structures, capacities, and dynamics of human consciousness cannot be acknowledged and appropriated in ad hoc fashion by theological anthropology.”\textsuperscript{130} This project follows Kelsey’s advice by appropriating phenomenological accounts of our embodied perception in an ad hoc fashion in an effort to articulate how we perceive without assuming that subjectivity and consciousness are the defining features of humanity. By doing so with the strand of phenomenology best represented by Merleau-Ponty, the project is better situated to proceed with an embodied account of perception.

These efforts serve to illuminate our embodied public agency within the modern hospital. The patient’s experience of a conversion in perception within the modern hospital can and should be understood through attention to public speech and practices. Therefore, the work of phenomenology in this project is linked with that of ethnography and history, and this account of social and institutional formation flows from Kelsey’s theological anthropology. In other word, the theological anthropology assumed by this project provides a foundation for normative work in Christian ethics seeking to connect moral action with the social formation of speech and perception.

1.6.2 Christological Account of Intersubjective Encounters

Merleau-Ponty’s account of double sensations hints at the possibility of intersubjective encounters understood through touching and being touched. Following that discussion, Merleau-Ponty goes on to consider whether true intersubjective understanding

\textsuperscript{130} Kelsey, Eccentric Existence, 832.
only would be possible through our mutual belonging to “some huge animal whose organs our bodies would be.” Merleau-Ponty rejects this possibility as laughable and perhaps even grotesque, and instead turns to a kind of “synergy” that is found “among different organisms, if it is possible within each.” While Merleau-Ponty dismisses this monstrous intersubjective intermingling out of hand, this is exactly the vision Paul gives of the body of Christ in his letter to the church in Corinth. “For just as the body is one and has many members, and all the members of the body, though many, are one body, so it is with Christ. For in the one Spirit we were all baptized into one body—Jews or Greeks, slaves or free—and we were all made to drink of one Spirit” (1 Cor. 12:12-13).

For Paul, this messy intermingling of bodies reveals that touching and being touched contains deeply moral, affective, and theological dimensions. Paul highlights the importance of interdependence for a community prone to instilling artificial divisions: “The eye cannot say to the hand, “I have no need of you,” nor again the head to the feet, “I have no need of you”” (1 Cor. 12:21). Moreover, such mutual belonging to one another is not given as an external ethical directive to be dutifully obeyed; instead, the connection with one another is to be felt in our bones. “If one member suffers, all suffer together with it; if one member is honored, all rejoice together with it” (1 Cor. 12:26). At the conclusion of this project, we will return to how our bodies are configured through touching and being touched in and by the body of Christ.

Beyond Paul’s understanding of the body of Christ, this project also considers the ways in which the intersubjective encounter of touching and being touched within the context of healthcare is a Christologically charged event. Matthew 25’s account of

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131 Merleau-Ponty, *The Visible and the Invisible*, 142
discovering the presence of Christ through care of the sick has proven to be foundational for the Christian practice of healthcare and the institution of the hospital. These themes will be explored at length in chapter four and the conclusion; for now, it is simply worth noting that the project operates with a theological vision that takes seriously the Christological ramifications of the encounter between patient and practitioner.

1.6.3 Pneumatological Account of Healthcare

Finally, one further theological account is constitutive of this project’s normative vision and its sustained attention to perception, language, embodiment, history, practices, institutions, and agency. It comes from the moment of Pentecost, which the apostle Peter interpreted through the words of Joel: “I will pour out my spirit on all flesh; your sons and your daughters shall prophesy, your old men shall dream dreams, and your young men shall see visions” (Joel 2:28; Acts 2:17). At Pentecost, new speech and perception is made possible through the pouring out of the Spirit on flesh. In light of this reality, this project operates with a pneumatological ethic, one that seeks to trace out the conditions and possibilities for discerning the presence and activity of God within the particular time and space of the modern hospital. The substance of much of this theological imaginary will unfold throughout the course of this dissertation, but a formal account is worth offering now as a conclusion to our methodological reflections.

Given this chapter’s overarching concern with moral agency, it is fitting that we conclude with pneumatology, for “where the Spirit of the Lord is, there is freedom” (2 Cor. 3:17). In this, we follow Eugene Rogers’s constructive work, *After the Spirit*, which offers a narrative account of the person and work of the Holy Spirit by focusing on the portrayal of
Jesus Christ in the Gospels.\textsuperscript{132} Through this examination, Rogers explores how the internal life of the Trinity is marked by the Spirit as the gift-giving interval between the first and second persons of the Trinity, making a “certain bidding and graciousness and gratitude” proper to the Trinitarian life.\textsuperscript{133} This gift-giving interval is crucial for our purposes, for Rogers goes on to claim, “the interval between the Son and the Spirit is the condition for the possibility of history, of freedom rather than mechanism, in the world.”\textsuperscript{134} The Spirit is at work in and through history in order to make possible human agency. Such a historical lens will be present throughout this project as we trace the different origins of three paradigmatic sites in the modern hospital.

Following Rogers, human freedom can be narrated theologically: the fire of the Holy Spirit inhabits our causal networks, melting down the hardened wax of our sinful habits and imprinting the image of Christ upon our lives as a seal. This theological position comports with our earlier discussion of contemporary trends in theological anthropology. It also makes possible a Christian account of the role practices have in rendering what Foucault called “docile bodies,” though this account of formation resists any assumption that violent power is constitutive of reality to its core.

The work of the Spirit is most clearly revealed as Christians are baptized and welcomed into the life of the Trinity, a life that all creation is destined to join. In baptism, Christians are incorporated by the Spirit into the body of Christ, and so participate in the

\textsuperscript{132} Rogers takes as fundamental that in every moment of Christ’s life the three persons of the Trinity are present in their distinct immanent relations while acting in creation indivisibly. And, at the same time, the Spirit is at work incorporating the baptized into the body of Christ, and so moving the external creation into the internal life of the Trinity. Eugene Rogers, \textit{After the Spirit: A Constructive Pneumatology from Resources outside the Modern West} (Grand Rapids, MI: Eerdmans, 2005), 11-14.

\textsuperscript{133} Ibid., 214. Rogers drawing from John Milbank to describe the gift-giving nature of this relation into which the Spirit incorporates human beings. See John Milbank’s “Can a Gift be Given? Prolegomenon to a Future Trinitarian Metaphysic,” \textit{Modern Theology} 11 (1995): 119-161.

\textsuperscript{134} Rogers, 32.
Trinitarian relations as revealed at the baptism of Christ, with the Father lovingly blessing the baptized, the Spirit descending and resting on flesh, and the enfleshed human being enabled to, like Christ, faithfully obey.\textsuperscript{135} It is key for us to note the pattern of the Spirit resting on flesh, for this rest makes possible creation sharing in the enfleshed freedom of Christ. Rogers describes this rest as the Spirit’s brooding work of conceiving the flesh of Christ. This rest is present in the incarnation, the baptism of Christ, the footwashing of Maundy Thursday, the Eucharist, anointing with oil, the tongues of fire at Pentecost, and “whatever other places she conceives” the flesh of Christ.\textsuperscript{136} The work of the Spirit is material work. As Rogers writes, “the Spirit has befriended matter. She has befriended matter for Christ’s sake on account of the incarnation.”\textsuperscript{137} As the Spirit befriends our bodies, our stories are patterned into the story of Christ, and our histories are taken up and engrafted into the very particular story of God’s relationship with Israel as revealed in Jesus Christ.

What might it mean for healthcare to participate in the Spirit’s work of befriending flesh? The answer to this question will have to wait for the constructive theological account of the practice of medicine and the institution of the hospital offered in chapter four and the conclusion. There we shall see how all three of this project’s normative theological sources can be drawn together and ordered. But before we describe how healthcare can participate in the Holy Spirit’s work of befriends our bodies, we must first recognize that there are a variety of spirits at work in modern healthcare. To do so, we will name and narrate the ways in which modern medical imaginaries construe the body as an enemy or an

\textsuperscript{135} Matthew 3:13-17; Mark 1:9-11; Luke 3:21-23.
\textsuperscript{136} Rogers, 62.
\textsuperscript{137} Rogers, 58.
object. In this way, this dissertation as a project in Christian ethics seeks to “test the spirits to see whether they are from God” (1 John 4:1).
Chapter 2

The Body as Enemy: Combat in the Surgical Ward and a Just-War Inspired Bioethics

Rage, rage against the dying of the light.
— Dylan Thomas, “Do Not Go Gentle into that Good Night”

How long should we continue to fight death using medicine’s growing armamentarium of interventions?
— Sharon Kaufman, *Ordinary Medicine*

Make a habit of two things—to help, or at least to do no harm.
— Hippocrates

2.1. Surgery, Harm, and Healing

The Hippocratic Oath begins by invoking “Apollo Physician and Asclepius and Hygieia and Panacea” as the gods by which the oath taker swears. As we noted earlier, modern readers of the oath often move right past these gods in order to engage what they take to be the oath’s true moral content. But this opening line is worth considering, and not simply because the gods invoked are associated with healing. Since the names of Asclepius and his daughters Hygieia and Panacea are simply given, why is it that the name of Asclepius’s father, Apollo, has an additional descriptor: “Apollo Physician”? We can find one plausible reason in an even more ancient Greek discourse on the gods: the *Iliad*. At the start of Homer’s epic poem, we find that Apollo’s priest, Chryses, has been offended by Agamemnon. Chryses calls out for vengeance, and Apollo, “god of the plague,” strides forth.

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in wrath, unleashing the arrows of his plague upon the Greek horses, dogs, and, finally, men. How is it that the same god invoked as a healer in the Hippocratic Oath is the dealer of plague and death in the *Iliad*? The fleshly interventions of Apollo are a double-sided and dangerous affair. This ambiguity points to a challenge faced by all healthcare practitioners: efforts to heal are often fraught with the possibilities of harm. Because of this, careful specifications and boundaries must be placed around healthcare in order to ensure that the practice is devoted to healing the body. In other words, it is for good reason that the Hippocratic Corpus passes down the admonition that efforts to help must be bound within a framework committed to doing no harm.

The need for boundaries around such ambiguity is captured in the Hippocratic Oath’s infamous prohibitions of abortion and euthanasia. However, rather than focus on these controversial passages, this chapter takes as its starting point an often overlooked proscription in order to better understand how the oath construes the relationship between healing and harm. For those taking the Hippocratic Oath, surgery was a forbidden practice: “I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.” The inclusion of this prohibition within the Hippocratic Oath is rather remarkable. It stands out in antiquity, where physicians practiced surgery with little stigma, and also in the Hippocratic Corpus itself, which discusses surgical

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5 Homer, *The Iliad*, trans. Robert Fagles (New York: Penguin Press, 1990), 1.45, 78. The Greek name given is Smintheus (literally “mouse Apollo”), which Fagles gives and then translates as “god of the plague.” Mice were known to be associated with plague, which Apollo unleashes upon the Greeks.

theory and practice at length. Although there is little scholarly consensus over why the ban on surgery was included or on what the ban itself entails, its startling presence can be taken as a sign that cutting is a morally significant act, worthy of further consideration. Therefore, just as in chapter one, we see that attending to the wider contexts of the Hippocratic Oath reveals morally salient features.

This chapter considers the moral transformations that have accompanied the practice of wielding the surgical scalpel changing from a banned practice in the Hippocratic Oath to becoming one of the chief factors in the rise of the modern hospital. The history of this transformation is the story of disciplining the cutting of flesh so that it serves distinct and limited goods. It is the history of how boundaries were placed around a morally fraught practice so that it could become incorporated within a moral vision of healthcare devoted to healing within the bounds of doing no harm. If surgery is to comport with the Hippocratic Oath’s vision of healthcare, then a medical morality must be in place to ensure that the violence inherently involved in using the knife is limited in its harm and aimed towards healing. The particular understanding of violence, harm, and healing on display in the previous sentence is a fragile but real moral achievement, one that has developed over time to place limits around surgical intervention analogous to the limits that just war theory places around military acts.

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7 Darrel W. Amundsen, "Medicine and Surgery as Art or Craft: The Role of Schematic Literature in the Separation of Medicine and Surgery in Late Middle Ages," Transactions and Studies of the College of Physicians of Philadelphia, 1, no. 1 (1979): 44-46. Amundsen also notes the other infamous case of surgery being foresworn by a physician: Galen enigmatically claimed that when he returned to Rome he gave up his practice of surgery to those called surgeons. Amundsen and medical historian Ovsei Temkin consider Galen’s claim to refer only to complex surgical procedures, 45-46. Regardless of this explanation, Galen’s comment stands out in antiquity like the Hippocratic Oath’s ban on surgery.

8 Edelstein himself takes the Hippocratic Oath to proscribe the practice of surgery as unfitting for physicians, but even he recognizes the depth of scholarly debate over the question. Edelstein, “The Hippocratic Oath: Text, Translation, and Interpretation,” 26-33.
To understand this moral vision, we first turn to the surgical ward as a paradigmatic medical site. Recall that the term “site” refers to a set of discourses, practices, and practitioners deeply connected to recognizably distinct modes of imagining and engaging the human body within modern healthcare. Within the surgical ward, we see healthcare imagined as engaging the body as an enemy in a limited and disciplined way. In our investigation of this medical imaginary, we begin with a phenomenological account before turning to ethnographic and historical understanding. In doing so, we follow our methodological commitment to consider moral action within the arrangements of discourses, practices, and practitioners that enable perceiving the patient’s body in recognizably distinct ways. This work is required to understand a formative medical imaginary present within the modern hospital, as revealed within the surgical ward as a paradigmatic medical site. Here we see the body imagined and engaged as an enemy, both because of the current arrangement of discourses, practices, and practitioners, and also because of the histories of this medical site’s relationship with warfare. This medical imaginary carries with it significant theological and philosophical underpinnings. For a fitting moral response to this medical imaginary, we turn to James Childress, who offers a just-war inspired approach to bioethics.

In order to recognize the fragility of this achievement of placing surgical interventions within the bounds of an overarching commitment to heal while doing no harm, we will contrast the medical imaginary found within the surgical ward with a related but distinct medical imaginary found within the oncology ward. The surgical ward’s carefully disciplined interventions seeking the good of each patient dates back to the military hospital, but the oncology ward’s wide-ranging “War on Cancer” seeks the ultimate defeat of its enemy, with each patient’s body serving a provisional role within that broader fight. Here, a focus on
research combines with a commitment to total warfare in a way that stands in stark contrast to the patient-centered, just-war approach within the surgical ward. The oncology ward's related but distinct medical imaginary shows that there are other, less morally disciplined ways of understanding the body as enemy within the modern hospital. In order for a just-war inspired bioethics to befit the work of the oncology ward, substantive transformations are required to discipline this medical imaginary and its interventions in order to seek the good of each particular patient. Before discussing these, we will begin with a phenomenological investigation of how the body is perceived within the modern surgical ward.

2.2 Phenomenological Investigations in the Surgical Ward

2.2.1 A Surgeon’s Cry

In *Heartsounds*, Martha Weinman Lear describes the struggle of her husband, Harold Lear, against heart disease. Harold Lear was a surgeon who, following a heart attack, underwent open-heart surgery, and he then experienced a series of postsurgical complications that were difficult for healthcare practitioners to identify and treat. All of this was difficult for him to come to terms with. One night, Martha Weinman Lear woke to hear her husband crying out, “Where is my adversary?” In the midst of his pain, “it was his neat surgical mind demanding an adversary, an enemy, a pathology, recognizable forces of death and disease against which he might pit his own skills.” As his wife tells the tale, Harold

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Lear’s formation as a surgeon made the lack of a distinct opponent to name and combat particularly difficult for him as he died.

Lear’s story of a surgeon-turned-patient displays a medical imaginary that revolves around the need for a clearly identified enemy and detailed plan of attack. In this chapter, this medical imaginary is depicted through a series of investigations: first, a phenomenological description of how pain and death come to be located and embodied in particular agonistic agents, whether external or internal; second, an ethnographic account of how this mode of imagining and engaging the body is instantiated and passed on in the surgical ward; and third, a “history of the present” that examines how developments in surgery and the hospital have made such an imaginary possible. In order to understand the fitting response to the moral concerns uncovered by this medical imaginary, a crucial question must be asked: can a bodily enemy be named and engaged in a bounded and limited way? If so, then medical morality can follow the logic of just war, as seen in various surgical moral exemplars. If not, then the hospital becomes the domain of total warfare against an ultimate enemy, and interventions on the patient’s body serve a provisional role in that fight. We can see this related but distinct medical imaginary in the fusion of research and therapy found in certain forms of modern oncology.

We begin by returning to the work of Elaine Scarry that we first examined in chapter one in order to develop a phenomenological investigation into how surgeons and patients come to perceive the body as an enemy. As we saw earlier, Scarry’s book, *The Body in Pain*, begins with a description of the ways in which persons are undone and reconstituted through torture. At several places in her account, Scarry makes clear that torture parallels, in perverse ways, the perception and response to pain found in modern healthcare. So here we
consider one possible pathway of perception made possible by the epistemic vulnerability of
the person in pain. We can draw from the similarities and differences Scarry names between
torture and healthcare in order to construct a phenomenology describing how the body in
pain is perceived in the surgical ward, recognizing that we will explore two other possible
pathways for perceiving the body in the modern hospital in chapters three and four.

2.2.2. Phenomenology of an Inflamed Appendix

Consider Lauren, a woman in her mid-twenties who has been suffering from stomach
pain for hours. At first, she describes it as a “dull pain.” Recently, the pain has become even
more intense, shifting lower and to the right; this pain is no longer dull but is “sharp.” This
solitary adjective is not up to the task of communicating Lauren’s pain as it further
intensifies, and so she cries out in an effort to offer better description: “It feels as if a knife
is tearing my insides into pieces!” By the time Lauren arrives at the hospital, the pain has
made it difficult for her to speak. She rocks back in forth in the fetal position, alternating
between moaning and vomiting. Eventually, she encounters a surgeon who says, “Your
appendix is inflamed and could rupture at any minute. It could kill you. I need to operate
and take it out. There are minimal risks to the surgery, but I think it is necessary to save your
life.” Unable to speak, she nods her head in assent. At this moment, Lauren’s surgeon has
offered her a new language to describe what is going on, and she adopts this mode of
speech as part of the new life given to her by surgery. While recovering from an
appendectomy, Lauren inhabits this new language, displaying its power to give words to what
she just viscerally experienced. “I was in pain because I had appendicitis. My appendix nearly
killed me, but my surgeon took it out and saved my life.”
In this brief description of Lauren’s ordeal, pain’s pressure on language is evident. Recall Elaine Scarry’s argument that pain’s “resistance to language is not simply one of its incidental or accidental attributes but is essential to what it is.”\(^\text{10}\) Pain not only resists but “actively destroys” language because physical pain “has no referential content. It is not of or for anything.”\(^\text{11}\) While Scarry may overstate the purposelessness of pain, we can at least state that pain requires interpretation in order to be understood as meaningful, even as pain places pressure on frameworks of meaning. Pain leaves us epistemically vulnerable to a variety of meaning making-frameworks through how it “actively destroys” the language that has ordered our bodily inhabitation of the world. We can see this at the start of Lauren’s pain. When the perception of a “dull” aching sensation has no referential object, it cannot be further verbalized and so properly integrated within our orientation in and through the world. But because the “dull” pain can be ignored, its threat to Lauren’s linguistic grip on reality is relatively minor. As the pain grows, however, Lauren uses stronger adjectives; her pain becomes “sharp.”

Eventually, these words also are unable to carry the weight of Lauren’s pain. Scarry says that because there is “only a small handful of adjectives” for pain and these words all lack referential content, “one passes through direct descriptions very quickly and…almost immediately encounters an “as if” structure: it feels as if…”\(^\text{12}\) So even though pain has no direct referential content, this “as if” structure is a linguistic effort to give an analogous referent to pain. Over and over again, Scarry claims, “two and only two metaphors” appear on the other side of the ellipse:

\(^{\text{10}}\) Elaine Scarry, The Body in Pain, 5.
\(^{\text{11}}\) Ibid., 4, 5; emphasis in original.
\(^{\text{12}}\) Ibid., 15.
The first specifies an external agent of the pain, a weapon that is pictured as producing the pain; and the second specifies bodily damage that is pictured as accompanying the pain. Thus a person may say, “It feels as though a hammer is coming down on my spine” even where there is no hammer; or “It feels as if my arm is born at each joint and the jagged ends are sticking through the skin” even though the bones of the arms are intact and the surface of the skin is unbroken.\textsuperscript{13}

These understandings of weapon and wound may not just be metaphorical; Scarry is quick to note that a real weapon or wound may be present in any particular instance of pain. We will return to this story of weapons and wounds when we consider the history of surgery’s presence and growth in military conflicts. The metaphors of weapon and wound for pain are found throughout history, as early as the \textit{Iliad} and the book of Job.\textsuperscript{14} For our present investigation into a phenomenology of pain, Scarry’s crucial insight is that the “language of agency” found in both weapon and wound enables one to “externalize, objectify, and make sharable what is originally and unsharable experience.”\textsuperscript{15} In Lauren’s story, we see this language of agency first emerge as she describes feeling “as if a knife is tearing my insides into pieces.” Here we see an effort at objectifying pain; it is described “as if” it were of a blade’s cut. And so in an effort to give language to an ever-intensifying and consuming experience, the weapon offers analogous referential content to Lauren’s pain.

But the webs of language and agency offered through this “as if” structure are too feeble to hold a person in severe pain for very long. Recall that Scarry describes pain as undoing the integration of self, world, and language: “Intense pain is also language

\textsuperscript{13} Scarry, \textit{The Body in Pain}, 15.
\textsuperscript{15} Scarry, 16.
destroying; as the content of one’s world disintegrates, so the content of one’s language disintegrates; as the self disintegrates, so that which would express and project the self is robbed of its source and its subject.”

As we saw in the last chapter, one’s self, world, and language are all inextricably intertwined. Pain disrupts an embodied sense of self and world; no longer can they be perceived as worded in intelligible ways. Phenomenologist Fredrik Svenaeus describes this as “a process in which the body becomes increasingly hard to tolerate and cope with in displaying its foreign and uncontrollable sides.” Commenting on Scarry, Svenaeus says that pain’s assault upon language leads “to a collapse of all attempts to find oneself at home in the world for the one who suffers.” And we can see Lauren’s self, world, and speech all in tatters as she curls up in a ball, moaning and vomiting. Scarry describes this destruction of pain as bringing about a “reversion to a state anterior to language, to the sounds and cries a human being makes before language is learned.”

Here, in this fetal state, Lauren is vulnerable on multiple levels. In her epistemic vulnerability, Lauren is open to receiving a new way of imagining her self, her body, and her world. When her surgeon names her pain as appendicitis, this linguistic offering is the first step in the emergence of a new self and world. As we shall see, this language is bound up with an entire constellation of practices and people, making possible a stable medical imaginary for Lauren to adopt. In the act of surgery, the surgeon’s gift of a new language is inscribed on the edge of a scalpel, which cuts to create the conditions for the possibility of

16 Ibid., 35.
18 Svenaeus, “The Phenomenology of Chronic Pain,” 118.
19 Scarry, 4.
20 As discussed above in chapter one, because this conversion occurs through this contingent meshwork of people, practices, and discourses, it need not have occurred this way. Even if a disciplined encounter with parts of the body as an enemy seems most fitting, there are other ways to understand and engage the body. We must be reminded of this contingency precisely because it is so difficult to remember in the modern hospital.
Lauren’s conversion into a new mode of perceiving her embodied self. Before the first slice of the scalpel, though, anesthesia completes what pain began, entirely eliminating Lauren’s voice. Lauren has been rendered completely passive, first by her pain and then by her surgical team.\(^{21}\) Within the carefully controlled environs of the operating theatre, Lauren’s surgical team works, in Scarry’s words, “to repair the ground for the return of the world itself.”\(^{22}\)

This is a fraught moment, both phenomenologically and morally, as violence is inflicted in an effort to heal. The weapon of the scalpel meets the part of her body that has become a weapon against herself. Scarry recognizes the ambiguity of this encounter when she admits that the “verbal sign” of weapon or wound “is so inherently unstable” that it must be “carefully controlled.” In medicine, Scarry claims, this sign has been stabilized in an effort to assist the patient. However, the inherent instability of verbalizing pain means that this “language of agency” could easily be mobilized to afflict. According to Scarry, “one of the central tasks of civilization is to stabilize this most elementary sign.”\(^{23}\) As we shall see, the history of surgery’s incorporation into modern medicine can be understood as exactly this kind of moral achievement. Even when carefully controlled, cutting is always precarious, one slip away from running afoul of the Hippocratic admonition to do no harm. In our examination of the oncology ward, we will see what happens when violent therapies are not

\(^{21}\) Drawing from Scarry, Fredrik Svenaeus says,
To suffer pain is to find oneself in a situation of passivity in relation to the feelings that hurt one. Being hurt by a weapon is the kind of metaphor that comes to our mind when we try to describe pain, because pain is a kind of passive state in which something hurtful is done to us, by another person, or by processes of injury and disease.

Svenaeus, “The Phenomenology of Chronic Pain,” 121.

\(^{22}\) Scarry, 34.

\(^{23}\) Ibid., 13.
controlled within the bounds of an ethic devoted to healing within the wider commitment to do no harm.

2.2.3 Conversion in the Surgical Ward

First, though, we must see how Lauren’s conversion is made complete after surgery. When she assents to being the surgeon’s patient, she begins to take up the self, world, and language offered by her surgeon. As she recovers from surgery she learns to see herself as a patient whose life was threaten by appendicitis. The webs of a language made real through the success of her surgery now bear the memory of her pain. Lauren’s pain was given ‘real’ referential content in the diagnosis of her inflamed appendix as a threat to her very self.

Lauren’s body had become her enemy. To describe how the body in pain becomes an enemy, Scarry builds upon her description of the language of agency, claiming:

Regardless of the setting in which [the person in pain] suffers (home, hospital, or torture room), and regardless of the cause of his suffering (disease, burns, torture, or malfunctioning of the pain network itself), the person in great pain experiences his own body as the agent of his agony. The ceaseless, self-announcing signal of the body in pain, at once so empty and undifferentiated and so full of blaring adversity, contains not only the feeling “my body hurts” but the feeling “my body hurts me.”

We can see how the metaphorical language of agency enables the imaginative conflation of the injuring weapon and one’s own body. Scarry argues that for the person in pain the body is “made a weapon against him, made to betray him on behalf of the enemy, made to be the enemy.” In the face of this assault, the person in pain cries out for assistance.

For Lauren, this bodily betrayal was met by the power of her ally, the surgeon. When her body became an enemy, her surgeon was there to take it out and save her life. The surgeon’s power was focused down to the edge of a scalpel, which inflicted violence in an

24 Ibid., 47.
25 Ibid., 48.
effort to eliminate the part of her body that had become an enemy and save the rest of her embodied self. Since the first onslaught of her pain, Lauren’s body had become a battlefield, and she learned to see it as such. In the surgical ward, a team of powerful allies led by the surgeon help ensure her survival, and she emerges from the operating room transformed into a patient recovering from appendicitis. As a changed person, Lauren inhabits a reconfigured world that she describes through the language given by her ally and savior from death, the surgeon. Such a transformation involves the instantiation of new understandings of embodiment and medical authority, and for a better understanding of this process we turn to the work of William Cavanugh.

In *Torture and the Eucharist*, Cavanaugh combines Scarry’s work and his time with those tortured in Chile under Pinochet to argue:

> One way to think about this destruction of the victim’s world is to say that the effect of torture is the creation of individuals. Pain, as we have seen, is the great isolator, that which cuts us off in a radical way from one another. With the demolition of the victim’s affective ties and loyalties, past and future, the purpose of torture is to destroy the person as a political actor, and to leave her isolated and compliant with the regime’s goals.

Much of Scarry’s argument is about the kind of person created in the torture chamber. Cavanaugh extends her argument to claim that pain in torture makes possible the formation of a certain kind of citizen, one compliant to a regime and its purposes. In Lauren’s example, we can see how the pain of appendicitis destroys her self, world, and language, and in response the power of the surgical ward shapes a new subjectivity, Lauren-as-patient, who speaks a new language and inhabits a new self and world. In ways that are both related and deeply distinct, the Chilean regime and the modern hospital both operate in the world of pain, one inflicting it and the other attempting to alleviate it. In both the torture chamber

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and the surgical ward, distinct modes of authority are revealed and instantiated. In the operating theatre, the hospital has made real a certain kind of medical authority.

Lauren’s bodily disruption led to a conversion that enabled her to perceive her appendix as her enemy. This is a morally salient transformation, but we are not yet in a position to fully understand the contours and moral implications of this medical imaginary. In order to do so, we must first give an account of the discourses, practices, and practitioners that create the conditions and possibilities for such a conversion. For although Lauren’s surgeon obviously played a role, a thorough ethnographic account of the modern surgical ward is necessary in order to understand what made possible this mode of perception. Through that ethnographic work, followed by a historical account of the rise of this medical imaginary, we will be in a position to describe the morally salient features of this medical imaginary, and from there discern a fitting moral response.

2.3 Ethnographic Investigations in the Surgical Ward

2.3.1 Surgery as Controlled Violence

In *Bodies in Formation*, Rachel Prentice offers an ethnography of the formation of surgeons that highlights the importance of control for the surgical task. She begins her examination of the moral dimensions of surgical training by stating:

A surgeon I know describes what she does as “controlled violence.” These two words define surgery as the use of physical force to promote healing or improve function. The phrase also tersely captures the ethical stakes of surgery. The Hippocratic Oath and its most common paraphrase, “First, do no harm,” is medicine’s first and most important moral code. Surgeons, in particular, must balance
According to Prentice, control in surgery is necessary for two interrelated reasons. First, because surgery is inherently violent, control is a crucial limiting factor that makes cutting subservient to healing the body. And second, if healthcare practitioners have long been guided by the Hippocratic injunction “to help, or at least to do no harm,” then serious moral safeguards must be in place in order to properly guide the incision of the surgical knife as it opens the body. In other words, the violence of surgery must be controlled in order to heal rather than harm. Prentice draws from the etymologies of violence and harm in order to maintain a conceptual distinction between the two, saying,

According to the *Oxford English Dictionary*, “violence” is an Old French word describing the use of physical force that causes injury or damage. Etymologically, the connection of violence to the morally neutral “physical force” suggests that sometimes “violence” has a strong moral connotation, but not always. In contrast, the morally laden Old English word “harm” means evil, whether in intent or effect, as perpetrated upon a person or thing.

As a surgeon told Prentice, the difference between violence and harm is “ethically vast but practically narrow.” Maintaining a distinction between the two “often rests upon the surgeon’s first word, ‘control.’” This distinction is evident in *Do No Harm*, the aptly named memoir of British neurosurgeon Henry Marsh. Marsh claims that observing surgery for six months convinced him to pursue the practice, particularly because he finds “its controlled and altruistic violence deeply appealing.” As we shall see, the discipline required to control violence and use it for healing is difficult both to achieve and maintain. Recall that Elaine

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27 Rachel Prentice, *Bodies in Formation: An Ethnography of Anatomy and Surgical Education* (Durham, NC: Duke University Press, 2013), 137. “First, do no harm” is a commonly cited paraphrase of the Hippocratic Oath’s basic moral framework, but it does not appear to occur exactly in this way anywhere in the Hippocratic Corpus.
28 Ibid., 137.
29 Ibid.
Scarry claimed that the “verbal sign” of weapon or wound “is so inherently unstable” that it must be “carefully controlled.” According to Scarry, such careful control is a significant achievement, one that can prevent the forceful interventions of healthcare from sliding toward the torturer’s logic.

In what follows, the ethnographic work of Prentice and others on the surgical ward is used to help describe the medical imaginary within the surgical ward. These ethnographic studies uncover how the modes of perception, speech, and action on display in our opening phenomenological description of appendicitis are made possible, with particular attention to how the violence of surgery is stabilized within a moral framework seeking healing while avoiding harm. In describing this process of stabilization, numerous parallels between surgery and the military will emerge, as both attempt to control the use of violence to achieve agreed upon and acceptable ends. As Stefan Hirschauer notes in his ethnography of surgery, “affinities to military language” are found throughout the practice, even in “basic terms of surgery such as ‘tactics’, ‘invasive methods,’ ‘invasion of germs.’” Furthermore, the core of surgery, the operation, is a term shared with the military and defined as a “planned movement of one side, limited in its goal, duration and space, mostly related to fighting.” Although Hirschauer is quick to note the limitations of military metaphors, he claims that there is a deep similarity between surgery and combat, revealed in “the antagonism of bodies and the relation of forces of two sides.”

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31 Scarry, 13.
33 Ibid., 282.
surgeons, *Forgive and Remember*, Charles Bosk records one surgeon’s pithy take on this reality:

“Surgery is a body-contact sport, there is no question about it.”

From this ethnographic work, we will then turn to consider the deep historical roots of these connections between the surgical ward and war. These ethnographic and historical investigations are essential for understanding the moral contours of the surgical ward’s medical imaginary. By giving this thorough descriptive account of the field of moral action, we will then be in a position to discern a fitting moral response to imagining the body as an enemy. We begin with ethnographic work on the surgical ward in an effort to better understand the nature of the conversion that Lauren experienced.

**2.3.2 Control in the Operating Theatre**

The forceful antagonism of surgery occurs in a carefully controlled environment, and so we begin with the space of the operating room, which was once known as the “operating theatre” where surgeries were publicly conducted before a crowd of interested spectators in tiered seating. Given the modern emphasis on aseptic surgical conditions, this name is largely an anachronism. But the term “operating theatre” is illuminative, as it suggests a connection with a “theater of operations” in military combat. In its ideal state, the operating theater is much like a combat theater, with clearly defined lines of authority, rules of engagement, and mission objectives. Moreover, important distinctions are continually being made between combatants and noncombatants and also between friends and enemies. These distinctions are made through a series of transformations undergone by the bodies of the patient and the medical team. These changes mark the operating room as a separate

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34 Charles L. Bosk, *Forgive and Remember: Managing Medical Failure*, 2nd ed. (Chicago: The University of Chicago Press, 1979; 2003), 13. This description of surgery as a “body-contact sport” is a touchstone reference throughout the ethnographic literature.
space, one filled by authorized medical bodies and devices. The operating theater is devoted to minimizing harm to the patient, and this commitment is safeguarded through increasingly stringent protocols of control for both patient and practitioners.

In an effort to reduce the risk of harm to the patient, protocols of control govern which foreign bodies can interact with the patient’s body. This often begins the night before surgery, when patients are to refrain from food and drink in preparation for safely undergoing the anesthesia that makes their surgery possible. On the day of surgery, access to the patient’s body begins to be restricted in a series of zones, often beginning with the very entrance to the hospital. From there, only a certain number of people may be allowed in the waiting room. This small group is winnowed down even further as a few close family members may be allowed to briefly be with their loved one to offer final words of prayer and encouragement. Finally, and depending upon the procedure, only the next of kin may be trusted to accompany the patient slightly further. Regardless of how these gatekeeping functions are particularly structured, the end result is always the same: the body of the patient is set apart as belonging completely to the medical team as it approaches the operating room. All other foreign bodies, from foods to friends and family members, are removed at various intervals. They all are potential bearers of bodily harm, and as such they cannot be allowed to approach and enter the operating theater.

By far, the most intense protocol of control surrounding the patient’s body is the constellation of practices focused on preventing the spread of infection to vulnerable and open bodies on the operating table. The operating room is a space that sits at the center of what Prentice names as “several zones of increasing sterility.” 35 Within the operating room, a

35 Prentice, 140.
rigid logic defines which surfaces are deemed sterile and which are non-sterile; once a sterile surface comes in contact with a non-sterile object it is deemed contaminated. All operations are “concerned with avoidance of contamination of the patient from the outside,” and a significant subset of operations contain cleanliness protocols to prevent “contamination of the patient and the medical staff from inside the patient.”36 In other words, rituals of sterility primarily focus on threats to the patient’s body that come from the people and surfaces within the operating theatre, but they are also concerned with the dangers that a patient’s body poses to itself as it is cut open. Before the moment of surgical incision, the boundaries of sterility are carefully policed in a series of safeguards marking each increasingly sterile zone:

Staff members monitor each zone more tightly than the last. Nurses at a station called a “control desk” restrict access to operating suites, a circulating nurse watches over the operating room, and the entire operating team watches over the sterile area to ensure that only those with permission and preparation enter. Medical students earn the right to occupy the innermost zone by learning how to scrub and by demonstrating social skills that convince the surgeon of their readiness to approach the patient.37

The language of monitoring and authorized access enables us to more fully imagine the operating room as a carefully controlled site of forceful engagement with the patient’s body. This discipline is on display in the people, practices, and modes of interaction that constitute surgery in the operating room.

The constellation of people within the operating theatre orbits around two bodies, those of the surgeon and the patient. The surgeon and the patient are at the heart of surgery’s “zones of sterility,” and intricate and detailed practices make this possible.


37 Prentice, 140.
“Scrubbing in” is the paradigmatic ritual of sterility, signifying and setting apart the bodies trusted and authorized to touch the patient’s open body without the risk of harm. Through this process of purification, medical practitioners are prepared to handle both the patient’s body and those sterile instruments that will come in contact with it. After washing for several minutes, those scrubbing in don a sterile gown in order to prevent unsterilized body parts or clothing to come in contact with any sterile surface. At the same time, the patient’s body is also being prepared. After scrubbing in, a surgical technician or nurse will sterilize the patient’s body at and around the site of incision. The rest of the body is draped in sterile cloths in order to prevent the spread of infectious material, both into and out of the incision. These sterilization rituals are necessary preconditions for the act of incision to be minimally harmful and so morally acceptable.

We will return to the bodies of the surgeon and the patient in a moment, but first it is important to describe four kinds of practitioners that surround them. First, the sterile surgical technician or nurse serves as a direct extension of the surgeon’s agency, ordering the instruments and providing them when needed—ideally, before being asked. Second, those in the process of surgical training inhabit a variety of positions depending upon their trustworthiness, as marked by their progression in training. As Prentice describes it, each surgical trainee is attempting to master a different aspect of the “control of violence” within surgery. For Amal, the first-year resident, control means maintaining sterility and staying out of the way; for Julie, the chief resident, control means mastering minimally invasive techniques and widening her perceptual horizon; for Nick, the master surgeon, control means choosing not to operate when he fears he will do more harm than good. For surgeons in academic practice, control also means constructing an operating environment and surgical field in which trainees can learn while keeping

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38 Katz, "Ritual in the Operating Room,” 337.
patients safe. The surgeon’s craft builds from simple techniques to complex relationships of technique, procedure, and anatomy to more complex exercises of wisdom and judgment. At each level, good practice requires the embodiment of control. At each level of training, surgical residents are entrusted with more and more responsibility as they prove their ability to control their actions in ways that minimize harm. As Bosk describes it, the residents and medical students “at the bottom of the hierarchy” are “the noncommissioned officers of the surgical world.” In order to prove their merit and move up the ladder, they are constantly questioned and pushed: “trainees must continually be incited to exercise their obligation to practice control. They must understand that they are doing violence by invading and altering patients’ bodies, but that violence must not become harm.”

Third, the circulating nurse, who does not scrub in, further extends the surgeon’s agency by touching non-sterile surfaces, relaying messages in and out of the operating theater, and performing a variety of other transitional acts. The circulating nurse is a liminal figure, standing between the sterile operating room and the world outside. Fourth, the anesthesiologist plays a dual role, both rendering the patient’s body docile for the surgeon while also monitoring the body’s vital signs in case the surgical invasion begins to cause too much trauma. Hirschauer describes their work as follows:

Narotizing patients is ‘controlled poisoning’ (as an anaesthetist put it to me). It overcomes the resistance and vital forces of the patient-body….On the other hand, the patient-body is kept alive by the anaesthetists, and they help to increase its resistance against the surgical invasion, or to use an expression from athletics: its staying power.  

39 Prentice, 167.  
40 Bosk, 9-10.  
41 Prentice, 167.  
42 Hirschauer, 290.
In this dual role, anesthesiologists display the moral complexity of the medical imaginary displayed within the surgical ward. Their “controlled poisoning,” much like surgery’s overall “controlled violence,” is a calibrated action that places a patient at risk as part of a greater effort to promote their healing and flourishing. As Scarry notes, this kind of action is unstable, and requires careful discipline to prevent it from becoming harmful. These four kinds of practitioners surround the surgeon and the patient, to whom we now turn for a closer examination of their encounter.

The attending surgeon is at the center of efforts to order surgical interventions towards the patient’s health and flourishing. After the threat of outsiders is minimized through increasing zones of sterility, and after the threat of the patient’s own body moving or reacting is removed through anesthesiology, the surgeon is able to isolate the portion of the patient’s body which has become a threat to their self. Sterile drapes cover all other body parts as the surgeon focuses in on the site of incision, where distinctions are continually being made between friendly flesh and the targets of this act of controlled violence. Hirschauer uses militaristic language to describe how the surgeon engages this portion of the patient’s body:

After the incision, a step-by-step occupation of the patient-body takes place. The surgeon-body extends itself into the flesh: with fingers, clamps, suction tubes and cutting instruments. One layer after the other is removed, camp is pitched, and the expedition continues. The visual reduction by textiles [surgical draping] reveals itself as one step in a process of targeting, which is now realized by instrumental means. The operator surrounds an organ, trying to spare the neighbouring parts of the body.

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43 The complicated nature of anesthesia’s work is demonstrated in debates over whether Do Not Attempt Resuscitation (DNAR) orders need to be temporarily lifted when a patient is under anesthesia for a procedure, since something like resuscitation may be necessary to prevent the risk of anesthesia from becoming harmful to the patient.

44 Hirschauer, 299.
In this “step-by-step occupation,” the patient’s body becomes both the scene of battle and the enemy. “Neighboring parts” next to the target of the intervention are protected, much like noncombatants in warfare. Into this battlefield enters the surgeon’s hand and scalpel. Even as he recognizes the importance of his surgical team’s contributions, for the attending Henry Marsh the moment of surgery “is still single combat.” Paul Kalinithi was by all accounts an exemplary neurosurgeon, and in his memoir, written as he was dying from cancer, he thoughtfully reflects on the role of a warlike attitude. Even as he recognizes the brittleness of a patient or family member’s resolve to fight cancer, he still found that “in the immediacy of surgery, a warlike attitude fit.” For Kalinithi,

In the OR, the dark gray rotting tumor seemed an invader in the fleshy peach convolutions of the brain, and I felt real anger (Got you, you f**ker, I muttered). Removing the tumor was satisfying—even though I knew that microscopic cancer cells had already spread throughout that healthy looking brain. The nearly inevitable recurrence was a problem for another day.

In his ethnography of the surgical ward, Charles Bosk echoes Kalinithi’s first-person account, stating, “It is not unfair to recognize that there is a gladiator dimension to surgery and surgeons. Surgeons take up scalpel against disease; they resist with force its invasion on the body. When death comes, the struggle is ended.” In describing the combative nature of the surgeon, Kalinithi and Bosk give little attention to the patient at the center of these encounters.

45 Marsh, 25.
47 Bosk, *Forgive and Remember*, 90. Bosk’s description resonates with the commitments of Dr. Rieux, the surgeon at the center of Albert Camus’s famous novel, *The Plague*. In a particularly revealing passage, Rieux states that “the order of the world is shaped by death,” and in such a world, his duty is “to struggle with all our might against death.” When reminded by his interlocutor that all his victories will be temporary, since death comes for us all, Rieux displays the resigned determination the surgeon-as-soldier; he admits that his work is “a never ending defeat.” Albert Camus, *The Plague*, trans. Stuart Gilbert (New York: Vintage Books, 1991), 126.
This raises the question of the role of the embodied patient: is she a besieged ally, a noncombatant, the field of battle, or, at times, the enemy itself? At differing times and in different contexts, the patient’s body can be all of these things. But if the work of surgery is a controlled violence pursuing healing within the framework of a commitment to do no harm, then we can offer a morally disciplined approach to these multiple understandings of the embodied patient. On this account, the patient is the primary combatant: he faces a bodily threat to which he is struggling to respond, and he or his surrogates request assistance from a surgical team. The act of surgery originates in the patient’s request for assistance. Prentice describes how a surgeon, preparing to operate on an impinged nerve in a patient’s arm, respects this ordering by requesting to “borrow” the patient’s arm for a bit. “The request to ‘borrow’ the arm invited the patient to exercise a different kind of agency: rather than agency to move the arm, he had the agency to ‘lend’ the arm to her, which was safer.”

In surrendering their body to surgery, the patient allows his body to become a battlefield, trusting that the surgical team will seek to protect the rest of the body like an innocent civilian while targeting the enemy invader, disordered structure, rebellious organ, etc. But as he emerges from surgery, again the patient becomes the primary agent; as any good surgeon knows, no surgery can succeed without the patient’s body working to heal its incisions.

Various moral questions arise from this account of disciplined engagement: how to ensure that the patient is respected as the primary and privileged actor, how to avoid unwelcome and unilateral action, how to protect the noncombatant status of the rest of the body, etc. We have to understand the formation of a disciplined medical imaginary capable of making the moral distinctions implied by these questions. In order to do so, we turn to

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48 Prentice, 63.
consider several morally salient practices from before and after the operating theatre. Through examining them, we will understand the formation that makes possible a fitting moral response to the surgical ward’s medical imaginary.

2.3.3 Discipline Before and After the Knife

Well before the hand-to-hand combat described by Kalinithi, the surgeon’s effort at disciplining the scalpel faces its ultimate test prior to the operating room, when the surgeon is faced with the excruciating decision of whether or not to operate. As Prentice notes, the decision not to operate is one of “the hardest decisions surgeons make, going against the desire to do something to help the patient and against surgery’s general orientation toward action.”49 But it is exactly this sort of restraint that is necessary to subjugate the practice of medicine toward the good of healing. “Healing in surgery,” according to Prentice, “is rooted in carefully crafted action.”50 As all surgeons know, operations that are brilliant displays of technical prowess can also mean debility and even death for the patient, for each surgery subjects a patient to “risk and trauma.”51 According to Marsh, a senior surgeon must learn to consider “the risks of the operation and how they had to be justified by the risks of doing nothing.”52 Acquiring the prudence necessary to weigh this proportionality and the fortitude to resist calls for action is a hard-earned moral achievement. As Marsh says, “Knowing when not to operate is just as important as knowing how to operate, and it is a more difficult skill to acquire.”53

49 Ibid., 146.
50 Ibid., 168.
51 Boss, 29.
52 Marsh, 36.
53 Ibid., xix.
Because this skill is so difficult to acquire, and because the surgical ward is marked by inherently unstable efforts to respond to pain, we should be unsurprised by failures to maintain this control, even as we look to see the craft to discipline itself.\textsuperscript{54} As noted above, we need to show that the medical imaginary on display in the surgical ward has found ways to sufficiently stabilize and direct its bodily invasions within a moral framework devoted to the patient’s health and flourishing. By being habituated into an ethics of “controlled violence,” practitioners within the operating theatre are constantly working at the sort of stabilization that Scarry demanded. But what happens when they fail to do so? To answer this question, we must turn to the moral discipline of surgery that occurs after an operation: the weekly Mortality and Morbidity Conference found throughout surgical practice in the hospital. Here we find surgery’s most prominent ritualized commitment to doing no harm.

In the weekly Mortality and Morbidity Conference, surgeons give an account of unexpected failures they experienced in the operating theater. Bosk describes this as “the major ritual that substitutes for the public sanctioning of attending” surgeons. At a Mortality and Morbidity Conference,

Attending surgeons publicly abuse themselves before an audience of their colleagues and subordinates. They publicly claim that they made mistakes in the handling of the case. They put on the hair shirt, as the argot of surgery has it. When an attending puts on the hair shirt, he points out to the group what lessons he learned from treating the patient; he explains why he might better have followed some other course of action; and he urges all to consider the case before acting on similar cases in the future.\textsuperscript{55}

Through this practice, attending surgeons openly accept ultimate responsibility for all that occurs in the operating room. It does not matter if some other practitioner made the crucial

\textsuperscript{54} One prominent example that sits slightly outside the primary focus of this project is the role of medical practitioners in capital punishment in the U.S. For more on this, see Atul Gawande, "When Law and Ethics Collide—Why Physicians Participate in Executions," \textit{New England Journal of Medicine} 354, no. 12 (2006): 1221-1229.

\textsuperscript{55} Bosk, 138-139.
mistake; the senior surgeon takes responsibility for having created and maintained an atmosphere in which such an error occurred. Bosk describes this public accounting as the senior surgeon making “the working of his own professional superego transparent. He shows what considerations should inhibit a too hasty impulse to act.”56 More recently, Atul Gawande notes that surgeons still take this event very seriously, and “this institution survives because laws protecting its proceedings from legal discovery have stayed on the books in most states, despite frequent challenges.”57 In other words, the state has recognized the Mortality and Morbidity Conference as a sanctioned mechanism for the surgical guild to maintain its own internal moral order.

In our investigations so far, we have seen a phenomenological account of how a patient’s body became perceived as her enemy, and our ethnographic observations have shown the arrangements of discourses, practices, and practitioners that enable this distinct mode of imagining and engaging the body. But how did this come to be?

This medical imaginary and its internal morality is a historical achievement, one that requires constant maintenance in order to ensure that surgery’s acts of controlled violence comport with the Hippocratic injunction to at least do no harm. Therefore, we turn now to the history of surgery’s incorporation into the modern hospital. As we shall see, surgery’s rise to prominence in the nineteenth century occurs, in part, through a series of wars and the elevation of a certain kind of masculine character as a heroic ideal. These changes, coupled with the rise of more disciplined hospitals and surgical practices, enabled surgeons to overcome the historical disdain many physicians showed toward their craft. Through these

56 Ibid., 142.
57 Atul Gawande, Complications: A Surgeon’s Notes on an Imperfect Science (New York: Metropolitan Books, 2002), 57. It is worth noting that Henry Marsh does not have as much faith in the Mortality and Morbidity Conference; he thinks it has become a rote proceeding. Marsh, Do No Harm, 155.
changes and the rise of antisepsis and anesthesia, surgery became an essential part of the modern hospital and a catalyst for its growth in the early twentieth century. This history chronicles how the medical imaginary on display in modern surgical ward came to be. But because this historical achievement is contingent, it is also tenuous, as we shall see when we compare it with the rise of a related but distinct medical imaginary in the oncology ward. Both the surgical and oncology wards have profoundly shaped the modern hospital, and so examining them both is salient for our investigations of moral formation in the modern hospital. In doing so, we will uncover how the surgical ward may be capable of a more controlled kind of violence than the oncology ward. By clarifying these two distinct but related medical imaginaries, we will be in a better position to discern the fittingness of moral responses to them both.

2.4 Histories of the Surgical Ward

2.4.1 Origins of the Military Hospital

As we saw in Elaine Scarry’s work, efforts to give voice to pain often take on an “as if” structure: “it feels as if an arrow is piercing my side.” This metaphorical language resonates in large part because of a visceral history of violence written into the human body; our past is filled with human flesh torn open by the weapons of war. Here, Foucault’s genealogical investigation of the body is particularly revealing; recall that he describes the body as “the inscribed surface of events” and defines the task of genealogy as exposing “a body totally imprinted by history.”58 The modern patient’s body is still shaped and acted upon within contexts marked by the memory of the violence of combat, even for those who may have

58 Michel Foucault, “Nietzsche, Genealogy, History,” 83.
only seen images of war. Similarly, modern surgeons may have never set foot in a battlefield, but their practice—and the institution they practice within—has been indelibly marked by the military. To better understand how modern surgery came to be “controlled violence,” we turn to examine the history of how this practice came to be housed within the modern hospital, with a particular focus on the militaristic contexts within which these transformations occurred. We must do this historical work in order to understand the role of this medical imaginary in shaping the institution of the modern hospital. This historical account helps us see the role of combat surgery and the military hospital in shaping both our current practice of surgery as well as the modern hospital. This will better prepare us for discerning how a just-war inspired bioethics may be a fitting moral response to this medical imaginary.

According to Guenter Risse, the Greek asclepeion and the Roman valetudinarium were the earliest Western precursors to what is considered the modern hospital. The asclepeion was a Greek healing temple devoted to the worship of Asclepius, son of Apollo, and the valetudinarium was a Roman medical facility for either slaves or soldiers. Neither, however, is considered the first hospital. The asclepeion did not include physicians but instead only contained religious authorities, while the valetudinarium, although containing trained medical practitioners, was only open to certain subsets of the population—either slaves or soldiers, depending upon the location. 59 In chapter four we will explore the first hospital in Christian Cappadocia. But for now we begin our investigation into the history of surgery’s medical imagination and its place within the modern hospital by examining the Roman valetudinarium, particularly in its military form.

The roots of the modern military hospital can be traced back in part to the first century CE, when a series of forts were built along the Rhine and Danube rivers at the Roman Empire’s northern frontier. Within these structures, the Romans constructed stand-alone buildings for treating valetudinarians, people lacking in *valetudo* (health). The *valetudinarium* (pl. *valetudinaria*) were exclusively for wounded and sick Roman soldiers. They replaced a series of temporary tents serving as field hospitals, and a variety of medical personnel served within them, organized according to military discipline and standard rankings. The primary medical care available was good food and rest within a clean environment that provided opportunity for exercise. While respected, surgery was considered to be a dangerous last resort for the wounded. Following battle, surgeons fought against the damage done by blades and projectiles, and also against the slow march of gangrenous tissues. The harm incurred in the violence of battle was met by the violence of a surgeon’s hand seeking to heal.

As one of the earliest precursors to the modern hospital, the *valetudinarium* shows that the history of surgery and the history of the hospital are closely linked to the history of warfare. This connection is most clearly found in the space of the military hospital, where we find a tradition that carries forward a certain kind of surgical encounter with the wounds caused by weapons. As medical historian Roy Porter observes, “war is often good for medicine” in at least two ways: “It gives the medical profession ample opportunities to develop its skills and hone its practices. It can also create a postwar mood eager to beat

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60 Ibid., 41.
61 Ibid., 51.
62 Ibid., 54. This is, of course, more like modern medical care than we would like to admit.
63 Ibid., 54-55.
The development and expansion of the surgical craft through warfare carries forward a vision of a medical encounter in which violence to what it means for the “frontier” of surgery to be expanded in this militarized settings. That surgery developed within the context of military hospitals is not merely incidental. Instead, this history is crucial for understanding how the modern practice of surgery as “controlled violence” is responsible for the explosive growth of hospitals in the twentieth century. To explore these connections and this medical imaginary in further detail, we turn to the long nineteenth century and its wars in order to explore how surgery and the hospital are transformed.

2.4.2 John Hunter, A New Paradigm of Masculinity, and the Rise of Surgery

In 1790, shortly after the start of the French Revolution, John Hunter, the Scottish “father of modern surgery,” was appointed Surgeon General of the British Army. A few years later his Treatise of the Blood, Inflammation, and Gun Shot Wounds was published posthumously following his death in 1793. This appointment and publication serve as capstones to a life that both represented and made possible the elevation of surgery within Scotland and England. While the emphasis on Hunter’s importance as a singular individual can often be overstated, his influence loomed large in the imagination of nineteenth-century surgeons, as seen in “The Hunterian Oration,” an annual lecture given at the Royal College

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of Surgeons of England. At the close of an 1877 lecture, James Paget describes how Hunter's legacy was perceived at the time,

And now mark what he did for surgeons. Before his time they held inferior rank in the profession….they were subject to the physicians, and very justly so, for the physicians were not only better learned in their own proper calling, but men of higher culture, educated gentlemen and the associates of gentlemen. From Hunter's time a marked change may be seen. Physicians worthy maintained their rank, as they do now, and surgeons rose to it….Yes, more than any man that ever lived, Hunter helped to make us gentlemen.66

By claiming that Hunter helped transform surgeons into gentlemen, Paget refers to centuries in which surgeons were viewed as lower class manual laborers associated with barbers, butchers, and bloodletters. This phenomenon was particularly pronounced in Great Britain, and varied throughout Europe.67 At the University of Paris, medicine had been classified since the thirteenth century as a theoretical discipline, a subset of physics (hence the term physicians), over and against the manual task of surgery, a subset of the mechanical arts.68

The influence and esteem of university educated surgeons was more pronounced in southern Europe, particularly in Italy, where there had always been a small class of highly

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67 France is an interesting case, given that the university distinctions between physicians and surgeons were abolished in the French Revolution. For an overview of differing roles and classifications for surgeons in various countries, see Owsei Temkin, “The Role of Surgery in the Rise of Modern Medical Thought,” Bulletin of the History of Medicine 25 (1951): 248-259, esp. 248-251.

68 Darrel W. Amundsen, "Medicine and Surgery as Art or Craft: The Role of Schematic Literature in the Separation of Medicine and Surgery in Late Middle Ages," Transactions and Studies of the College of Physicians of Philadelphia 1, no. 1 (1979): 43-57. Amundsen describes how Hugh of St. Victor, writing in Paris, attempted to classify medicine and surgery together as practical arts. In reaction to this move and in an effort to reclaim their profession’s intellectual prestige, proponents of medicine pushed for a hard break with surgery, with the result that medicine became theoretical and surgery a mechanical art. This reaction becomes inscribed in the curriculum at the University of Paris, where “the professional and ideological separation of medicine is first manifest” (57).
educated surgeons that viewed themselves as physicians’ peers. For these elite surgeons and physicians, “the smell of the barber shop” was “equally offensive.”

Through Hunter we can see how the profession of surgery in Great Britain began to be raised from barber to elite status. A small group of learned and ambitious surgeons sought to transform the status of surgical elites in Great Britain. Medical historian Christopher Lawrence chronicles their influence by examining the caricatures of physicians and surgeons found throughout popular press. Where a physician is imagined “as a lean, grave, learned gentleman,” surgeons are seen as rotund figures capable of manual strength but marked by a weaker intellect. Lawrence finds evidence of the success of these efforts to raise the status of surgeons in the popular portrait of John Hunter, which depicts him like a physician, “a thin, cerebral man reading the books of scholars and the book of nature.”

Even more than the success of these depictions of elite surgeons, surgery’s rise in esteem depended upon a transformation in social ideals that occurred through the wars of the long nineteenth century. John Hunter himself gained much of his surgical experience and prestige through his military service, and so this period begins with Hunter helping surgeons become less like barbers and more like gentleman. From there, surgery in the long nineteenth century undergoes a series of changes that results in surgeons being viewed as “national heroes.” For example, the funeral of surgeon Joseph Lister filling Westminster

69 Vivian Nutton, "Humanist Surgery," in The Medical Renaissance of the Sixteenth Century, (Cambridge: Cambridge University Press, 1985): 98. Nutton draws from the letters of sixteenth-century humanist physician Johannes Langes to show that “the smell of the barber shop” was a term of disparagement that did not apply to learned surgeons that he encountered.


71 Lawrence, “Medical Minds, Surgical Bodies,” 183.

72 Ibid., 189.
Abbey was attended by “dignitaries from all over the world.”\footnote{Christopher Lawrence, “Democratic, Divine and Heroic: The History and Historiography of Surgery,” in \textit{Medical Theory, Surgical Practice: Studies in the History of Surgery}, ed. Christopher Lawrence (London: Routledge, 1992), 2.} During the wars with France that followed Hunter’s death, surgeons began to refer to themselves as joined with physicians in a common work and field.\footnote{Ibid., 6.} More importantly, in the decades that followed, the social ideals to which medical practitioners aspired shifted in fundamental ways. The Crimean War (1853-1856) was a major impetus to calls for reform due to deep popular dissatisfaction with military leadership. The aristocratic ideal no longer held as much sway in the Victorian era, and the physician’s “lean, grave, learned gentleman” image—achieved by John Hunter and aspired to by elite surgeons—was no longer the only social ideal.\footnote{Ibid., 183.} In its place, there “was a “democratization” of heroism” that centered on the common soldier, and this was then “mediated through the figure of the army surgeon”\footnote{Michael Brown, “‘Like a Devoted Army’: Medicine, Heroic Masculinity, and the Military Paradigm in Victorian Britain,” \textit{The Journal of British Studies} 49, no. 3 (2010): 596.} in order to transform healthcare.

Here we also see the emergence of a new paradigm of masculinity, one that persists today. The valiant and action-oriented surgeon, along with the colonial explorer, frontiersman, missionary, and others, carried this ideal forward. These exemplars of a new kind of masculinity performed risky work at the cutting edge of progress. In places like “the frontier, the West, the ‘Dark Continent,’ the operating theatre….notions of masculinity, heroism, and civilization were constructed and played out.”\footnote{Christopher Lawrence and Michael Brown, “Quintessentially Modern Heroes: Surgeons, Explorers, and Empire, c. 1840–1914,” \textit{Journal of Social History} 50, no. 1 (2016): 152.} For surgeons, this meant that their earlier image of strength and action did not have to be completely disavowed, but was instead transformed. And so Victorian surgeons wedded the intellectual prestige gained by Hunter and others with their traditional portrait of strength, “accommodating it to the new...
muscular masculinity to enhance their profession’s claims to medical and social leadership.”

This new paradigm and its expansionist impulse complicated the notion of discipline present in the depiction of surgery as ‘controlled violence.’

We can find the beginnings of a moral response to this freewheeling frontiersman ethos in the work of John Hunter himself, who recognized the limits of surgery and looked to respect and assist the body’s own healing powers. The ideal surgeon, according to Hunter, would cooperate with the body as the “natural surgeon,” whose opinion needed to be consulted and whose remedies had to be respected in order to maximize the prospects of recovery.”

In his *Lectures on the Principles of Surgery*, Hunter described the act of operating as an acknowledgment of the insufficiency of the healing arts. In other words, cutting with the knife is a limited state of exception to the normal rules governing healing. According to Hunter, operating “is like an armed savage who attempts to get that by force which a civilized man would get by stratagem. No surgeon should approach the victim of his operation without a sacred dread and reluctance.”

Hunter’s moral sensibility is echoed in contemporary neurosurgeon Henry Marsh’s memoir, which begins with the line, “I often have to cut into the brain and it is something I hate doing.” But the rise of the action-oriented surgeon in the nineteenth century posed a threat to Hunter’s idea that surgeons should approach operations with “sacred dread and reluctance.” The dichotomy Hunter presumes between forceful savagery and controlled civilization becomes conflated in the

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78 Ibid., 153. This depiction was present in how surgery narrated its own history, as “Victorian histories of surgery began to use the Romantic language of heroic, individual struggle” to describe a new figure, the “surgical genius.” Lawrence, “Democratic, Divine, and Heroic,” 7.


81 Marsh, *Do No Harm*, 1.
Victorian era’s masculine hero. Even as Hunter’s words serve as a cautious check on the more undisciplined impulses of this new paradigm, they stand in danger of being nominally acknowledged and substantively ignored.

How, then, do the very practices and discourse of surgery reinforce the discipline necessary for taking up the knife as an act of “controlled violence,” as described by contemporary ethnographers? This is accounted for through a series transformations in the hospital that, when combined with new technologies, helped create a context in which surgery could comport with the Hippocratic injunction to pursue healing within a framework committed to doing no harm. These transformations set the scene for the modern hospital. By attending to them we are better equipped to consider a fitting moral response to the medical imaginary housed within it.

2.4.3 Nightingale’s Reforms and the Crimean and Civil Wars

These transformations can be traced, in part, to the damning reports Florence Nightingale issued about the medical conditions she observed during the Crimean War. From her position at a British military hospital in Istanbul, Nightingale wrote highly publicized accounts of soldiers suffering in unorganized and unclean conditions, and she became a leading figure for medical reform in Great Britain and beyond. Through her letter correspondence and especially her widely referenced treatise *Notes on the Health of the British Army*, Nightingale chronicled the various ways that unsanitary and undisciplined medical care led to the deaths of British soldiers. In order to prevent the horrors that she witnessed in the Crimean War, Nightingale attempted to instill discipline in both the profession of nursing and the institution of the hospital. Her understanding of “ritual, discipline, and
loyalty followed a military model—based on her experienced during the Crimean War.”82 In between the end of the Crimean War and the outbreak of the American Civil War, Nightingale attempted to spread this vision in at least two ways. First, she transformed the practice of nursing by founding Nightingale’s Training School for Nurses in London, which served as a model for a new form of nursing. Through those she trained and those she inspired, Nightingale raised the standards and respect for nurses, and contemporary understandings of the nurse as a serious professional able to protest a physician’s orders for the good of the patient owe much to Nightingale. But just as importantly, Nightingale also spread her vision of disciplined healthcare by arguing for an institutional transformation of the hospital. It is to that legacy that we now turn.

Nightingale’s argument for the proper design and function of the hospital was deeply influential on both sides of the Atlantic. Following the Crimean War, Nightingale visited hospitals across Britain and France in order to imagine a better institution than the one she saw as killing wounded British soldiers. Nightingale saw the pavilion hospital — a long, well-ventilated structure with light-filled wards — as the paradigm of hospital design. For Nightingale and those that followed her, the moral and medical goods of cleanliness, sanitation, and a well-ordered hospital were inextricably intertwined. Infection and disease in the hospital were not unavoidable, but instead the result of lack of discipline and order. Those who failed to institute a disciplined regimen of care within an appropriate space were culpable, as were uncooperative patients.83

83 According to Charles Rosenberg, Nightingale’s deep moral commitment to disciplined care helps explain her resistance to the germ theory of disease, which rose to prominence during her lifetime. She feared that a strictly
Through her prominent writings, Nightingale’s promotion of the hospital as a disciplined space was influential in the Civil War and the rise of the modern hospital in its wake. Medical historian Margaret Humphreys goes so far as to say, “Florence Nightingale was the single greatest influence on Civil War hospitals and the people who worked in them.”\(^\text{84}\) Though the concept of the pavilion hospital already existed, “it was Florence Nightingale, and her little book *Notes on Hospitals*, who brought the pavilion plan of hospital architecture to the forefront of Civil War medicine…. [it] had ample air per bed, ventilation to prevent the accumulation of deadly foul odors, an adequate water supply, and abundant sunlight.”\(^\text{85}\) Much in the way the *valetudinarium* replaced field hospitals on northern Roman frontier, the pavilion-style hospital was a more stable anchor for medical care in the Civil War, particularly for the Union armies. Furthermore, the U.S. Sanitary Commission, in its work assisting medical care in the military, was profoundly influenced by Nightingale’s push for medical reform, and through it women were able to help raise the standards for medical care and hospital design.\(^\text{86}\) Although the Civil War did not foster any new major surgical techniques, it transformed American surgery by raising the standards of surgical practice, biological account of infection would prevent those responsible for creating disordered medical spaces from being held accountable. See Charles E. Rosenberg, “Florence Nightingale on Contagion: The Hospital as Moral Universe,” in *Healing and History: Essays for George Rosen*, ed. Charles E. Rosenberg (New York: Neale Watson Academic Publications, 1979):116-136; see also Charles E. Rosenberg, *The Care of Strangers: The Rise of America’s Hospital System* (Baltimore: The Johns Hopkins University Press, 1987), 128-135.

\(^{84}\) Margaret Humphreys, *Marrow of Tragedy: The Health Crisis of the American Civil War* (Baltimore: Johns Hopkins University Press, 2013), 63.


\(^{86}\) Margaret Humphreys chronicles the role that the U.S. Sanitary Commission played throughout the Civil War, with particular attention to the gendered nature of both their relief efforts and their disputes with military officials. They were eventually successful in getting their preferred candidate, William Hammond, in as surgeon general, and through him the Sanitary Commission spread Nightingale’s vision of disciplined sanitary care and hospital design. See Humphreys’s *Marrow of Tragedy*, especially her chapters “Connecting Home to Hospital and Camp: The Work of the USSC” and “The Sanitary Commission and Its Critics,” 103-151.
moving the field as a whole towards the elite status that John Hunter represented.\textsuperscript{87} Moreover, this standardization of care was joined to a transformation in standards of sanitation, along with a new vision of hospital architecture and discipline. That these transformations were recognized as fundamentally important at the time can be seen in Philadelphia a decade after the Civil War, where a World Fair-like festival celebrated “the clean, orderly, well-ventilated hospital ward” as “the greatest advance in nineteenth-century medicine.”\textsuperscript{88}

Throughout the rise of the modern military hospital and in the civilian hospitals it shaped, the Hippocratic tradition of moral reasoning has been engrained in this institution. In the preface to her Notes on Hospitals, Nightingale explicitly situates her plans for the hospital within the Hippocratic tradition, making clear that the “very first requirement” for a hospital is “that it should do the sick no harm.”\textsuperscript{89} The intense focus on disciplined care and spaces inspired by Nightingale helped create within the hospital the conditions and possibilities for surgery as a kind of “controlled violence” situated within a framework devoted to promoting the patient’s health and flourishing. Nightingale’s commitment to a disciplined care that minimizes harm is passed along within the institution of the hospital, as it makes a leap from military to civilian hospital.\textsuperscript{90} This can be seen in the work of John S. Billings, a Civil War surgeon who was tasked in 1876 with designing the newly endowed Johns Hopkins University Hospital. Through his experiences in the Civil War and his time studying hospital design in the following decade, Billings had become firmly convinced of

\textsuperscript{87} Ibid., 292-304.  
\textsuperscript{88} Ibid., 152.  
\textsuperscript{90} As Humphreys notes, the Civil War hospital was the first inpatient American medical institution that provided care to all. Prior to that, hospitals existed primarily for the poor, as those with money could afford better medical care in the privacy of their homes. See pp. 181-182.
the superiority of the pavilion hospital style when coupled with disciplined nursing care. Before finalizing his hospital design, Billings consulted Nightingale herself, and one of her protégés was appointed the first nurse matron at Johns Hopkins. In an address delivered at the opening of the hospital, Billings displays his commitment to the hospital as a disciplined, controlled site devoted to healing and not harm; like Nightingale, he invokes the Hippocratic moral framework and claims that a “cardinal principle of Johns Hopkins Hospital is that it shall do as little harm as possible.” Today, of course, Johns Hopkins is one of the leading medical centers in the world, and this Hippocratic principle is built into its institutional foundation.

### 2.4.4 Anesthesia, Anti/Asepsis, and Control in the Surgical Ward

The transformations in the hospital and surgery that occurred in and after the Crimean War and the Civil War became linked with a series of technical innovations, and this made possible a medical imaginary centered around “controlled violence” done to the body. One clear example of technologies related to the development of this medical imaginary occurred on October 16, 1846, in an operating theatre at Massachusetts General Hospital, where surgeon John Collin Warren excised a small tumor from the neck of Edward Gilbert Abbott. This brief procedure was made remarkable by the fact that Abbott was anesthetized beforehand by local dentist William T.G. Morton, making this the first public demonstration of surgery done under ether anesthesia. Upon the surgery’s successful conclusion, Warren

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91 Risse, *Mending Bodies, Saving Souls*, 402-408; see also Thompson and Goldin, 175-187.
94 Rather than beginning this historical investigation by highlighting these technical innovations as the central determinants of surgical ‘progress’ in the long nineteenth century, they are treated last, following Thomas Schlich’s own approach in “The Emergence of Modern Surgery,” 61-91. Schlich draws from shifts in the historiography of surgery that contextualize a story of technological progress and triumph within a more complex account of the field’s development.
pronounced to all in attendance, “the conquest of pain has been achieved.” Such a conquest is no small thing, given that the patient’s body traditionally suffered tremendously under the pain and shock that accompanied the knife. At the time, surgery was far from a routine procedure; nearly half of patients died after major operations due to “postoperative shock and septic complications.” Because of this, “required surgical dexterity and great speed” were prized, and extensive operations were shunned.

The growing use of anesthesia in surgery brought about two complexly related results. First, the technology assisted in the spread of the practice of surgery. As surgeons sought further to explore and colonize the body, anesthesia was a useful ally in convincing patients to go under the knife. At the same time, anesthesia meant that the theatrical surgeon, renown for performing complex operations at high speed before a rapt audience, was replaced by a more disciplined surgeon, methodically performing accurate incisions in a manner that made for a much less riveting spectacle. In his history of anesthesia in the nineteenth century, Martin S. Pernick describes this transformation and its effect on the operating theatre, saying, “Eliminating the wild, disorderly pre-anesthetic scenes of screaming and brutality made possible the eventual emergence of the controlled, efficient,

95 Risse, Mending Bodies, Saving Souls, 357.
96 Within two months of the operation at Massachusetts General Hospital, famed surgeon Robert Liston had taken up the practice in London. Risse, Mending Bodies, Saving Souls, p. 359. Use of anesthesia grew throughout the Crimean War, at first for the French and Russians and eventually for the British. See N.H. Metcalfe, “The Influence of the Military on Civilian Uncertainty about Modern Anaesthesia between its Origins in 1846 and the End of the Crimean War in 1856,” Anaesthesia, vol. 60, n. 6 (2005): 594–601. For American surgeons, it became a standardized practice through the Civil War; see Humphreys, Marrow of Tragedy, p. 13.
97 Christopher Lawrence makes the case that anesthesia merely assisted surgeons who were already advancing into the body with more invasive procedures. On his account, the common story that anesthesia made possible the expansion of surgery is convenient post hoc cover for an ambitious discipline. See Christopher Lawrence, “Democratic, Divine and Heroic,” 1-47; esp. 23-25. Lawrence’s account and the more common narrative are not mutually exclusive; instead, they are compounding factors of surgery’s expanding scope. For this reading, I follow what I take to be Thomas Schlich’s own engagement with Lawrence in “The Emergence of Modern Surgery,” 61-91.
rationalized modern operating room.” The conquest of pain meant that the surgical hand became much more controlled at the same time as its reach was extended. This two-fold theme of surgical control and expansion is on further display in the rise of antiseptic practices that occurred over the next several decades.

The pavilion hospital and the disciplined cleanliness promoted by Nightingale are followed by the rise of germ theory and antiseptic practices within the operating room. The latter half of the nineteenth century saw a series of debates over the nature and cause of infection, and it took quite some time for germ theory to become accepted. But those on differing sides of the debate could still agree on practices of care that prevented infection. Although the exact structure of pavilion hospitals was not necessary for the prevention of disease according to germ theory, the transformation in the institution’s order and approach to healthcare was crucial preparation for antiseptic and aseptic surgical practices. The disciplined approach promoted by Nightingale and her followers took on an even more combative overtone as the fight was taken to the germs. Joseph Lister developed a series of antiseptic practices, including spraying carbolic acid on surgical sites and dressing wounds in bandages soaked in carbolic acid, in order to kill the germs theorized by Louis Pasteur. According to Lister, these antiseptic practices were all done to ensure “the destruction of any septic germs which may have been introduced into the wound” and to “guard effectually


99 For example, Florence Nightingale only gradually came to accept germ theory late in life, but her early and consistent recommendations for sanitary nursing practices and hospital design helped stave off contagion. As mentioned in note 83, above, Nightingale’s early opposition to germ theory was driven by a desire to dispel the fatalistic perception that infection was inevitable. This did not mean that her sanitary recommendations were ineffective; rather, “Many of the goals she sought to achieve were entirely consistent with policies dictated a generation later by the implications of the germ theory.” Rosenberg, “Florence Nightingale on Contagion,” 130. For her evolving views on infection and germ theory, see Lynn McDonald, “An Introduction to Volume 16,” in *Florence Nightingale and Hospital Reform*, 23-29.
against the spreading of decomposition into the wound.” In an effort to enable healing to follow from surgery, these antiseptic practices combined offensive and defensive purposes. Therefore, the careful control of surgical technique made possible by anesthetics was situated within an operating theatre policed by medical interns spraying antiseptic carbolic acid throughout the operation.

Asepsis took this policing effort even further by attempting to create conditions in which no germs would be present at all. We saw this transformation reflected above in our ethnographic account of contemporary rituals of scrubbing into surgery. These aseptic practices “took the requirements on discipline and self-restraint up a level.” And so the controlled and methodical surgical work made possible by anesthetics became even more so. The first head of the Department of Surgery at Johns Hopkins, William Halsted, was infamous for his slow and meticulous style of surgery; for him, “control was the recipe for success.” This focus on control was made possible by changes in the hospital, practices of care, and anesthesia and antisepsis/asepsis. It represents an institutional transformation that constrains the rising Victorian frontiersman ethos within a context of control that makes possible surgery continuing to fit within a Hippocratic ethic. These transformations enable us to understand how the hospital operating room could become for many “the only ethical place” for surgeons to practice.

2.4.5 The Surgical Ward and the Rise of the Modern Hospital

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102 Ibid., 395.

At the turn of the twentieth century, the operating theatre became a transformative part of the modern hospital, and surgery’s acceptance within modern medicine is deeply bound up with this institutional change. As the operating theatre and the modern hospital integrate and develop together, they make possible the medical imaginary we are examining in this chapter. This transformation is encapsulated in the rise of appendectomy as the primary medical response to appendicitis.

From 1890 to 1920, American healthcare’s understanding of the disease and its treatment dramatically changed, moving from only a few practitioners seeing appendicitis as an exclusively surgical disease to nearly everyone agreeing that surgery was the fitting response. Thomas Schlich describes this transformation as representing a fundamental shift in approaches to surgery:

To the extent that surgery had become safer and more reliable, operative treatment was no longer restricted to emergencies. People started to see it as a routine treatment option. No intervention embodies this new attitude better than appendectomy. In 1890 most American doctors and patients would not have thought of surgery when seeing a case of appendicitis. In 1920, in contrast, appendicitis was clearly a surgical issue for the American medical profession and the general public. And, as hospital statistics in the first decade of the twentieth century suggest, patients were increasingly willing to undergo an appendectomy for this reason.

As surgery became a more controlled, safer intervention, and as appendicitis became known as a disease that inevitably returned with a vengeance even if a brief remission was achieved, practitioners and patients alike began to view appendicitis as necessitating a surgical response. Consequently, there developed a growing expectation that every

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106 Dale Smith notes that in 1896 several life insurance companies would not cover persons who had ‘recovered’ from appendicitis without having had an appendectomy, given what they had discovered about the rates of the disease’s reoccurrence and the patient’s eventual death without surgery. See Dale Smith, 428.
respectable community would have a hospital of its own. In this new paradigm, “towns needed hospitals, and hospitals needed well-trained surgeons.”

Appendicitis was a significant driving force for hospitalizations, and it was also “a major step in the transformation of the public and professional understanding of surgery’s place in medicine as the twentieth century began.”

The surgical imaginary chronicled throughout this chapter—healthcare as disciplined combat with wounded and diseased bodies to promote their healing—sits near the core of the modern hospital that emerged at the end of the long nineteenth century and the start of the twentieth century. By examining the history and ethnography of surgery as “controlled violence,” we now better understand what made possible the surgical encounter with Lauren described above. Lauren’s perception of her appendix as her enemy requiring a surgical response was made possible because of the history of developments that we have chronicled here. These transformations enable her surgical team to understand their incisions as controlled violence that made possible her healing rather than harming her. Substantive moral boundaries have been placed around this controlled violence, as we have seen in the history of the development of this medical imaginary.

As noted earlier, however, the bounds placed around this ethos are a contingent achievement, and because they are contingent there is no guarantee that they will endure. While the continued work of these boundaries is attested to in ethnographic and first-person accounts of the surgical ward, they are less present and more difficult to maintain in a related but distinct imaginary found within the modern hospital. In this medical imaginary, we see

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107 Ibid., 435.
108 Ibid., 441. Along with appendectomies, tonsillectomies and adenoidectomies were key to the rise of the modern hospital. The other driving force behind their growth was labor and delivery, as we will see in chapter four. Rosemary Stevens, In Sickness and in Wealth: American Hospitals in the Twentieth Century (Baltimore: The Johns Hopkins University Press, 1999), 105.
what happens when healthcare transforms from a limited intervention with specific goals for
the good of a particular patient into total war against disease, with the patient serving a
merely provisional role in that fight. To understand this medical imaginary, we turn from the
long nineteenth century to the twentieth century and its paradigmatic disease: cancer. In
making this turn, we shift from the history of the military hospital’s influence on the
modern hospital to the history of the influence of military-funded research on the modern
hospital. This shift means that we are moving from a medical imaginary focused on the
healing of an individual patient to one more concerned with winning larger battles against
diseases. As we will see, such a shift has profound moral implications for the practice of
healthcare and the institution of the hospital. By describing this shift, we will be in a position
to understand the possibilities and challenges facing a just-war inspired bioethics in both the
surgical and oncology wards.

2.5 The Oncology Ward’s Related but Distinct Medical Imaginary

We now turn from the surgical ward to the oncology ward in order to understand what
happens when medical interventions are no longer contained by a commitment to seek the
good of each particular patient. In idealized terms, in the surgical ward the heroic surgeon
engages in single combat for the sake of saving the patient, and in the oncology ward, an
army of researchers and clinicians fight together against the forces of cancer, with each
patient treated as a proxy war, helping hone oncology’s weapons and strategies. Therefore,
within the oncology ward, we find a related but distinct medical imaginary to that of the
surgical ward. The oncology ward’s medical imaginary represents a distinct mode of
perceiving the body, made possible by particular arrangements of discourses, practices, and
practitioners. In contrast to the history of the military hospital, the history of the oncology ward shows the influence of military research on the modern hospital. Ethnographic and historical investigations of the oncology ward, when contrasted with the surgical ward, enable us to understand the philosophical and theological underpinnings of these two medical sites. With those philosophical and theological backdrops in mind, we will then be in a position to examine the fittingness of James Childress’s just-war inspired bioethics as a moral response to these two medical imaginaries.

While the medical imaginary in the oncology ward is similar to that found in the surgical ward, the practices and realities of the two sites differ in at least two important ways. First, cancer is often not a spatially and temporally localized disease or wound. Spatially, metastasized tumors involve far more than just a single organ, and “liquid tumors” like leukemia and lymphoma are spread throughout the body. Temporally, treatment for cancer is spread out because it almost always involves several separate interventions. Because of this spatial and temporal expansion, the control of violence in surgery explored above is far harder to achieve in oncology; treatment for stage IV lung cancer is much riskier than an appendectomy. Second, while the history of surgery is filled with efforts to craft interventions that minimize harm while promoting healing, modern oncology has always been devoted to the defeat of cancer and, in a way, death itself. As we shall see, these differences in practices and histories lend themselves to two divergent medical imaginaries. Surgery’s place within healthcare is a contingent moral achievement that took quite some time, and in what follows, we will see that the history and practices of oncology do not yet lend themselves as easily to a moral framework devoted to avoiding harm and promoting healing. By examining these two medical imaginaries, we will be in a position to understand
the possibilities and challenges facing a just-war inspired bioethics as a fitting moral response.

2.5.1 Sontag’s Illness as Metaphor and a Martial Imaginary

The medical imaginary found within oncology is most famously captured in Susan Sontag’s *Illness as Metaphor*, which offers an influential description of our society’s approach to cancer. After undergoing therapy for breast cancer, Sontag argues that the “controlling metaphors in descriptions of cancer” are drawn from “the language of warfare,” as “every physician and every attentive patient is familiar with.” Sontag highlights this in descriptions of the disease:

Thus, cancer cells do not simply multiply; they are “invasive”….Cancer cells “colonize” from the original tumor to far sites in the body, first setting up tiny outposts (“micrometastases”) whose presence is assumed, though they cannot be detected. Rarely are the body’s “defenses” vigorous enough to obliterate a tumor that has established its own blood supply and consists of billions of destructive cells.\(^{109}\)

Sontag also draws attention to how warfare dominates our imagination of therapy:

Treatment also has a military flavor. Radiotherapy uses the metaphors of aerial warfare; patients are “bombarded” with toxic rays. And chemotherapy is chemical warfare, using poisons. Treatment aims to “kill” cancer cells (without, it is hoped, killing the patient). Unpleasant side effects of treatment are advertised, indeed overadvertised. (“The agony of chemotherapy” is a standard phrase.) It is impossible to avoid damaging or destroying healthy cells (indeed, some methods used to treat cancer can cause cancer), but it is thought that nearly any damage to the body is justified if it saves the patient’s life. Often, of course, it doesn’t work. (As in: “We had to destroy Ben Suc in order to save it.”)\(^{110}\)

Decades after Sontag’s *Illness as Metaphor*, her analysis still rings true. This can be seen on the website of MD Anderson, one of the nation’s leading cancer centers, which hosts a “Gallery of Cancer Stories.” While the images of the story tellers are diverse, their stories all merge into a single one: cancer can be fought and overcome with MD Anderson’s assistance. A


\(^{110}\) Sontag, 65.
physician and scientist declares, “Cancer, we’re fighting you one cell at a time.” A cancer survivor proudly proclaims, “I will crush you, cancer.” A board member announces, “MD Anderson will destroy you, cancer.” These various voices speak as one, joined together in a common cause to defeat cancer.

In order to understand how these voices can join as one in describing and perceiving cancer in the same way, we can return to Elaine Scarry’s argument in *The Body in Pain*. Scarry’s analysis of war illuminates the injuries both endured and inflicted in the “War on Cancer.” For Scarry, the central act of war is the injuring of bodies. In order to legitimate the conflict, these injured bodies must be re-storied as part of a meaningful narrative that justifies the war’s undertaking. The bodies injured in this contest are marked by a “referential instability,” just as we explored above with Lauren’s pain. These referentially unstable injured bodies, however, are not interpreted in the same way that the surgeon interpreted Lauren’s appendicitis. Instead, these individually injured bodies are collectively appropriated as part of a narrative that gives the war meaning. By describing the soldier going to war as setting out “to die for his country” or “to kill for his country,” Scarry argues that the nation gives meaning to the unstable acts of dying and killing by interpreting them as heroic sacrifices done for the country’s sake. Translated in terms of the “War on Cancer,” this means that the injuries involved, both oncology’s cutting, burning, and poisoning of patient’s bodies and the damage done by invasive malignant cancer, are given meaning in reference to this greater fight. In Scarry’s account, the “referential instability” that marks the bodies injured in this

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112 Scarry, 63.

113 Ibid., 121.
contest creates the conditions and possibilities for their appropriation as part of the narrative of the fight against cancer. As bodies are injured in cancer treatment, they are given meaning as part of the progress in the war against cancer, measured by the weeks and months of extended life-expectancy.

The “War on Cancer” makes possible a conflation of individual and corporate battles, which MD Anderson’s “Gallery of Cancer Stories” captures with powerful effect. This conflation also implies the fusion of therapy and research, which we can better understand through examining a brief essay by renowned evolutionary theorist Stephen Jay Gould. In “The Median Isn’t the Message,” Gould writes of his diagnosis of abdominal mesothelioma, a cancer almost certainly caused by asbestos exposure. Gould was deeply troubled by the statistic that those in his situation face a median mortality of eight months. In this brief essay, which has become a beloved text for the community of those living with cancer, Gould points out that mortality for his disease, and many other cancer diagnoses, is significantly “right skewed,” meaning that the survival period extends for quite a lengthy amount of time past the median mark. Gould focuses on ensuring that he is placed within this “part of the curve,” and he signs up for experimental therapy in order to extend the tail of the curve—and the probability of a long life—even further. Gould’s account describes none of the violent and visceral effects of his experimental treatment. Instead, by focusing on a survival curve, the work of experimental therapy is joined to a narrative of statistical progress in the fight against mortality, with no mention of the cost. Gould’s battle for

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114 Ibid.
115 Stephen Jay Gould, “The Median Isn’t the Message,” Discover 6, no. 6 (1985): 42. As Gould writes, “I was placed on an experimental protocol of treatment and, if fortune holds, will be in the first cohort of a new distribution with high median and a right tail extending to death by natural causes at advanced old age.” Remarkably, Gould lived for twenty more years before dying of another unrelated form of cancer, and many have been inspired by his story and argument to fight for better odds.
personal survival is joined with oncology’s struggle against death itself, as expressed through a mortality curve. And so both Gould and oncology adopt the “martial view that death is the ultimate enemy,” working together as allies as they “rage mightily against the dying of the light.”116 If the individual fight against cancer is really a part of a broader fight against death itself, then this total warfare will care little for the costs of the struggle.

### 2.5.2 Warfare in the Modern Oncology Ward

In Gould’s account, as in the voices from MD Anderson’s “Gallery of Cancer Stories,” we see a fusion of research and therapy that makes any individual patient’s fight against cancer a small skirmish within the wider “War on Cancer.” For an account of what makes such a medical imaginary possible, we turn to Siddhartha Mukherjee’s Pulitzer Prize winning book, *The Emperor of All Maladies: A Biography of Cancer*, which gives an overview of the contemporary oncology ward and also the history of its development. Mukherjee focuses much of his story on the history, people, and practices of the Dana-Farber Cancer Institute, where he received much of his training as an oncologist. Describing the ethos of this institution, Mukherjee says,

> Metaphors of war permeated the Farber. Cancer was the ultimate enemy, and this was its ultimate crucible, its epic battleground. Laboratory space and clinical space were deliberately intermingled through the floors to create the impression of a highly sophisticated interlocking machine dedicated to a single cause.117

The war against cancer, according to Mukherjee, is fought in an institute in which experimental and therapeutic spaces and practices are “deliberately intermingled.” Here we

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116 Ibid.
117 Siddhartha Mukherjee, *The Emperor of All Maladies: A Biography of Cancer* (New York: Scribner, 2010), 311. Mukherjee was trained at some of the leading American medical institutions: he went medical school at Harvard, was a resident at Massachusetts General Hospital, and was a fellow at the Dana-Farber Cancer Institute. He also has a D.Phil. in immunology from Oxford. Mukherjee represents the medical imaginary of elite physician-scientists working in the English-speaking oncology world today.
see a strong claim being made about the nature of the hospital: the hospital and its affiliated medical research centers are the battleground where wars against disease are waged through a fusion of research and aggressive therapy. William May describes the institutional changes brought by this martial medical imaginary, writing, “The hospital becomes a military compound. It acquires something of the hallowed-grisly status of a battleground.”

Within the hospital, the connection between cancer and warfare operates in related but subtly distinct ways for patients and medical practitioners. For patients, their individual fight against their cancer is the war on cancer, and the outcome of that battle is what matters to them. As a precondition for pursuing this success, patients volunteer their bodies’ services to the wider war against cancer in hopes of a personal victory. While the oncologists, in their role as physicians, also hope for the well-being of their patients, this goal is caught up within the more widespread campaign waged by the oncologist-as-researcher. For the medical researcher, a particular patient’s fight against cancer is at best one small skirmish to learn from in the long campaign against cancer. This “War on Cancer,” like the Vietnam War that was ongoing at the time of Nixon’s announcement, is a messy and muddled engagement without a clear vision of victory. By invoking the notorious explanation of needing to destroy a Vietnamese village in order to save it, Sontag highlights the complicated way in which oncology often seems to disregard the welfare of patients while pursuing the elimination of cancer cells. The patient may undergo radiation and chemotherapy in hopes that those injuries are making possible the restoration of their health, but the medical-industrial complex views those injuries as incidental damage in the fight to save future lives. In other words, while Sontag may have hoped that the body destroyed and then saved

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118 May, 65.
through cancer treatment was her own, many physicians-as-researchers inflict those injuries on present bodies in service to a future society.

This fusion between therapy and research in the oncology ward is most clearly revealed in the practice of clinical trials. Medical anthropologist Lochlann Jain draws from Elaine Scarry to understand how the randomized control trial (RCT) “virtually defines oncology as a professional field.” The RCT helps serve our “collective living on,” as patients in hope of an experimental cure sign up for treatments that often promise no therapy. Through their wide influence, RCTs have transformed modern medical centers, providing them massive amounts of funding while fusing therapy and research.\(^\text{119}\) Jain focuses on the nature of bodily suffering and sacrifice involved in RCTs, saying,

> Bodies lent to the cause of science suffer, and in many cases greatly, from cancer treatments, both standard and experimental. By promising a future it cannot know and asking patients to hurry to a sacrificial conclusion, the RCT ignores its own forms of violence and permission to harm.\(^\text{120}\)

Scarry notes that the success of warfare depends upon mobilizing the bodily injuries in support of the war’s cause, thus transforming wounds into “battle scars.”\(^\text{121}\) Consequently, the harmful nature of radiation burns and chemotherapy poisoning are easily glossed over by the narrative of patients fighting for their lives and oncologists looking to defeat cancer.\(^\text{122}\) To attend to these injuries closely would undercut morale and the war effort. Thus, it is

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\(^{121}\) Scarry, 80-81.

\(^{122}\) Jain, 121.
difficult for cancer patients to have the vision and language to see and speak in ways that do not take up this militaristic imaginary.

2.5.3 Historical Relations between the Oncology Ward and the Military

In order to describe how we arrived at the modern day practices of the oncology ward, we will examine Mukherjee’s *The Emperor of All Maladies*, which treats cancer as a historical character, an opponent worth knowing. Mukherjee is upfront about the martial nature of this story. “In a sense,” Mukherjee says, “this is a military history — one in which the adversary is formless, timeless, and pervasive. Here, too, there are victories and losses, campaigns upon campaigns, heroes and hubris, survival and resilience — and inevitably, the wounded, the condemned, the forgotten, the dead.” The people he describes throughout the book merely “exemplify the grit, imagination, inventiveness, and optimism of generations of men and women who have waged a battle against cancer for four thousand years.”123 In other words, healthcare practitioners (and, perhaps, patients) are but foot soldiers in a war that has lasted for millennia. The depiction we saw above from Sontag represents the culmination of this historical fight against cancer, as a martial imaginary has been shaped over time by its confrontation with a disease that demands a systemic response. The development of the oncology ward’s medical imaginary is bound up with the history of war in the 20th century, and this is revealed through a brief examination of the histories of chemotherapy and radiation therapies.

When Sontag claims “chemotherapy is chemical warfare,” she is not simply using a powerful metaphor.124 Rather, she is naming a deep truth about the development of this

123 Mukherjee, xviii.
124 Sontag, 65.
drug, as the effects of mustard gas in World War I spurred the Department of Defense to perform extensive research into various aspects of nitrogen mustard. One of those areas of research was the potential therapeutic applications of chemotherapy. When survivors of mustard gas were discovered to have depleted white blood cell counts, researchers at Yale contracted with the Department of Defense to investigate how nitrogen mustards might be used to target malignant blood cells. Their work and the therapeutic potential of nitrogen mustard gained widespread notoriety in large part because of the bombing of a US ship during World War II. In 1943, the USS John Harvey was stationed in southern Italy, and its cargo contained a secret supply of mustard gas to be used if the Allies decided to violate the Geneva Protocol by engaging in chemical warfare. After the ship was bombed, the victims of the gas’s spread were documented as suffering from a depletion of white blood cells and bone marrow. This event, coupled with the publication of research at Yale, spurred further work on the possibility of a liquid form of nitrogen mustard being used to treat cancer. To this day, derivatives of this nitrogen mustard chemotherapy are still in use.125

We also see the history of the military’s influence on the oncology ward at work within the development of radiation therapies. While radiation therapy already was in use via x-rays in the early twentieth century, the Manhattan project’s development of nuclear reactors enabled the creation of artificial radioactive isotopes tailored for precise treatment. Following World War II, American researchers in the Cold War and the atomic age were enraptured by the power of radioactive technologies. Medical and military research were deeply intertwined; for example, total body radiation treatment for leukemia was developed.

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through research trajectories following Hiroshima and Nagasaki.\textsuperscript{126} Cancer and the military “served as perfect foils for one another,” and the disease “enabled the government to demonstrate the humanitarian potential of nuclear technology.”\textsuperscript{127} The connection between cancer and warfare was officially sealed when Richard Nixon declared “War on Cancer” by signing the National Cancer Act of 1971.\textsuperscript{128} Since then, the language of warfare found within the oncology ward has only intensified.

\subsection*{2.5.4 Resisting the “War on Cancer”}

Given the current arrangement of the oncology ward and the history that has led to its development, is it possible to inhabit this medical site without succumbing to this mode of imagining and encountering the body? Some patients, for example, have found ways to resist this martial imaginary or to take up with it in creative ways. In his memoir, \textit{Mortality}, Christopher Hitchens claims while facing his cancer diagnosis that the image of struggle was unappealing to him. This was particularly true during chemotherapy, when “kindly people bring a huge transparent bag of poison and plug it into your arm, and you either read or don’t read a book while the venom sack gradually empties itself into your system.”\textsuperscript{129} Through the startling image of chemotherapy administered through a “venom sack,” Hitchens refuses to take up the language of fighting cancer and instead laments the attack on

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  \item[\textsuperscript{126}] Gerald Kutcher, “Cancer Therapy and Military Cold-War Research: Crossing Epistemological and Ethical Boundaries,” in \textit{History Workshop Journal}, 56, no. 1 (2003): pp. 105-130. See also Gerald Kutcher, \textit{Contested Medicine: Cancer Research and the Military} (Chicago: University of Chicago Press, 2009), as well as Mukherjee, 76-78. The Department of Defense and the National Cancer Institute were the major military and medical research funders. As a civilian initiative following the Manhattan project, the Atomic Energy Commission often operated at the intersection of medical and military research. For example, the Atomic Energy Commission funded an entire hospital at the University of Chicago dedicated to developing cancer treatments through radiation therapy. “Argonne Cancer Research Hospital,” \textit{The New England Journal of Medicine} 248, no. 23 (1953): 991-992.
  \item[\textsuperscript{127}] Jain, \textit{Malignant}, 181.
  \item[\textsuperscript{128}] Mukherjee, 180-190. The original bill introduced into the Senate by Ted Kennedy and Jacob Javits was titled the Conquest of Cancer Act.
  \item[\textsuperscript{129}] Hitchens, 7.
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his body involved in treatment. Others do not reject the martial imaginary but instead take it up in creative ways. For example, in famed writer and activist Audre Lorde’s memoir *The Cancer Journals*, she rejects the gendered shame and silence involved in a mastectomy. In its place, she embraces the image of the Amazonian warrior, who are said to have cut off their right breasts in order to make themselves more effective archers. In the face of gendered oppression, Lorde’s creative turn to the language and imagery of combat was life-giving. However, many patients and practitioners do not resist or creatively appropriate this martial imaginary, instead adopting a firm resolve to fight cancer to the very end. And it must be said that for many of them, significant value and purpose can be found in this combative posture.\(^\text{130}\)

In order to better understand the conditions and possibilities for resisting the medical imaginary we have discerned within the oncology ward, we must make a fundamental shift away from a combat-driven engagement with cancer to a focus on prevention. The “War on Cancer,” much like the Vietnam War in Sontag’s day and the “War on Terror” in our own, rarely devotes its resources to preventing the political, environmental, and social factors that are causally bound up with the rise of its enemy.\(^\text{131}\) But, as Mukherjee admits, any declining rates in cancer mortality are largely attributable to preventing either the disease’s occurrence or in catching it before it significantly develops. This reality is most striking in the case of lung cancer and the efforts made to reduce cigarette smoking in the United States. Moreover, death rates from colon, cervical, and uterine cancer have dropped dramatically due to

\(^\text{130}\) For more on the enabling power of a combative imaginary, see Hawkins, 61-77.

\(^\text{131}\) In reviewing *The Emperor of All Maladies*, historian Steven Shapin claims that the War on Cancer resembles the War on Terror more than the war on Nazi Germany. Steven Shapin, “Cancer World,” *The New Yorker*, Nov. 8, 2010, 78-83. Also see Michael P. Coleman, "War on Cancer and the Influence of the Medical-Industrial Complex," *Journal of Cancer Policy* 1, no. 3 (2013): e31-e34.
screening tests that identify cancer early and so enable minimally invasive treatment.\(^{132}\) And developing forms of treatment seek to “manage” the disease rather than “defeat” it. Such a shift, however, requires a transformation in the fundamental theological and philosophical assumptions that undergird this medical imaginary. By examining them, we will finally be in a position to discern a fitting moral response to the medical imaginaries we have discerned within the surgical and oncology wards.

2.6 Theological, Philosophical, and Political Underpinnings of the Surgical and Oncology Wards

In our examination of the medical imaginaries discerned within the surgical ward and the oncology ward, several sets of interrelated theological, philosophical, and political assumptions have been at work undergirding these distinct ways of imagining and encountering the patient’s body. The first is the relationship between hospitality and hostility within the modern hospital. The hostile bodily encounters of surgery and oncology are in tension with legacy of hospitality claimed by the hospital, though the degree of tension differs. The surgical ward, as befits its origins in the military hospital, largely controls these hostile encounters within an overarching commitment to hospitable healing, whereas the oncology ward, reflecting the influence of military research, becomes a site where the patient can be transformed from guest to sacrificial host. Second, the surgical and oncology wards contain related but distinct assumptions about the nature of friend-enemy relations within their practice. Drawing from the work of Carl Schmitt, we can see that these distinctions have theological roots. And finally, both the surgical and oncology wards contain an implicit

theological commitment to fighting death as an enemy. However, they may differ in the bounds they place around this commitment for the sake of the patient’s good. By examining these three sets of interrelated theological, philosophical, and political assumptions, we will have excavated the moral concerns of these medical imaginaries and so be prepared to consider a fitting moral response.

2.6.1 Hospitality and Hostility in the Modern Hospital

First, we begin with how the hostile bodily encounters within the surgical and oncology wards are understood as part of the wider commitments of the hospital and healthcare. As we have seen, in military hospitals surgery was often focused on saving the body from the damage done by the weapon of an enemy. But by the end of the long nineteenth century, surgery had become a cornerstone of the civilian hospital, and through this process surgical teams learned to engage in a controlled violent intervention against a delimited portion of the patient’s body. As in the story of Lauren’s appendectomy, a discrete body part was named and carefully removed as an enemy to her person. In the twentieth century, in contrast, oncology has aggressively approached the patient’s body as the target of interventions that privilege devastating power over careful control. For those fighting cancer, “nearly any damage to the body is justified if it saves the patient’s life.”

This can be seen vividly in Christopher Hitchens’s description of chemotherapy as a “venom sack [that] gradually empties itself into your system.” In different but related ways, and with varying degrees of discipline, both surgery and oncology have learned to name the patient’s body or

133 Sontag, 65.
134 Hitchens, 7.
some part of it as enemy. The modern hospital, while proclaiming itself as a hospitable institution, has in fact been deeply shaped through these influences.

Recall Elaine Scarry’s claim that the language surrounding pain is “so inherently unstable” that it must be “carefully controlled” in order to stabilize the sign of pain towards flourishing and away from destruction.\textsuperscript{135} Through the histories and practices examined above, we can see that surgery has been more successful than oncology in controlling its infliction of pain and violence in ways that order such acts toward the patient’s healing. When properly controlled, these acts fit within the vision of healthcare devoted “to repair the ground for the return of the world itself.”\textsuperscript{136} In other words, within surgery hostility has largely been ordered within a commitment to hospitable healing.

However, the instability that accompanies these hostile encounters means that the modern hospital can find itself wavering between promoting flourishing and inflicting destruction as it carries forward the medical imaginaries found within surgery and oncology. Scarry examines this duality through an etymological analysis:

\begin{quote}
[T]he protective, healing, expansive acts implicit in “host” and “hostel” and “hospitable” and “hospital” all converge back in “hospes,” which in turn moves back to the root “hos” meaning house, shelter, or refuge; but once back at “hos,” its generosity can be undone by an alternative movement forward into “hostis,” the source of “hostility” and “hostage” and “host” - not the host that willfully abandons the ground of his power in acts of reciprocity and equality but the “host” deprived of all ground, the host of the eucharist, the sacrificial victim.\textsuperscript{137}
\end{quote}

As a refuge in the midst of conflict, the military hospital sits at the hinge of hospitality and hostility, but the institution is ultimately committed to seeking the particular good of each

\textsuperscript{135} Scarry, 13.
\textsuperscript{136} Ibid., 34.
\textsuperscript{137} Ibid., 45. For further etymological investigations into hospitality, see Emile Benveniste, “Hospitality,” in \textit{Indo-European Language and Society}, trans. Elizabeth Palmer, Miami Linguistics Series No. 12 (Coral Gables, FL: University of Miami Press, 1973), 71-83. My thanks to Luke Bretherton for pointing me to this resource; we will examine his work on hospitality further in chapter four.
patient. And so surgery attempts, with varying degrees of success, to perform acts of bodily hostility within a framework of healing. In contrast, the oncology ward, as the inheritor of practices birthed by military research, can be more committed to victory in a wide-ranging war against cancer than to the good of each particular patient. Here, the patient can become the host in the sense of “the host of the eucharist, the sacrificial victim.” Their sacrifice is given for the good of those engaged in the overarching war on cancer.

As the inheritor and repository of these histories and practices, the modern hospital houses these tensed modes of engagement with the body. Within the modern hospital, guest-host relations are fraught when patients oscillate not only between being guest and host but between the contrasting understandings of host named by Scarry. On the one hand, the patient could be considered a host capable of engaging “in acts of reciprocity and equality,” and on the other hand, the patient could be a host offered up sacrificially for others. The discipline of the surgical ward seeks to contain these hostile encounters within the former sense of host; the aggressive medical imaginary found within the oncology ward tends towards the latter. We will return to the notions of hospitality and hostility at work within the modern hospital in chapter four.

### 2.6.2 Friend-Enemy Relations in Modern Medicine

If the hospital is an institution where the patient’s body is named as enemy, then a certain kind of authority is instantiated when medical practitioners engage patients in this way. We can better understand this distinct kind of authority operating within the modern hospital and medicine through the work of Carl Schmitt, who famously claimed that the fundamental political distinction is between friend and enemy. For Schmitt, this antithesis is
irreducible and at the heart of politics. We can draw an analogy between Schmitt’s account of politics to the understanding of medicine at work in the surgical and oncology wards, which then enables related philosophical and theological connections as well.

A medical analogy of Schmitt’s distinction is at work in Lauren’s appendicitis episode described above, where her estranged flesh is transformed into an enemy through the surgeon’s diagnosis and therapy. Lauren herself is befriended by the surgeon who names her appendix as an enemy, and they become allies in the fight. Schmitt describes the enemy as “the other, the stranger,” someone who is “in a specially intense way, existentially something different and alien, so that in the extreme case conflicts with him are possible.”139 For Schmitt, then, the enemy is the stranger always regarded as a potential combatant. This does not mean that politics is perpetual warfare; rather, the possibility of conflict determines political behavior.140 Such a possibility of conflict seems to determine behavior in the surgical ward, though, as we shall see, a slightly different conception is at work in the oncology ward.

Schmitt’s claim about the friend-enemy distinction in politics is crucial for our purposes on three fronts. First, this means that the body estranged by pain and suffering becomes an alien other that may require violent confrontation and subjugation. The patient’s body is always viewed through the lens of a possible conflict. Patients are supported by their medical allies, whose vigilant watch is necessary to monitor this hostile enemy and respond

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139 Ibid., 27.
140 As Schmitt says, “War is neither the aim nor the purpose nor even the very content of politics. But as an every present possibility it is the leading presupposition which determines in a characteristic way human action and thinking and thereby creates a specifically political behavior” 34.
to bodily threats with force.\textsuperscript{141} Therefore, even as a particular body part is isolated as the openly hostile enemy, the practices and discourses of this medical imaginary can easily construct the entire body as an enemy to be on guard against. The differences between surgery’s controlled violence and oncology’s total warfare can be understood in this way: surgery seeks to ally with the patient and much of her body against a discrete and local enemy, whereas oncology takes the entire body either to be an openly hostile force (i.e., metastatic cancer) or capable of becoming one (i.e., the mutation of normal cells).\textsuperscript{142} The power in such metaphors is that they are not limited to the surgical or oncology wards; for although they flow from the historical developments of particular arrangements of practices, discourses, and practitioners, they can offer an influential vision for numerous medical sites throughout the hospital.

This leads to the second reason Schmitt’s conception of the friend-enemy distinction offers a helpful analogy for understanding healthcare as found within the modern hospital. It explains the patient-practitioner relationship as an alliance in which both have agreed upon the enemy and are arrayed against it together as friends. In the case of surgery, this often results in the patient’s body being saved from a discrete hostile element. But in oncology, the patient can be forced to somehow disassociate their sense of self in order to construe their entire body, or much of it, as their enemy. The patient attempts to ally with the medical

\textsuperscript{141} We can see such an imagination at play in the words of French surgeon René Leriche, who claimed that “health is life lived in the silence of the organs” and that disease is that which “rebels against the law” of normal and expected functioning. Leriche’s claim is referenced in Georges Canguilhem’s \textit{The Normal and the Pathological}, 91, 96. This quotation first came to my attention through Sontag’s \textit{Illness as Metaphor}, 44, though she mistakenly attributes the reference to anatomist Marie François Xavier Bichat.

\textsuperscript{142} Cancer is often described using the language of rebellion, civil war, insurrection, etc. Schmitt explores these semantic and conceptual registers more thoroughly in \textit{The Theory of the Partisan}. There he traces the difference between the classical partisan, who was focused on local insurrections, to a more modern conception of global revolutionaries. In the latter case, as in the example of Lenin, “the real enemy” is transformed “into an absolute enemy.” In the oncology ward we are tracing the moral logic of an analogous “absolutization of the enemy.” Carl Schmitt, \textit{The Theory of the Partisan: Intermediate Commentary on the Concept of the Political}, trans. G. L. Ulmen (New York: Telos Press Publishing, 2007), 93.
practitioner against their body, even as such a disembodied relationship is difficult to maintain. But such alliances do occur, in a fashion, when the ultimate enemy is death itself.

Considering death as the true enemy is the third way in which Schmitt’s distinction is illuminative. When the diseased body is but an emissary of the final enemy, death, all efforts are devoted to fighting death’s claim on the living. According to William May, this medical imaginary cannot accept death as “a natural, biological event; quite the contrary, death looms as supremely antihuman, the absolute, invincible enemy, which, nonetheless, we must resist to affirm our humanity.”143 This fight against death is totalizing; it seeks to subordinate all other goals to its one purpose. This means that a medical practitioner’s commitment to the good of a single particular patient faces intense pressure to become secondary to the campaign against death, as seen especially in the oncology ward.

As “hospitals and the physician-fighter wage unconditional battle against death,”144 they promote modes of treatment that inflict deep suffering in an effort to stave off death by a few weeks or months. Even more troublingly, as medical practitioners understand their fight to be for all the living, the patient before them becomes a disposable foot soldier (“research subject”) sacrificed for the sake of current and future lives threatened by death.145 As people within the modern hospital make friend-enemy distinctions, with death as the ultimate enemy, both medical practitioners and patients are shaped within a political order described by Schmitt as possessing “the right to demand from its own members the

143 May, 63.
144 May, 66.
145 While, as we have noted throughout, this may be more common in oncology than surgery, it must be said that many patients have died while undergoing experimental surgical techniques. The difference is that surgical techniques still promise a good for each particular patient; Phase I oncology trials are offered just to ascertain the risk of the drug, with no benefit promised, even though desperate patients enroll in hopes of receiving “cutting-edge results.”
readiness to die and unhesitatingly to kill enemies.” If such a medical imaginary is not disciplined, then it lends itself to patients becoming sacrificial “hosts.” As their bodies are broken by experimental treatments, medical practitioners distribute the gift of their lives as a benefit for all those that come after them in the fight against death. Therefore, Schmitt’s work in political theology reveals to us analogous theological themes at work in contemporary healthcare.

2.6.3 Fighting Death

As we have seen, Schmitt and Scarry both draw from theological discourses to describe our modern contexts, and their work reveals to us that theological assumptions also undergird the medical imaginaries found within the surgical and oncology wards. The concluding set of theological assumptions we will examine has already been broached by our engagement with Schmitt. In these medical imaginaries, we find a theological framework in which death is considered the ultimate enemy. By examining these theological roots, we will be in a position to turn to a discussion of fitting moral responses.

The apostle Paul proclaims, “The last enemy to be defeated is death” (1 Cor. 15:26), and echoes the prophet Isaiah looking forward to when “death has been swallowed up in victory” (1 Cor. 15:54b; cf. Isa. 25:8). Crucially, however, this defeat of death is an eschatological triumph; according to the apostle John, the death of death itself will occur at the final judgment (Rev. 20:13-14). Augustine develops this further by differentiating between the first death of the current body and the second death of eternal separation from God. Augustine argues that under the conditions of the fall Christians experience the first death as a complex event. The separation of the soul from the body in and of itself is not

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146 Schmitt, *The Concept of the Political*, 46.
good, and so Augustine can clearly state that “death is an evil”\(^{147}\) and that “it is a good to no one while…suffering it.”\(^{148}\) But for the righteous, Augustine argues that this first death can also be considered good insofar as it brings their souls to God. For the unrighteous, however, the death of the body is an unmitigated evil. And so Augustine says, “Of the first and bodily death, then, it may be said that it is a good for good men and an evil for evil men.”\(^{149}\)

Allen Verhey develops this Augustinian strand with an even more focused emphasis on the lamentable evil of bodily death. In *The Christian Art of Dying*, Verhey argues that the eschaton, “that good future, God’s final triumph over death, is not yet. God has “already” trumped over death in the resurrection of Jesus, but our full participation in that triumph is still sadly not yet.”\(^{150}\) For Christians, the current life is lived in a tension between gratitude for the current good gifts of creation and longing for the world to be set right. Verhey describes this tension as understanding that “life is a great good, but not the greatest good” and also that “death is an enemy, but an enemy already defeated not by medicine but by the power and faithfulness of God displayed in raising Jesus from the dead.”\(^{151}\)

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\(^{148}\) Ibid., 13.6.


\(^{150}\) Allen Verhey, *The Christian Art of Dying: Learning from Jesus* (Grand Rapids, MI: Wm. B. Eerdmans Pub., 2011), 96; see pp. 89-109 for his development of a position poised between death fought as an ultimate enemy and death commended as a friend, both of which represent Christian theological tendencies.

\(^{151}\) Verhey, *The Christian Art of Dying*, 392. His formulation echoes his fellow Reformed ethicist William May, who writes, “In the Christian theist setting, neither life nor wealth of life can command as an absolute good; neither death nor suffering can threaten as an absolute evil, that is, as powerful enough to deprive human beings of the absolutely good.” May, 70.
In our contemporary context, however, these eschatological commitments have been collapsed within an immanent frame. Because of this, the theological desire for divine victory over death becomes wedded to the work of modern medicine, which instead of participating in God’s work of healing is now seen as the only hope for redemption. By demanding medicine’s victory over death, this theological vision erodes the capacity for practitioners to remain committed to the good of a single patient even and perhaps especially as they are dying. Insofar as modern medicine focuses on patients as useful in the war against death, it struggles to understand why patients might give up fighting and instead seek other goods with the time they have remaining. In response to the theological distortion at work within this medical imaginary, William May offers a theological corrective:

The theistic setting yields two general policy consequences that modify the military model for medical practice. First, the destructive reality of suffering and death provides some theological warrant for the struggle against these evils. Fighting these real evils makes Christian sense. However, these evils, while real, are not ultimate. Therefore, they do not justify an absolutely unconditional medical struggle against suffering and death.

In the terms we have used so far, May proposes that the medical imaginaries found within the surgical and oncology wards renounce total warfare and instead commit themselves to waging just war. Such a model would commit itself to placing controlled limits around violent acts and to maintaining friend-enemy distinctions that refuse to let the entirety of patient’s body be named as enemy.

By investigating the medical imaginaries of the surgical and oncology wards, we have unearthed key theological themes operating within these medical sites. A theological effort to place the fight against death within a broader vision of human flourishing requires the moral

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152 Charles Taylor lays the groundwork for this kind of analysis in *A Secular Age* and *Sources of the Self*, which Gerald McKenny extends more directly to medicine in *To Relieve the Human Condition.*

153 May, 71.
disciplining and ordering of the arrangements of discourses, practices, and practitioners that have developed within these two medical sites. While the surgical ward’s historical development and contemporary practice lend themselves more easily to this moral discipline, substantive moral effort is required to maintain the surgical ward’s commitment to controlling forceful interventions within a wider commitment to the healing of each patient. Given the oncology ward’s historical development and contemporary practice, deep and serious transformations are necessary to resist the oncology ward’s impulse towards a total war imaginary. In other words, something like a just-war inspired bioethics may be fitting and necessary for these two medical sites. Therefore, we now shift from questions of moral description to those of moral prescription, as we consider fitting modes of moral response to the medical imaginaries we have discerned within the surgical and oncology wards. In particular, we turn to the work of prominent bioethicist James Childress for a moral schema that seeks to maintain medicine within the logic of just-war.

2.7 James Childress and a Just-War Inspired Bioethics

Although it may seem strange to turn to just-war theory in a work on bioethics, the very field of bioethics, particularly as it relates to Christian ethics, is defined in part by figures who have done just this. Paul Ramsey, one of the foundational figures in the modern field of Christian ethics, wrote numerous works in just-war theory and bioethics. And, more recently, Lisa Cahill and Oliver O'Donovan have contributed to both fields, with Stanley Hauerwas providing a pacifist analogue.\textsuperscript{154} This chapter, however, considers the Christian

\textsuperscript{154} See, for example, Ramsey's \textit{War and the Christian Conscience: How Shall Modern War Be Conducted Justly?} (Durham, NC: Duke University Press, 1961) and \textit{The Just War: Force and Moral Responsibility} (New York: Charles
ethicist whose work in bioethics has proven most influential: James Childress. By exploring the conceptual connections between Childress’s work in just-war theory and bioethics, we will see more clearly the structure of his moral reasoning, and we will also be able to discern how his just-war paradigm responds to the moral schema and conflicts uncovered within the surgical ward and the oncology ward. The limited and controlled nature of surgical interventions seek to comport with the Hippocratic injunction “to help, or at least to do no harm.” Childress’s approach to bioethics aligns in many ways with this stream of moral reasoning. In contrast, the medical imaginary of the oncology ward needs serious transformation if it is to be ordered by a just-war inspired bioethics. We end this inquiry by

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155 I am grateful to Tobias Winright, himself a significant contemporary contributor to just-war theory and bioethics, for a conversation early in the development of this project about the connections between Childress’s just-war theory and his bioethics, and also for sharing with me the text of a conference presentation he delivered on this topic. In it, Winright briefly notes connections between Childress’s work on prima facie duties and principles in just-war and bioethics before offering a historical account of the theological origins of just-war theory, with particular attention to the development of virtue for an adequate moral approach to conflict. See Tobias Winright, ”Bioethics and Just War Ethics Will Meet,” presentation for panel on ”Justice and Peace Have Kissed: The Inclusive Posture of Just War Theory,” at the Annual Meeting of the American Society for Bioethics and Humanities, San Diego, CA, October 18, 2014. For more of Tobias’s work on just-war theory, see his essay, “The Liturgy as a Basis for Catholic Identity, Just War Theory, and the Presumption against War,” in Catholic Identity and the Laity, College Theology Society Annual Vol. 54, edited by Tim Muldoon (Maryknoll, NY: Orbis Books, 2009), 134-151; see also the essay he co-authored with Mark Allman, “Growing Edges of Just War Theory: Jus Ante Bellum, Jus Post Bellum, and Imperfect Justice,” Journal of the Society of Christian Ethics 32, no. 2 (2012): 173-191; and his introduction to a compilation he co-edited, “Introduction,” in Can War Be Just in the 21st Century?, eds. Tobias Winright and Laurie Johnston (Maryknoll, NY: Orbis Books, 2015), iii-xxvii.

asking how a just-war inspired bioethics might be set in service to a medical imaginary ultimately devoted to bodily peace.

2.7.1 Childress in Context: Theological and Philosophical Foundations

Over the past fifty years, James Childress has deeply shaped the field of bioethics as one of its earliest and most preeminent members. Trained at Yale in religious ethics, his early work focused on civil disobedience, just war, and pacifism, and, as we shall see, this literature provides an important conceptual backdrop for his more prominent work in bioethics.

Childress was one of a select few philosophers and theologians consulted in the writing of The Belmont Report, the influential document on research ethics produced by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. At the same time as The Belmont Report was being drafted, Childress was collaborating with Tom Beauchamp, the commission's staff philosopher. Together, Beauchamp and Childress co-authored the leading bioethics textbook, Principles of Biomedical Ethics, which was originally published in 1979 and is now in its seventh edition. In order to better understand the relevance of Childress’s work to the moral questions raised in the


158 Beauchamp replaced Stephen Toulmin as staff philosopher for the commission, and he was responsible for much of the original draft of The Belmont Report. In contrast to Jonsen and others who claim that Principles of Biomedical Ethics was developed out of the intellectual groundwork laid by The Belmont Report, Beauchamp maintains that the two documents were drafted concurrently. He says, "There was reciprocity in the drafting, but the influence ran bilaterally." Beauchamp also maintains that the two publications "developed substantially different moral visions, and that neither approach was erected on the foundations of the other," 27. Beauchamp claims that Principles of Biomedical Ethics was focused on clinical ethics and health policy, whereas The Belmont Report was concerned with research ethics. For more on the historical dispute between Jonsen and Beauchamp, see their respective juxtaposed chapters, "On the Origins and Future of the Belmont Report" and "The Origins and Evolution of the Belmont Report," in Belmont Revisited: Ethical Principles for Research with Human Subjects, ed. James F. Childress, Eric M. Meslin, and Harold Shapiro (Washington, D.C.: Georgetown University Press, 2005), 1-11, 12-46.
surgical and oncology wards, we focus primarily on his own writings and the role played by just-war thought within them. This examination will then be used to illuminate a key conceptual component of the influential *Principles of Biomedical Ethics*. 

Before relating the medical imaginaries described above with Childress’s work on just war theory and bioethics, it is worth noting how Childress relates to the overall methodological approach to bioethics offered throughout this project. His co-authored text, *Principles of Biomedical Ethics*, has been criticized by many for ignoring the contexts within which moral action occurs. In fact, it clearly exemplifies the approach to moral theory described in chapter one as solely concerned with an abstracted moral decision without attending to the modes of perception and the arrangements of discourses, practices, and practitioners that frame moral action. While this could be explained as the inevitable result of the convergence of rule utilitarianism (Beauchamp) and rule deontology (Childress), it is not a critique that could be applied easily to all of Childress’s own writing. Throughout his career, Childress has engaged with the challenges of the connection between moral description and moral theory. Although Childress himself acknowledges that “narrative, metaphor, and analogy” are “generally neglected in *PBE [Principles of Biomedical Ethics]*,” he rightly points to his own work as engaging more deeply with the important questions raised by moral description and imagination.  

Childress collects a variety of essays engaged with these questions in his book *Practical Reasoning in Bioethics*, which begins with a chapter entitled, “Metaphor and Analogy in Bioethics.” In it he argues that this “aesthetic dimension of moral discourse” is “central to

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moral discourse and action in health care and in bioethics” even as it is “too often overlooked, especially in conceptions of bioethics oriented to principles, rules, or theories.” Childress goes on to argue that metaphor, analogy, and symbol are deeply related to “principles, rules, and theories” and that these two approaches to moral reasoning “need and even presuppose each other.” Such an approach shares deep formal similarities with the work of this project, which seeks to display the ways in which the concerns foregrounded by distinct modes of perceiving and inhabiting the world lend themselves to differing approaches to moral theory. Beyond that, Childress also claims that differing metaphors in healthcare “can be assessed by how well they illuminate rather than distort both what is going on and what should be done.” In what follows, Childress’s own moral theory will be shown to be a fitting moral framework for a world perceived as filled with moral conflict.

Before he became known as a bioethicist, Childress began his academic career working in more overtly political ethics. His dissertation, published as *Civil Disobedience and Political Obligation: A Study in Christian Social Ethics*, attempts to offer a theological and moral “framework for the discussion and justification of civil disobedience.” After establishing early on that “nonviolence is an essential feature of disobedience,” towards the end of the work Childress examines what other “restrictions should be placed upon the forms and

\[^{162}\] Childress, “Preface,” in *Practical Reasoning in Bioethics*, x.
\[^{163}\] James F. Childress, *Civil Disobedience and Political Obligation: A Study in Christian Social Ethics* (New Haven, CT: Yale University Press, 1971), x
means or conduct of civil disobedience.” In order to do this, he extends the work of just war theory to analyze acts of civil disobedience. Childress claims:

The “just war doctrine” offers a set of considerations for determining when war is justified, and analogous criteria must be employed in determining when civil disobedience is justified, although perhaps it is more accurate to suggest that civil disobedience is subject to the same general demands of morality as any other action rather than that it is illuminated by just war criteria. However that may be, certainly the appropriate criteria for evaluating civil disobedience coincide to a great extent with traditional just war criteria such as just cause, good motives and intentions, exhaustion of normal procedures for resolving disputes, reasonable prospect for success, due proportion between probable good and bad consequences, and right means.

In this work on civil disobedience, then, Childress offers his first extension of just war theory into other areas of moral analysis. Importantly, Childress hints that “analogous criteria” to just war theory might serve as the “general demands of morality.” Although he does not follow this point further here, we shall see that Childress continually returns to analogues of just war criteria throughout his career, indicating that it serves as a fundamental framework for his evaluation of moral action.

Aside from this explicit point of connection, Childress lays further theological and philosophical foundations in his first work for extending just war theory to other modes of moral reasoning. Childress argues that “a pluralist approach” to moral principles and values “is most consistent with an adequate, balanced interpretation of God's creative, ruling, and redeeming will.” Such a pluralist approach to morality reflects a theological commitment to

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164 Ibid., 9, 202.
165 Ibid., 204. Interestingly, this claim immediately follows a quotation from Ralph Potter, who argued that when “any use of force” is subjected to moral analysis “some analogue to the just war doctrine emerges.” In his gloss on Potter, we can see that Childress goes even further than Potter’s own extension of just war theory, claiming that just war criteria might serve as the “general demands of morality.” Ralph Potter, War and Moral Discourse (Richmond, VA: John Knox Press, 1969), 49-50; cited in Childress, Civil Disobedience and Political Obligation, 204-205.
“the whole idea of God,” which means that “God's creating, ordering (sustaining and restraining), and redeeming purposes and actions” must all be taken seriously. When applied to theories of the state, this means that one single principle, such as order, cannot be valued to the exclusion of others, like justice. Childress notes that his pluralist perspective is influenced by the work of philosopher W.D. Ross, and he develops this philosophical influence later in the book through Ross's concept of *prima facie* obligations and duties. *Prima facie* duties often come into conflict and are assigned no priority. But they “can be outweighed and overridden” through taking into consideration the totality of all relevant *prima facie* obligations. Through this work of balancing, one’s actual obligations in any particular situation emerge.

Through just-war theory and the concept of *prima facie* duties, Childress developed conceptual resources for balancing competing moral commitments that he then extended into other areas of moral reflection. He first directly connects the logic of *prima facie* duties and just war theory in a 1974 essay attempting to clarify Reinhold Niebuhr's position on violence. In order for Niebuhr to consider violence as a “necessary evil” and “last resort,” Childress argues that he must be committed to nonviolence as a *prima facie* duty, not a pragmatic choice. Even as a *prima facie* obligation like nonviolence is overridden, “residual

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167 Childress, *Civil Disobedience and Political Obligation*, 102. Here Childress explicitly invokes Paul Ramsey and through him the influence of H. Richard Niebuhr, Ramsey's teacher.

168 Ibid., 103, n. 112.

169 As an example of conflict between *prima facie* duties, Childress describes the tension between the duty that fair play imposes on all to obey the law and the duty to engage in actions to change unjust policies even if they are civilly disobedient. Ibid., 162-163.

170 Ibid., 163. Below we consider whether or not Childress is consistent about this lack of priority or order among *prima facie* obligations. His early work in just war theory and bioethics both seem to indicate a prioritization of the *prima facie* obligation to do no harm.
effects of violated *prima facie* duties are very important,” and this helps to explain why Niebuhr maintains that feelings of guilt accompany acts of violence.\(^{171}\)

### 2.7.2 Childress on Just War

Childress's essay on Niebuhr became the second chapter of his 1982 book *Moral Responsibility in Conflicts*, and in its revised form the essay refers the reader to another book chapter, “Just-War Criteria,” for further development of Childress's use of *prima facie* duties.\(^{172}\) The “Just-War Criteria” essay is an expanded version of a seminal piece that Childress first published in 1978.\(^{173}\) Childress's just-war essay has proven deeply influential, particularly in its claim that just-war theorists and pacifists “reason from a common starting point. Both begin with the contention that nonviolence has moral priority over violence.”\(^{174}\)

This “presumption against violence” is cited as the starting point for the just-war work developed by both Lisa Cahill and Richard Miller.\(^{175}\) Further, it is cited by the U.S. Conference of Catholic Bishops in their 1983 pastoral letter *The Challenge of Peace*, where they claim that “extraordinarily strong reasons” must be present in order to override “the presumption in favor of peace and against war.”\(^{176}\) This marked a significant shift in social


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teaching for the U.S. Catholic Church, and moreover stands as a key development in the modern tradition of just war reasoning. Because of this, and because of the importance Childress’s work in just-war theory has for his approach to bioethics, a summary of his just-war position is merited.


178 The distinction between balancing prima facie duties and specifying absolute duties is also a point of difference between Childress and his utilitarian collaborator, Tom Beauchamp. Both positions are contained within their Principles of Biomedical Ethics (see, for example, pp. 17-24 of the 7th edition), but Childress explicitly recognizes this as a conceptual tension in "Principles of Biomedical Ethics: Reflections on a Work in Progress," 63.

Childress describes his approach to just-war as a “rational reconstruction” of the “historical deposit of just-war criteria.” In crafting his theory, Childress sets out to “show how the traditional just-war criteria can be reconstructed, explicated, and defended in relation to the prima facie duty of nonmaleficence—the duty not to harm or kill others.”

By claiming that just-war theory begins with nonmaleficence, Childress names this tradition of moral reasoning as deeply akin to that found in the Hippocratic tradition, which, as we saw above, is committed "to help, or at least to do no harm." Childress frames just-war theory as an effort to understand the necessary conditions for overriding a prima facie duty not to injure or kill another, along with how one should act when overriding this obligation. These two considerations are the foundations of jus ad bellum and jus in bello criteria, which govern the morality of initiating and conducting a just-war. Childress summarizes his rational reconstruction of just-war theory as including the following criteria:

[L]egitimate or competent authority, just cause, right intention, announcement of intention, last resort, reasonable hope of success, proportionality, and just conduct. All of these criteria taken together, with the exception of the last one, establish the jus ad bellum, the right to go to war, while the last criterion focuses on the jus in bello, right conduct within war, and includes both intention and proportionality, which are also part of the jus ad bellum.

When these criteria are met, the prima facie duty of nonmaleficence can be overridden in the pursuit of other important prima facie duties, such as upholding justice and protecting the innocent. Even as this occurs, the overridden prima facie duty is not erased, but instead remains through “moral traces,” a term Childress draws from Robert Nozick and which connects with his earlier engagement with Reinhold Niebuhr. Through these “moral traces,”

179 Childress, Moral Responsibility in Conflicts, 64.
180 As we shall see below, Childress's commitment to pluralism eventually overrides his prioritization of nonmaleficence present in his early work on just-war theory and bioethics.
181 Ibid., 64-65.
182 Ibid., 71.
the overridden *prima facie* duty “has ‘residual effects’ on the agent's attitudes and actions.” These moral traces lead to the regret and perhaps even remorse over the choice of action, which are manifest in the restraint displayed through *jus in bello*. Moreover, because for Childress “peace remains the ultimate aim of a just war,” the conduct of the war should accord with this purpose, and so “the view that war is ‘total’ and without limits” is unacceptable. We will return to the importance of “moral traces” and avoiding total warfare when we place Childress's theory in conversation with the medical imaginaries found within the paradigmatic medical sites of the surgical and oncology wards.

Childress ends his essay on just-war criteria by returning to his opening commitment to nonmaleficence, claiming, “If we accept this *prima facie* duty of nonmaleficence and if we accept the responsibility to think morally about the use of force in a sinful world, we should be committed to a framework and procedure of reasoning that is at least analogous to just-war criteria.” Here we again see Childress hint at the wider implications of his work in just-war theory. And, in fact, Childress's commitments to nonmaleficence and to thinking about moral conflicts in a broken world are foundational for his work in bioethics. Because of that, we can recognize the distinct presence and influence of just-war reasoning throughout his bioethical writings, to which we now turn.

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183 Ibid., 69.
184 Ibid., 72.
185 Ibid., 92. Childress also claims that he has offered a formalist just-war theory amenable to different substantive understandings of justice and morality. Such an approach to just-war reasoning mirrors the early position of principlism that he develops with Tom Beauchamp. As Childress recounts, the earliest editions of *Principles of Biomedical Ethics* “developed the four principles plus related rules out of a convergence or ‘overlapping consensus’ between rule utilitarianism (Tom's favored theory) and rule deontology (my favorite approach).” Therefore, the use of just-war criteria in balancing *prima facie* duties does not depend on deep substantive moral agreement, either in political ethics or bioethics. However, it should be noted that beginning with the fourth edition of the *Principles of Biomedical Ethics*, Beauchamp and Childress based their “argument on ‘common morality,’ not on the convergence of these two types of ethical theory (even though we still recognized and affirmed this convergence).” The philosophical adequacy of their notion of “common morality” is outside of the scope of this project, but they do maintain that is “a metaethical thesis, not an empirical one.” Childress, “*Principles of Biomedical Ethics: Reflections on a Work in Progress,*” 50-51.
2.7.3 Childress's Just-War Inspired Bioethics

In 1981, Childress published his first book-length treatment of bioethics, *Priorities in Biomedical Ethics*, and in it he adopts just-war reasoning to engage questions of the ethics of human subjects in research. Childress again refers to his approach as a “pluralist” model of ethics, and in pursuing it he argues that analogous criteria to those in just-war theory “are used whenever we encounter situations that involve conflicting values, duties, or obligations.”

Given Childress's involvement with the *Belmont Report*, which was issued three years prior as guidance for research ethics, it perhaps should not come as a surprise that his first application of just-war theory to bioethics occurs by analyzing human subjects in research. Once again, Childress begins with the commitment to do no harm, and he proceeds to use just-war criteria to argue for when this commitment can be overridden. Childress gives the following criteria for human subject research:

First, there should be a *morally important reason* for the research….Second, there should be a *reasonable prospect* that the research will generate the knowledge that is sought….Third, the use of human subjects in this research should be a matter of *last resort*; their use should be *necessary*….Fourth, the research should meet the principle of *proportionality*….Fifth, the research must have the subject's *voluntary and informed consent* to participate….It is important to identify a sixth standard: Are the benefits and burdens of research fairly and equitably distributed among the population?….Finally, we need to establish and maintain procedures to ensure that these criteria are met.

These criteria for human subject research almost exactly align with the just-war criteria that Childress developed a few years earlier. Most are self-evidently the same, and only a few needing clarifying. In an important move, voluntary and informed consent takes the place of “legitimate or competent authority,” and procedures ensuring the criteria are met becomes “just conduct” for medical research. The just-war criterion of announcement of intention

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187 Ibid., 55-58.
becomes a part of voluntary and informed consent. Out of the seven criteria for human subject research, the only one that may not have a direct analogue in Childress’s just-war theory is the fair and equitable distribution of the benefits and burdens of research, and even it has strong parallels with the just-war criterion of “right intention.”

A year after Childress published this connection between just-war criteria and human subject research, he extended the use of just-war reasoning into clinical medicine in his 1982 book *Who Should Decide?: Paternalism in Health Care*. Childress begins by reflecting on the role of the metaphor of paternalism before examining the *prima facie* duties of beneficence and respect for persons. Following the Hippocratic tradition, Childress differentiates between beneficence and nonmaleficence, and he quotes the Hippocratic axiom that medical practitioners should seek “to help, or at least to do no harm.” In order to justify paternalistic action by a healthcare practitioner, the following conditions must be met:

[I]t is essential, first, to rebut the presumption of an adult’s competence to make his or her own decisions. The second condition for justified paternalism is the probability of harm unless there is an intervention. The third condition is proportionality—the probable benefit of intervention should outweigh the probable

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189 Childress modulates Kant in regards to respect for persons, claiming, “Perhaps it is better to say not that we should respect his *ends*, but that we should respect them as *his* ends, i.e., as his representation of his values, purposes, and choices.” It is also interesting to note that Childress argues nonmaleficence is an obligation contained within the *prima facie* duty of respect for persons, just as he claimed that nonmaleficence was implied by the duty of beneficence. Childress, *Who Should Decide?*, 56.
190 Ibid., ix.
harm of nonintervention. Fourth, it is necessary to assess modes of paternalistic action, such as deception and coercion. Effectiveness is not sufficient. In general, the least restrictive, least humiliating, and least insulting means should be employed.¹９¹

These four conditions are a slightly shortened and condensed appropriation of just-war criteria. Legitimate authority in just war becomes a question of decision-making competence in medicine. Just cause, right intention, and last resort are all potentially carried within the condition of “the probability of harm unless there is an intervention.” Proportionality is a direct parallel between the two approaches, with the just-war criterion of a reasonable hope of success possibly collapsed within it. Finally, proper “modes of paternalistic action” in medicine matches the just-war criterion of just conduct, and may also include the need for announcement of intent.¹９²

By examining Childress’s development of just-war criteria into the concerns of bioethics, we are now better prepared to recognize the influence of just-war theory on the most important book in bioethics, Childress and Beauchamp’s Principles of Biomedical Ethics. The book sets out the position known as principlism, in which the four principles of autonomy (changed in later editions to “respect for autonomy”), nonmaleficence, beneficence, and justice are set forth as normative for modern biomedical practice. From its first edition, the book has described its four principles using language that strongly echoes passages from Childress’s influential essay on just-war theory. The principles are described using W.D. Ross’s understanding of prima facie duties. Also, Robert Nozick’s notion of “moral traces” is once again referenced to explicate the abiding nature of a prima facie

¹９¹ Ibid.
¹９² A few years later, Childress makes a related but different set of connections between just-war criterion and the conditions for overriding “the prima facie principle of respect for autonomy.” For those conditions, he lists proportionality, effectiveness, last resort, and least infringement. He points his readers to the 3rd edition of Principles of Biomedical Ethics “for a somewhat different formulation.” James F. Childress, “The Place of Autonomy in Bioethics,” Hastings Center Report 20, no. 1 (1990): 15, 17 n. 12.
obligation even as it is overridden. Beginning with the third edition in 1989, the notion of balancing the four principles is introduced using criteria drawn directly from Childress's work in just-war theory. In the book's most recent edition, the conditions that constrain balancing the four principles are:

1. Good reasons can be offered to act on the overriding norm rather than on the infringed norm.
2. The moral objective justifying the infringement has a realistic prospect of achievement.
3. No morally preferable alternative actions are available.
4. The lowest level of infringement, commensurate with achieving the primary goal of action, has been selected.
5. All negative effects of the infringement have been minimized.
6. All affected parties have been treated impartially.

These conditions align with most, though not all, of Childress's just-war criteria. Condition 1 can be read as just cause, condition 2 as reasonable hope of success, condition 3 as last resort, and conditions 4-6 as combining elements of proportionality, right intention, and just conduct. Despite these parallels, Beauchamp and Childress make no mention of just-war theory in the text or notes of *Principles of Biomedical Ethics*. However, Childress admits the connection in an essay reflecting on the book, and he does so using the language we have traced throughout his work, saying, “In short, the criteria for assessing wars and several other actions are similar because war and these other actions infringe upon some prima facie

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duties or obligations—an infringement that requires justification and can be justified along
the lines suggested by the criteria."\(^{196}\)

Interestingly enough, Childress’s just-war criteria of legitimate authority and
announcement of intention do not make it into the conditions that constrain balancing the
four principles. Recall that in his 1981 *Priorities of Biomedical Ethics*, Childress makes
“voluntary and informed consent” a research ethics analogue for legitimate authority and
announcement of intention. He does something similar when addressing paternalism in *Who
Should Decide?*. This important criterion may be left out of *Principles of Biomedical Ethics*
because the *prima facie* duty of respect for autonomy is one of the four principles whose
conflict is supposed to be mediated by these balancing conditions. In other words, the
conceptual framework Childress and Beauchamp use to balance the four principles is
structurally predisposed to favor something like informed consent in medicine. Given that
*Principles of Biomedical Ethics* has been criticized by many for privileging respect for autonomy
above all other principles, this is a crucial point. In his original just-war article, Childress
names “legitimate or competent authority” as the just war criteria that is “really a
presupposition for the rest of the criteria,” for it “determines who is primarily responsible for
judging whether the other criteria are met.”\(^{197}\) So, even though this criterion is not explicitly
named in *Principles of Biomedical Ethics*, its absence in a conceptual schema meant to privilege
it as a criterion before all others means that the *prima facie* duty of respect for autonomy may
be favored from the start over the other three core principles.


We see this playing out in modern bioethics where, as in just-war criteria, the question of who is the legitimate or competent authority often functions as a presupposition for all other moral considerations. Therefore, by attending to the way that Childress’s work in just-war theory illuminates his work in bioethics, we are now in a position to see that his use of just-war theory may help explain why Childress and Beauchamp’s principle of respect for autonomy may be conceptually privileged within their bioethical theory. We now turn to further explorations of how this connection between just-war theory and bioethics casts light on important elements of Childress’s work.

To do this, we can draw from a lecture Childress delivered at the U.S. Air Force Academy in 1992, later published as War as Reality and Metaphor: Some Moral Reflections. In it, he explores how the language of warfare has suffused our public discourse in a variety of areas. Childress’s primary point is that in these debates we are prone to ignore the importance of “moral limits in war.” “In short,” Childress says, “we forget the just-war tradition, with its moral conditions for resort to war and for waging war.” Tempted by either a “seedy realism” or “an equally dangerous mentality of crusade,” we neglect the important constraints that ought to attend any use of force. Childress again invokes the parallels between just-war theory and other moral reasoning that engages with conflicting prima facie duties. To display the fittingness of this connection, Childress explores the moral issues that arise in the use of war as a metaphor, and his primary focus is on the moral issues involved with understanding medicine as warfare. In other words, in this lecture at the U.S. Air Force Academy, Childress briefly considers the central question of this chapter: when the practices

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of medicine are understood as hostile encounters with the body as an enemy, what kind of moral response is fitting?

To understand the prevalence of the metaphor of medicine as warfare and its problems, Childress details the argument of Susan Sontag’s influential work, *Illness as Metaphor*, referenced above. In particular, Childress recognizes the problem of overtreatment as one that often arises when “death is the ultimate enemy.”199 For medical practitioners, patients, and families, “death signals defeat and forgoing treatment signals surrender.” In understanding medicine as warfare, Childress claims we have lost “the sense of limits.” He briefly names a few moral limits from just-war theory that need reclaiming in the practice of medicine, including the importance of “the limits of discrimination—distinguishing combatant from non-combatant—and the limits of proportionality” along with “a reasonable prospect of success.”200 By making these brief connections between just-war criterion and a fitting moral framework for modern medicine, Childress positions us to judge the moral adequacy of his just-war inspired bioethics as a response to the moral schema and conflicts uncovered in the surgical and oncology wards.

2.7.4 *Just-War Inspired Bioethics and the Surgical Ward*

Recall that the historical process of incorporating surgery into the wider practice of healthcare so that wielding the scalpel became a form of limited and controlled violence. In so doing, surgery learned to discipline its practices and so adhere to the Hippocratic tradition. Thus, we can say that the medical imaginary found within the surgical ward and the just-war theory crafted by Childress both begin with a presumption against violence. As we

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200 Ibid.
saw earlier, Childress’s just-war criterion is developed from the principle of nonmaleficence.\textsuperscript{201} His first book in bioethics takes it as axiomatic that “\textit{ceteris paribus}, the principle of not harming others (including imposing risks) takes priority over the principle of benefiting others.”\textsuperscript{202} And Childress often invokes the Hippocratic tradition, saying, for example, that the “Hippocratic principle \textit{primum non nocere} (first of all, or at least, do no harm) presupposes the distinction between not harming and doing good and gives the former priority over the latter.”\textsuperscript{203} This emphasis on nonmaleficence is a commitment to moral boundaries being placed around the proper practice of medicine. If violence is to occur, it must be justified, controlled, limited, and devoted to the restoration of true peace.

Analogues of just-war criteria are also at work in the practice of surgery, as displayed above in sources ranging from the lectures of famed British surgeon John Hunter at the end of the eighteenth century to contemporary ethnographies of surgical training. Recall that ethnographer Rachel Prentice argued that surgeons view their craft as “controlled violence,” and so they “must balance the physical forces used to invade and alter patients’ bodies against the possibilities of doing harm.”\textsuperscript{204} And so if violence is to be done, disciplined control is necessary to avoid harm and maintain devotion to the goal of healing. In this way, Childress’s development of a bioethics grounded in just-war criteria, prioritizing doing no harm while balancing competing moral commitments, is a fitting moral response to the

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\textsuperscript{201} Recall that Childress works “‘to show how the traditional just-war criteria can be reconstructed, explicated, and defended in relation to the prima facie duty of nonmaleficence—the duty not to harm or kill others.’” Childress, \textit{Moral Responsibility in Conflicts}, 64.
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\textsuperscript{202} Childress, \textit{Priorities in Biomedical Ethics}, 110. This prioritization of doing no harm even finds its way into the first edition of \textit{Principles of Biomedical Ethics}, where Beauchamp and Childress admit “we have certain duties not to injure others that are not only distinct from but also more stringent than our duties to benefit others.” Beauchamp and Childress, \textit{Principles of Biomedical Ethics}, 1st ed., 69.
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\textsuperscript{203} Childress, \textit{Who Should Decide?}, 29.
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\textsuperscript{204} Prentice, \textit{Bodies in Formation}, 137.
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medical imaginary within the surgical ward and the moral problems that arise from the practice of “controlled violence.”

Beyond these strict criteria, Childress’s emphasis on the importance of “moral traces” remaining after prima facie duties are overridden also has strong parallels in the practices of the surgical ward. We can examine these through an engagement with Augustine, whose work was foundational for just war theory. Childress references Augustine when he draws attention to the “residual effects” on attitudes and actions that remain from the duty to do no harm even as violence occurs in a just war. In a famous passage in Book XIX of The City of God, Augustine argues that “the wise man” will be compelled by the demands of society, “which he thinks it wicked to abandon,” to “take his seat” on the judge's bench and so serve as a public official. Augustine then goes on to admit that part of the wise official's duty is to “wage just wars,” but Augustine's emphasis throughout is on the mournfulness that ought to accompany such actions. Augustine goes so far to say that “if anyone endures them or thinks of them without anguish of soul, his condition is still more miserable: for he thinks himself happy only because he has lost all human feeling.”

As we saw above, evidence of these mournful “moral traces” is present in the reflections of surgeons on their practice. Recall that British surgeon John Hunter claimed

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205 For more on the importance of “moral traces” in Childress’s thought and their relevance for contemporary healthcare and bioethics, see Aline H. Kalbian, “Moral Traces and Relational Autonomy,” Soundings: An Interdisciplinary Journal, 96, no. 2 (2013): 280-296.

206 In particular, Childress references Augustine to argue that regret and perhaps even remorse may be a fitting response. Childress, Moral Responsibility in Conflict, 69-70.

207 Augustine, 19.6.

208 “Surely, however,” Augustine writes, “if he remembers that he is a human being, he will be much readier to deplore the fact that he is under the necessity of waging even just wars. For if they were not just, he would not have to wage them, and so there would then be no wars at all for a wise man to engage in.” Augustine, 19.7.

209 Augustine, 19.7. Augustine gives further evidence for the connection between just-war theory and bioethics when he describes the two necessary conditions for a well-ordered peace in terms remarkably like those used in the Hippocratic tradition: "And the order of this concord is, first, that a man should harm no one, and, second, that he should do good to all, so far as he can." Ibid., 19.14.
that every operation should be accompanied by “a sacred dread and reluctance” and neurosurgeon Henry Marsh began his recent memoir with the line, “I often have to cut into the brain and it is something I hate doing.” These paradigmatic figures within the practice of surgery find it appropriate to lament these necessities, and such a moral discipline is particularly fitting given surgery’s historical efforts to restrain an expansionist impulse within the practice. Therefore in this concept of “moral traces” we can see further evidence of Childress's just-war inspired bioethics as a proper moral framework for the medical imaginary found within the modern surgical ward.

In a recent essay, Richard Miller develops this notion of “moral traces” even further, arguing that “just-war morality involves a spiritual exercise—an ascesis—demanding political elites and ordinary citizens to discipline their attitudes, practices, and representations of the other.” Augustine's thought continues to be illuminative for just-war reasoning; Miller draws from the importance of confession in Augustine's thought to argue that the practice is a crucial part of the ascesis necessary for modern just-war. For Augustine, confession was not simply a private affair, and Miller develops this further, saying of confession,

> Such personal reports are part of a more general practice of rendering oneself accountable to standards that one does not wishfully create (or project), objective norms by which to measure one’s subjective leanings and desires. Confession, in short, is a matter of making oneself accountable to standards and purposes beyond one’s immediate interests.

The formation of character involved with confession is deeply linked to the formation of the memory of a people. And here there is a deep connection between Miller's just-war argument for confession and a central practice of the modern surgical ward. For in surgery's

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210 Hunter, Lectures on the Principles of Surgery, 210; Marsh, 1.
212 Ibid., 224.
weekly Mortality and Morbidity Conference, we find surgeons engaged in the work of
confession. As attending surgeons stand before their peers and subordinates, recounting
their mistakes and failures for all to hear and learn from, they are seeking to remember
rightly as they hold themselves and their community accountable to the standard's of their
craft. This is the work captured in Charles Bosk's ethnography of surgical training, aptly
named *Forgive and Remember*. When senior surgeons “put on the hair shirt” and confess their
mistakes, they are recommitting themselves and all who work with and under them to the
moral standards and limits that mark surgery's incorporation into a tradition of pursuing
healing within a framework of doing no harm.²¹³

In several ways, then, the just-war inspired moral framework offered by Childress
responds to the moral issues discerned within the surgical ward. We can even describe
particular actions within the surgical ward using just-war criteria. Through informed consent,
patients exercise their own legitimate authority to actively name their surgical team as agents
authorized to act on their behalf through surgery’s controlled violence. The surgical team
reassures patients by announcing their intent to intervene for the patients’ good. Surgeons
are trained to operate only when they have a just cause and a reasonable hope of success,
and surgery is often treated as a last resort. The common parlance of “minimally invasive
surgery” indicates the continual concern for proportionality, and attending surgeons work to
form trainees capable of differentiating between the targets of their intervention and the
nearby flesh that deserves protection.

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²¹³ Charles Bosk, *To Forgive and Remember*, 139. In an essay describing surgery in MacIntyrean terms, Daniel Hall
notes that the Mortality and Morbidity Conference is a routine practice only for surgeons. Daniel E. Hall, “The
Indeed, much of surgical training in the operating theatre can be seen as instilling adherence to the norms of just conduct. Pre-operating checklists, sterilization practices, and further aspects of the ritual of the operating theatre can be understood as ensuring that the requirements of *jus ad bellum* and *jus in bello* have been met. The rest of the surgical team often functions as reminders of this moral tradition, checking to make sure that the intervention adheres to these requirements. If it does not, nurses and anesthesiologists have the power to halt the surgery, either before it begins or during the procedure. By monitoring the operating theatre and the patient's body, nurses and anesthesiologists can function like U.N. military observers, but with real authority to halt a conflict immediately. In this way, the surgical ward's moral framework is not simply reinforced post-hoc during Mortality and Morbidity Conferences, but is actively instilled and policed throughout the practice and site of surgery. Further connections could be made between just-war criteria and the practices, discourses, and practitioners of the surgical ward. In fact, it may be necessary for the craft of surgery to begin more explicitly naming these moral connections and limits, not least because of the rising prominence of elective procedures that may not meet the criteria of a just-war inspired bioethics. Rather than further specifying these moral boundaries, which requires prudence and contextual discernment, we instead turn to the oncology ward in order to set in relief a medical imaginary that requires deep transformations in order to be placed within the moral limits of just-war criteria. In doing so, the reader is invited to make imaginative and analogical connections between the moral problems facing the surgical and oncology wards and their two related but distinct medical imaginaries.

### 2.7.5 Just-War Inspired Bioethics and the Oncology Ward
After connecting just-war criteria and the morality of modern medicine in his lecture *War as Reality and Metaphor*, Childress briefly notes that modern medicine has deep similarities with modern total warfare. In doing so, he references William May’s *The Physician’s Covenant*, which claims,

Modern medicine has tended to interpret itself not only through the prism of war but through the medium of its modern practice, that is, unlimited, unconditional war. Before the twentieth century, the West, by and large, subscribed to the notion of a just war…But in the twentieth century, the democracies, as well as the totalitarian states, waged total, unconditional war with the commitment of all means, extraordinary as well as ordinary, to the victory. Just so, hospitals and the physician-fighter wage unconditional battle against death. At their worst, and before the advent of federal regulations, a few professionals used unconsenting patients in research protocols in the name of the general war against disease, even though no visible benefits would come to the patients in question. And at their most zealous they sometimes subjected patients to the ordeal of battle without any hope of victory.

May describes how this “unconditional battle against death” conscripts patients into research trials that provide them with no benefit and also pushes them to fight on with no reasonable hope of success, a practice characteristic of the oncology ward’s medical imaginary.

Childress’s response to this serious moral challenge is merely to assert that we must make medicine as total warfare “accountable to the moral tradition of just war.” Such an approach to bioethics has little purchase on reality if it does not connect with the practitioners, practices, and discourses at work in the modern oncology ward.

In order to understand the depth to which oncology displays a shift from just to total warfare in modern medicine, we can consider the oncology ward’s medical imaginary using a

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215 May, 66.
216 Childress, *War as Reality and Metaphor*, 14. In this way, Childress indicates that the metaphor of total warfare has been tried and found wanting according to his criteria for all metaphors in healthcare, which “can be assessed by how well they illuminate rather than distort both what is going on and what should be done.” Childress, *Practical Reasoning in Bioethics*, x.
set of categories for “how war becomes/became total.” According to one account, there are four distinct “varieties of ways in which war, by becoming total, can break out of the restraints of the just-war tradition”: first, what is claimed as just cause for war may become total; second, the means of war may become total; third, combatant status may become total; and fourth, last resort may become a hollow criterion when the military becomes so incorporated into a society that it “renders null the notion of any transition from peace to war.” All four of these conditions are present in the oncology ward's medical imaginary. Death as the ultimate enemy is a total cause for war in the oncology ward; the unrelenting assault of chemotherapy and radiation totals the means of oncology's fight; combatant status is totalizing when all body cells are seen as potentially cancerous; and the rise of a medical-industrial complex conflating research and therapy in oncology in an all-out effort to prevent and manage cancer makes it difficult to distinguish between peace and war.

In order to reestablish the limits of a just-war inspired bioethics, these four areas demand response, and in responding to each of these areas we will necessarily engage this medical imaginary's theological roots. We can trace out the contours of a fitting response following the Augustinian claim from both Allen Verhey and William May that life is not an ultimate good and that death is not an ultimate evil. If this is true, then in response to the first area of war becoming totalizing, the cause of oncology's fight can be just, but it is not a total one. There are other goods for the patient to pursue than the defeat of death. In fact, recognizing that treating a patient's cancer is not an all out assault on death itself would be a fundamental shift in the oncology ward's medical imaginary. Such a recognition also has

218 Ibid., 130-135.
219 Verhey, The Christian Art of Dying, 392; May, 70.
implications for the second category of ways in which war becomes total, as totalizing modes of treatment in chemotherapy and radiation may need to be rejected at times in favor of therapy more fitting for the pursuit of a particular patient’s holistic and finite flourishing.

The final two aspects of how war becomes total war may be the hardest to confront in the modern oncology ward. In order to reestablish noncombatant status and distinguish between peaceable and combative therapeutic engagements with the body, we may have to change the very way cancer is understood and described and how its treatment is pursued.

The confusion between combatant and noncombatant in the modern oncology ward points to a longstanding difficulty in just-war theory. As Richard Miller notes, those attempting to adhere to just-war morality must undergo a form of “ascesis” in order to “discipline their attitudes, practices, and representation of the other.”

Miller was, of course, following Augustine in describing the difficulty of properly understanding and relating to the other. Earlier we saw that Augustine emphasized that the wise public official will mourningly wage just wars. Immediately after those reflections, he goes on to say, “In the miserable condition of this life, we often believe that someone who is an enemy is a friend, or that someone who is a friend is an enemy.”

This confusion between friend and enemy is often expressed by those reflecting on cancer as their body betraying them.

In response, Augustine offers no easy words of comfort, for he admits that this life is marked by both the betrayal and death of friends. Following Augustine, we can describe an ascesis fitting for the present age in which we learn to properly grieve the bodily betrayal and death that mark the current life in light of the final hope of resurrection. This ascesis is

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220 Miller, “Just War, Civic Virtue, and Democratic Social Criticism,” 224.
221 Augustine, 19.8.
222 Ibid., 19.8. Augustine goes on to say that grief over the betrayal of a friend is even more painful than grief for a friend’s death, and true consolation can be found only in the eternal peace offered after the resurrection and final judgment.
particularly fitting for the oncology ward, which instead of promising the defeat of death, could become a site where we might painfully learn to grieve bodily betrayal and the claims of death. Resistance may be necessary, but it ought to always be done in the hope of securing a bodily peace, however provisional. The ascesis that would mark the oncology ward’s incorporation into a just-war morality would also train us to discern and celebrate the proleptic inbreaking of life wherever it is found, learning to see our bodily peace in light of eternal peace, even as we recognize that it is only fully realized on the other side of death.  

Augustine’s work also provides a response to the final category of ways that war becomes total, and we can see how this applies to the oncology ward. In The City of God, Augustine argues that peace with the body and peace with the soul are both necessarily bound up with a social peace. Social peace is itself a fraught category during what Augustine describes as the saeculum, this present age when we live within the peace offered by the earthly city as we journey towards the true and final peace found within the heavenly city. For Augustine, pilgrims in this life should make use of this earthly peace and preserve and follow the “customs, laws, and institutions by which earthly peace is achieved and maintained...provided only that they do not impede the religion by which we are taught that the one supreme and true God is to be worshipped.” In order to understand what might constitute impeding the true worship of God, Augustine turns to the notion of sacrifice to distinguish between acceptable earthly peace and earthly peace that cannot comport with heavenly peace. For Augustine, the true city of God “sacrifices to none” but God, and so any effort to order a people around alternate worshipful sacrifices must be resisted.

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223 Ibid., 19.17.
224 Ibid.
Stanley Hauerwas connects this notion of sacrifice with warfare, and especially the modern reality of total warfare, saying, “For in spite of the horror of war, I think war, particularly in our times, is a sacrificial system that is crucial for the renewal of the moral commitments that constitute our lives.”

Hauerwas's description of the modern sacrifices of war are also fitting for the contemporary oncology ward. Recall Lochlann Jain’s claim that those enrolled in randomized control trials enable the collective living on of a people, and how Elaine Scarry traced the various manifestations of the root word “hos” to show how hospitality and refuge can become hostility directed towards a sacrificial victim. Within the oncology ward, those lives sacrificed in the war against cancer, especially those enrolled in medical research, renew our commitment to fight on in life against death itself.

In order to resist the claims of a medical-industrial complex devoted to total warfare against death and cancer, as its emissary, we can draw from Augustine's notion of true sacrifice in which the heavenly city participates in Christ's sacrifice and no others. Hauerwas sets the “undeniable” sacrifices of war alongside the person of Jesus, in whom God “has forever ended our attempts to sacrifice to God in terms set by the city of man.”

Founded by, existing in, and ordered to Christ, the heavenly city can make use of peace offered by the earthly city while rejecting any fundamentally disordered notion of justice and sacrifice.

Within the oncology ward, this framework enables the celebration of the goods of bodily peace as they are attained while always seeing them in light of more fundamental goods. This approach also offers a lens through which to discern and reject the notion of sacrifice offered by a medical-industrial complex that often knows no difference between peace and

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226 Jain,118-119; Scarry, 45.
war in the body.²²⁸ For Augustine, the heavenly city belongs to Christ and through that participation becomes God's “most wonderful and blessed sacrifice.”²²⁹ The body of Christ, broken for the blessing of the world, offers a different notion of sacrifice than the broken bodies that fill the data sets of randomized control trials.

In these four broad areas, we can see how a just-war inspired bioethics would seek to order the oncology ward’s medical imaginary within the limits of just-war theory. But insofar as the medical imaginary of the surgical ward needs to be disciplined within the limits of just-war morality, the above responses are also fitting for that site as well. The same is true throughout the modern hospital and for any medical practitioner, practice, discourse, and/or site that imagines the body as an enemy and engages it as such. This approach enables the real goods offered by a medicine that engages the body as an enemy to be appreciated without becoming disordered. The moral discipline necessary for this discernment follows from the Hippocratic tradition’s pursuit of healing with a framework of commitment to doing no harm. By focusing on the moral boundaries necessary in conflict, this moral response can be a fitting approach to bioethics in the modern hospital, but, as we shall see, it is not the only one, nor is it perhaps the most fundamental.

2.8 Conclusion: A Note of Caution

²²⁸ These connections between Augustinian political theology and bioethics are indebted to the work of recent Augustinian scholars seeking to interpret what it may mean to make use of the peace of the earthly city while not conflating such peace with the final purposes of the heavenly city. See especially Luke Bretherton, Christianity and Contemporary Politics and Resurrecting Democracy. Among many other works, Charles Mathewes's work on the ascesis of citizenship is also influential for the above account, as is Eric Gregory’s work on Augustine's account of the ordering of loves. See Charles Mathewes, A Theology of Public Life, and Eric Gregory, Politics and the Order of Love: An Augustinian Ethic of Democratic Citizenship.

²²⁹ Augustine, 19.23.
Even as we rightly recognize the relevance of Childress’s early work in just-war theory and bioethics, it is worth noting that his later work moves away from implicitly prioritizing nonmaleficence followed by beneficence to embracing a more thoroughgoing pluralism of *prima facie* duties.\(^{230}\) The emphasis on nonmaleficence in Childress’s just-war criterion and the Hippocratic tradition is eventually overridden by Childress’s theological and philosophical commitments to real moral pluralism and conflict. Because of this and also because of the rising importance of respect for autonomy within his work with Beauchamp, Childress eventually backs away from his prioritization of nonmaleficence.\(^{231}\) Childress himself admits that he was “tempted” to rank or scale *prima facie* duties at one point but that he later settled on the position that “all principles and rules are equally prima facie binding.”\(^{232}\) Such a shift results in a framework less fitting for disciplining the violence inherent in the surgical and oncology wards. Because of this, the conceptual underpinnings of Childress’s more thoroughgoing pluralism and its conflictual implications are worth considering.

Recall that Childress grounds his pluralist approach in “an adequate, balanced understanding of God’s creative, ruling, and redeeming will.”\(^{233}\) In an appreciative essay examining Childress’s theological commitments, his former student Courtney Campbell notes that this pluralist moral and theological schema is able to accommodate “genuine

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\(^{230}\) Childress’s early work in just-war theory and bioethics builds off of nonmaleficence, even as he offers provisos about no absolute ranking of *prima facie* duties. This position is summed up in his claim, “Although some prima facie obligations are more stringent than others (e.g. nonmaleficence is more stringent than beneficence), it is not possible to provide a complete ranking or a scale of stringency of obligations.” Childress, *Moral Responsibility in Conflict*, p. 68.

\(^{231}\) Where this principle was privileged in the first edition of *Principles of Biomedical Ethics*, the most recent edition reflects this shift with a hesitant proviso, saying, “This formulation of stringency with respect to nonmaleficence may have an initial ring of plausibility, but we should be cautious about constructing axioms regarding priority.” Beauchamp and Childress, *Principles of Biomedical Ethics*, 7th ed., 151-152.

\(^{232}\) Childress, “*Principles of Biomedical Ethics*: Reflections on a Work in Progress,” 59.

\(^{233}\) Childress, *Civil Disobedience and Political Obligation*, 103.
moral dilemmas and even moral tragedy, irresolvable conflicts of moral obligations.\textsuperscript{234} However, Childress’s approach is conceptually unable to offer a theological and moral account of how the nature and purposes of divine and human life might be understood in any sort of coherent or unified whole. Campbell notes this theological difficulty, stating, “The ultimate inseparability of the triune divine nature has no analogical counterpart at the level of Childress’s practical ethics.”\textsuperscript{235} Childress’s epistemic humility is in many ways appropriate for us as fallen and finite creatures, for we should not presume to understand the divine nature or the ends of human life with any sort of final clarity. And yet we can hold out hope that such understanding is given eschatologically as a gift and perhaps in partial and proleptic ways as we labor towards our ends. The only human being who has received this gift fully in the present age is also the one in whom the nature and purposes of divine and human life cohere as one: Jesus Christ.\textsuperscript{236}

But what does rather abstract thought on the unity of the divine nature and of the moral life mean for our concerns with the modern hospital? The lack of unity in Childress’s approach leaves us in a world of thoroughgoing conflict, which makes it difficult, if not impossible, to understand how to situate moments in which one \textit{prima facie} duty overrides another within an overarching moral and theological framework.\textsuperscript{237} For the moral issues at stake in this chapter, this means that medical practitioners engaging in controlled violence are left with few resources to understand and imagine how their work fits within an overall

\begin{footnotes}
\item[236] See David Kelsey’s \textit{Eccentric Existence}, in which Kelsey argues that the three narratives of God relating to all that is not God to create, to reconcile, and to draw into eschatological consummation are held to be one in Jesus Christ.
\item[237] This is to echo Alasdair MacIntyre’s arguments in \textit{After Virtue} and numerous other writings about how modern ethics and politics are distorted by a lack of teleology. My thanks to Luke Bretherton for making this connection.
\end{footnotes}
commitment to the health and flourishing of their patients. And yet just-war inspired bioethics must remember the limits of medical interventions on this side of death, for death comes for all despite the advancements of medicine.  

But to close on a more hopeful theological note, medical practitioners can devote themselves to their work freely because setting things right is not ultimately up to them. William May explores this through the notion of covenant, arguing that a covenant grounded in Christ “allows the Christian to sit loose to the world: to enter the world without panicking before it or getting mired in it. The covenant deepens ties to the world precisely because it has lightened them.” A key way that medical practitioners can remember that their ties to this world are both deepened and lightened is through ordinary practices of bodily care that carry little of the promise or peril of battle against disease and death. Practices of bodily peaceableness like cleaning wounds, giving baths, and attending with caring bedside manners all serve to remind patients and practitioners of the goodness of the body even as it seems riddled by the emissaries of death. A key challenge here, of course, is how the division of labor in the modern hospital makes it structurally difficult for some medical practitioners to practice bodily care in these ways. In his early work, at least, Childress conceptually acknowledges the importance of these practices. Near the close of his essay on just-war criteria, he states,

In conclusion, pacifists and just-war theorists are actually closer to and more dependent on each other than they often suppose. Just-war theorists sometimes overlook the fact that they and the pacifists reason from a common starting point. Both begin with the contention that nonviolence has moral priority over

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238 Allen Verhey opens The Christian Art of Dying with a pithy reminder of this reality, saying, “People have been dying for a while now. It started, I guess, with the first human being, and ever since then the death rate has been right around 100 percent.” Verhey, The Christian Art of Dying, 1.

239 May, 127.
violence….While pacifists can remind just-war theorists of this presumption against violence, pacifists also need just-war theorists.240

Childress’s just-war inspired bioethics offers the considerable resources of just-war theory to the moral conflicts that pervade modern medicine, particularly when the body is engaged as an enemy. As such, it is a great gift. But it too needs to be reminded what peace of the body actually entails when, in Childress’s own words, “peace remains the ultimate aim of a just war.”241 Childress does not offer a substantive account of peace, but in chapter four we shall explore what bodily peace entails through examining the labor and delivery ward.

First, however, we must wrestle with a medical imaginary that has been present, though muted, in the above descriptions of surgery and oncology. The histories of the surgical and oncology wards both contain threads that emphasize the scientific and objective nature of medical practice.242 Rather than engaging the body as an enemy, much of modern medicine treats the body as an object to be mapped and manipulated. This medical imaginary avoids framing encountering the body through the filter of combat, but that does not mean that objectivity is not a medical imaginary worth interrogating. In fact, scientific objectivity in medicine may provide cover for a more totalizing mode of engaging the body than anything found in the martial imaginaries explored above. We can see one moving and troubling example of this in the very witness of Susan Sontag, who proposes in Illness as Metaphor that “the most truthful way of regarding illness—and the healthiest way of being

240 Childress, Moral Responsibility in Conflicts, 93.
241 Childress, Moral Responsibility in Conflicts, 72. In their own ways, Lisa Cahill’s Love Your Enemies and Daniel Bell’s Just War as Christian Discipleship: Recentering the Tradition in the Church rather than the State (Grand Rapids, MI: Brazos Press, 2009) both address this concern as it relates to just-war theory.
242 See, for example, Thomas Schlich, “The Technological Fix and the Modern Body: Surgery as a Paradigmatic Case,” 71-92; this theme also runs as a secondary thread throughout Mukherjee’s The Emperor of All Maladies. The fusion of surgery and medicine in France played an important role in what Foucault termed the birth of the clinic, which we will explore in detail in the next chapter. See Toby Gelfand, Professionalizing Modern Medicine: Paris Surgeons and Medical Science and Institutions of the Eighteenth Century (Westport, CT: Greenwood Press, 1980), along with Risse, Mending Bodies, Saving Souls, 335.
ill—is one most purified of, most resistant to, metaphoric thinking." The language of scientific objectivity offers itself as one far more “purified” of metaphoric thinking than the martial language of oncology. But Sontag’s son, David Rieff, tragically chronicles in his memoir how Sontag continued to fight her war against death itself under the guise of pursuing the advancements of cutting-edge oncology research. Rieff says that Sontag “died as she had lived: unreconciled to mortality,” and her proposals for metaphor-less thinking were contradicted by her own journals, which were “punctuated with the repeated notation: ‘Cancer = death.’” Even as she proposed objectified language for illness, Sontag fell prey to the siren call of the promises of progress offered by oncology’s scientific researchers, and her remarkable life ended by raging against the dying of the light as she died fighting against a cancer caused by earlier chemotherapy.

In order to discern the totalizing mode of engaging the body offered by objective scientific discourse, we now turn to the modern Intensive Care Unit. Here, the body is imagined and engaged as an object, and we will seek to discern fitting moral responses to the problems that arise within such a medical imaginary.

243 Sontag, 3. Ironically, a few lines before this claim about the removal of metaphoric thinking, Sontag begins her book with what has become in its own right a famous metaphor for illness. She says, “Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place.” Anne Hawkins notes the irony of this opening in Reconstructing Illness, 22-23.


245 Ibid., 13, 28.

246 Ibid., 71.
Chapter 3

The Body as Object: The Medical Gaze in the ICU and Separatist Bioethics

You need to merge your knowledge of the person with the hospital knowledge.
— Daughter-in-law of a frequently hospitalized patient¹

Might it not be that only theology can save medicine?
— Jeffrey Bishop, The Anticipatory Corpse²

3.1 Introduction

Consider this scene: a patient in the Intensive Care Unit (ICU) is surrounded by a group of people in laboratory coats examining various numerical reports about her bodily functions. Because no other diagnostic tests are required to ascertain an accurate map of her body and its problems, the team of physicians determines that several interventions are required to prevent her body from continuing on a pathway towards death. Nurses, respiratory therapists, and others carry out their will, providing the IV drip with new medications, intensifying the whoosh of the mechanical ventilator, and bringing in a portable dialysis machine to purify her blood. All the while, the patient is still and voiceless while these interventions keep her bodily systems in motion. The family asks a few questions in an effort to understand the body of their loved one in ways that approximate the medical team’s knowledge. In the words of one daughter-in-law of a frequently hospitalized patient, “You need to merge your knowledge of the person with the hospital knowledge.”³

¹ Sharon Kaufman, …And a Time to Die: How American Hospitals Shape the End of Life (Chicago: University of Chicago Press, 2005), 85.
³ Kaufman, …And a Time to Die, 85

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What makes this scene possible? How did the patient’s body become understood as numbers by a team of people dressed in lab coats, as if the patient’s bedside was a laboratory bench and her body a petri dish? To answer these questions, we will consider the ICU as a paradigmatic medical site within the modern hospital. In it, we find the clearest distillation of a modern scientific understanding of the practice of medicine. Recall from chapter one the term “site” refers to a set of practices, discourses, and practitioners deeply connected to recognizably distinct modes of imagining and engaging the human body within modern healthcare. Within the ICU, we can discern a medical imaginary that construes the patient’s body as an object, and this medical imaginary is deeply formative for medical practitioners today. After all, for medical students their first “patient” is a corpse, as they spend their first semester of medical school dissecting a cadaver in gross anatomy. And in the ICU, nurses, therapists, and others often serve as an extension of the physician’s will and so further instantiate this medical imaginary.

In order to understand the medical imaginary found within the ICU as a paradigmatic medical site, we will begin with phenomenological investigations into the pathway of perception that enables a patient to perceive their body as object. We will then place this phenomenological work within the institutional context of the ICU as we consider the ethnographic and historical investigations into the development of distinct arrangements of discourses, practices, and practitioners that create the conditions and possibilities for perceiving the body in this way. This medical imaginary is undergirded by a set of theological, philosophical, and political assumptions. By articulating them we will be in a

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position to consider what moral response is most fitting for the medical imaginary found within the modern ICU.

If in the ICU the body becomes an object to be mapped and manipulated, then what moral response is warranted? We will consider two bioethical responses to this medical imaginary found within the work of H. Tristram Engelhardt, Jr. The first, an individualistic libertarian emphasis on permission, will be weighed against the second, an implicit communal option found within Engelhardt’s and developed in more separatist directions by the work of Jeffrey Bishop. In discerning which of these two moral responses is most fitting, we will see the methodological import of our phenomenological, ethnographic, historical, theological, philosophical, and political inquiries. If the ICU paradigmatically displays how the body is imagined and engaged throughout the modern hospital, then a radical moral response may be required.

3.2 Phenomenological Investigations: From Bodily Disruptions to “Disease State”

Recall from chapter one our discussion of the epistemic vulnerability that accompanies bodily disruption. When a person is estranged from her body, she is rendered vulnerable to new ways of perceiving her body and inhabiting the world. In this chapter, we investigate one such pathway of perception, as found paradigmatically in the modern ICU. In this medical site, an institutional arrangement of discourses, practices, and practitioners has developed to enable a medical imaginary in which the body is imagined and engaged as an object. Given the epistemic vulnerability that marks all moments of bodily disruption, the formative power of this site must be taken into consideration. To do so, we begin with a
phenomenological account of how the body is perceived in modern medicine. From that, we can discern how the ICU is a particularly intense site for the conversion described by one patient’s family member as “merg[ing] your knowledge of the person with the hospital knowledge.” To better understand this pathway of perception, we begin with the work of philosopher Kay Toombs.

3.2.1 A “Shared World of Meaning”?

In her work, Toombs uses the resources of phenomenology to investigate “the decisive gap between lived experience and scientific explanation,” which she claims “is at the root of the fundamental distortion of meaning in the physician-patient relationship.” Although Toombs is focused primarily on the relationship between physician and patient, this project takes her focus on those two actors as a way of directing our attention to the different ways of perceiving the body present in this encounter. Toombs investigates how “the patient’s apprehension of the body-in-illness differ[s] from the physician’s conception of the diseased body.” Through reflecting on that difference, Toombs discerns a process by which the patient’s perception of her body comes to approximate the physician’s.

Toombs begins by arguing that the patient and the physician inhabit two distinct worlds of intersubjective understanding. Drawing from the work of Alfred Schutz, she argues that a variety of bodily expressions, ranging from smiling to wincing to talking, all work together in language to establish a “shared world of meaning.” Such a “common world is constituted in the encounter with other individuals through the establishment of a

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5 Sharon Kaufman, ...And a Time to Die, 85.
7 Ibid., xiv.
8 Ibid., 8.
Toombs first demonstrates that patients and physicians originally inhabit “separate worlds, each world providing its own horizon of meaning” by considering their distinct approaches to focusing on and understanding the bodily disruption that marks illness. Physicians draw from scientific categorizations that mark “objective” space and time, whereas the lived experience of ill patients leaves them with a negligible frame of reference as they “subjectively” endure a disorientation of much of what has made sense of their embodied lives. The unique experience of the ill patient makes it “difficult to communicate the experience to others on the basis of a shared set of typifications,” but physicians are trained to categorize and so attempt to translate the patient’s experiences. The inevitable inadequacy of this translation leaves patients and physicians at an impasse, for although they assume they are talking about the same thing when they discuss an illness, their speech comes from different worlds and describes different realities. Here we see the fundamentally isolating nature of bodily disruption, which we described in previous chapters using the work of Elaine Scarry, which Toombs also references.

However, the epistemic vulnerability that marks this isolation means that the worlds of patients and medical practitioners can merge through the transformative power of the practices and discourses found within the modern hospital. As we saw in our opening scene, the hospital system pressures patients and those who speak with and for them to accommodate their world of meaning, as best they can, to the one shared by their medical practitioners. This powerful creation of a shared world of intersubjective meaning not only

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9 Ibid., 9.
10 Ibid., 10.
11 Ibid., 21.
forcefully transforms the patient’s world of meaning, but also takes away possibilities for medical practitioners to step outside of the dominant medical imaginary. Once patients become objective bodies, docile and mute, practitioners recognize little resistance to the patterns of hearing and seeing that accompany the medical gaze.

3.2.2 Pathway of Conversion: Four Levels of Making Meaning of Bodily Disruption

In order to understand how this transformation of meaning could occur, a more detailed phenomenological account of the experience of illness in modern medicine is necessary. Such an account will enable us to understand the conversion of perception found paradigmatically within the ICU and made possible by its arrangement of discourses, practices, and practitioners. In her phenomenological inquiry, Toombs draws from the work of Jean-Paul Sartre, who explicitly engages the phenomenon of illness in Being and Nothingness. Sartre’s analysis of pain and illness “identifies four distinct levels of constitution of meaning: pre-reflective sensory experience, ‘suffered illness,’ ‘disease,’ and the ‘disease state.’” The first three levels describe the phenomenon of illness for the patient, with the third level, “disease,” moving towards the physician’s understanding, which is represented by the fourth level, the “disease state.” By examining this process, we can better understand the pathway of perception that occurs within the modern ICU.

Toombs makes an important qualification, saying, “In this context I am focusing for the most part on illness which relates directly to the disruption of the body rather than illness which is experienced as a disorder of mental functioning. This is not intended to suggest an arbitrary distinction, or to imply that a careful analysis of mental illness is not warranted” (n. 51, 129). This project follows Toombs in focusing on illness as bodily disruption. A thorough analysis of the medical imaginaries that shape our understanding of mental illness is crucial work, but beyond the scope of this project. For phenomenological accounts of mental illness, see, for example, Matthew Ratcliffe, Feelings of Being: Phenomenology, Reality, and the Sense of Reality (Oxford: Oxford University Press, 2008) and Giovanni Stanghellini, Disembodied Spirits and Deanimated Bodies (Oxford: Oxford University Press, 2004).

Toombs, 31.
The first level, pre-reflective sensory experience, occurs when one’s bodily sensation or appearance indicates that all is not well. This could occur through any of the senses: feeling an itch or acute pain, seeing a new rash or lump, smelling an unexpected discharge, hearing a ringing noise, or tasting something metallic on the tongue. At this level, no reflective categorization of the experience has occurred; the body is simply experienced as that sensation. The bodily experience may not necessarily indicate illness, for a sore back does not automatically mean metastatic cancer or any other form of illness. As Toombs observes, it could just be the result of digging in the garden. She notes that it is the unusual or alien nature of the pre-reflective sensory experience that is necessary for illness to be reported in the first person as symptoms. Or, in the idiom of this project, this is the moment when the body first becomes strange.

The second level, “suffered illness,” comes about when we begin to reflect on this pre-reflective sensory experience. In such reflection, we attempt to apprehend the experience within a network of meaning that can give it some sense. For Toombs, following Sartre, this move is an effort to give the body over to consciousness:

The lived experience of the body itself becomes the focus of attention. Pain or other bodily dysfunction disrupts one’s ongoing engagement in the world. The body can no longer be taken for granted and ignored. Rather, the bodily disruption must be attended to and interpreted.  

Attending and interpreting a bodily disruption makes possible conversion into a new frame of meaning and perception. Here there is a shift from directly sensing and unreflectively thinking or speaking about certain experiences to a conscious attempt to interpret what is going on. The “bodily disruption” becomes a “psychic object,” something centered in our reflection. Toombs draws from Tolstoy’s *The Death of Ivan Ilych* to describe this process:

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15 Ibid., 35.
But suddenly in the midst of those proceedings the pain in his side…would begin its gnawing work. Ivan Ilych would turn his attention to it and try to drive the thoughts of it away but without success. It would come and stand before him and look at him, and he would be petrified and the light would die out of his eyes, and he would again begin asking himself whether It alone was true. And his colleagues and subordinates would see with surprise and distress that he, the brilliant and subtle judge, was becoming confused and making mistakes….And what was worst of all was that It drew his attention to itself not in order to take some action but only that he should look at It, look it straight in the face: look at it without doing anything, suffer inexpressibly.16

In this passage, we see Ilych move from Toombs’s first level to the second as certain pre-reflective experiences (“the pain in his side” beginning “its gnawing work”) come to the forefront as he “turn[s] his attention to it.” The localized disturbance becomes connected to a larger whole. On Toombs’s terms, this is “suffered illness.” For Ilych, this “It” stands so fiercely in the foreground of his thought that it threatens to shatter his mind and decimate his reality, which, as we saw in Elaine Scarry’s work, is a real threat for all those undergoing severe pain and illness. In order to tame the sheer chaotic threat of the unknown, “It” needs a name. On this second level, where bodily disruption becomes a psychic object through reflection, the “suffered illness” is still an immediate experience and part of the lived body. The disruption (and with it, the body) has not yet become objectified. This occurs in the movement from suffered illness to disease, to which we turn now.

In this third level, persons experiencing “suffered illness” begin to understand their bodily disruption within a new system of meaning. For Toombs, this third level is known as “disease,” and in it the suffered illness becomes objectified. The body of the sufferer becomes an object to behold through the lens of the perceptions and concepts of others. The person becomes a patient as she enters into a third-person perspective that perceives the

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body as an object, “a neurophysiological organism which possesses a certain objective nature.” This third-person perspective is not simply a helpful tool to enable a clearer understanding of “suffered illness.” Instead, recalling our discussion from chapter one, it involves a fundamental shift from the lived body to the objectified body. Those suffering give themselves over to the explanatory power of others. Thus, for example, dizziness and pain in the chest become part of a system of medicalized meaning and take on new significance as a “heart attack” or, more properly, as a “myocardial infarction.”

To expand this point, Toombs engages the early writings of H. Tristram Engelhardt, Jr., whose work we will engage at length later in this chapter. Engelhardt describes the translation of our experience of bodily disruption into medicine’s explanatory schema as the way in which “the life-world structured by scientific expectations” becomes paradigmatic for a person’s perception of her bodily disruptions. We experience “the need for naming, for an account of the significance of suffering,” and physicians and scientific medicine are present and willing to offer just such a naming. “What many see as puzzling findings,” argues Engelhardt, “the physician sees as a disease.” Toombs describes this naming as primarily stemming from a desire for explanation from the one suffering, which is undoubtedly true; however, Engelhardt displays the purpose and power of the forces of medicalization as they are brought to bear on the lived experiences of those suffering illness. It is “a part of the physician’s task,” he says, “to bring [patients] to alter their life-world, to

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17 Toombs, *The Meaning of Illness*, 35. In *Being and Nothingness*, Sartre says, “It is by means of the Other’s concepts that I know my body. But it follows that even in reflection I assume the Other’s point of view on my body; I try to apprehend it as if I were the Other in relation to it.” Jean-Paul Sartre, *Being and Nothingness: A Phenomenological Essay on Ontology*, trans. Hazel E. Barnes (New York: Washington Square Press, 1992; 1943), 465.
18 Toombs describes this objectification of the body as representing “a ‘being-for-others’ in that it is known to the sick person by means of concepts derived from others.” Toombs, 35.
20 Ibid., 146.
21 Ibid., 142.
experience their lives in terms of the doctor’s understanding of the patient’s suffering.”

While the creation of some intersubjective understanding between patient and practitioner is crucial, Engelhardt views the transformation as decidedly one way:

This change in the everyday life-world of the patient is key to successful treatment. Until patients see themselves as, for example, hypertensives or diabetics, they tend to show failures of compliance. They do not follow in a reliable fashion the physician’s suggestions for therapy. They have not yet come to experience themselves as sick, or sick in the way the physician wishes them to experience themselves. They do not regularly do the things that hypertensives or diabetics ought to do, because their life-worlds are not yet structured by the relevances presumed by the physician’s treatment plan.

Although Engelhardt’s point could easily be dismissed as still-lingering paternalism from an earlier age of medicine (the comment is from 1982), it deserves more serious consideration, for in order to provide “successful treatment,” modern medicine does indeed require the creation of a certain kind of subjectivity. The bodily disruptions attended to as “suffered illness” need to be given over to the classificatory schema and power of modern conceptions of “disease.” Other modes of interpretation are available, though they are less suited to the efficient operations of modern medicine. Engelhardt reveals the subtle and often unintentional ways that the medical establishment brings forces to bear to create a conception of “disease,” which can then be linked up with what Toombs describes as a suffering person’s need for explanation in order to create an interpretation of “disease” that involves objectifying the body. In the profound words of the previously referenced daughter-in-law, “You need to merge your knowledge of the person with the hospital knowledge.”

Here we see that the pathway of perception chronicled by Toombs and

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22 Ibid., 148.
23 Engelhardt, “Illnesses, Diseases, and Sicknesses,” 152.
24 Kaufman, …And a Time to Die, 85. For more on this merger, see Fredrik Svenaeus, The Hermeneutics of Medicine and the Phenomenology of Health: Steps Towards a Philosophy of Medical Practice (Dordrecht: Kluwer Academic Publishers, 2000), especially Part 3, “The Hermeneutics of Medicine,” 119-175, where he draws from Gadamer
Engelhardt is essential for the work of medicine, which can be understood most clearly in the modern ICU, as we shall see in a moment. Following our ethnographic and historical investigations of that site, we will consider whether moral concepts like “consent” and “permission” are fitting given this formative power for shaping how the patient’s body is imagined and engaged.

It must be acknowledged, however, that even as patients objectify their diseased bodies, such an understanding can never fully dominate as long as they are living. As Toombs notes, “I do not believe that it is possible for patients ever to conceive of their illness exclusively in terms of pathophysiology since patients necessarily live their illnesses. That is, the patient’s perspective never completely merges with the physician’s.” Patients may work to merge their knowledge of their bodies with the hospital’s knowledge in an effort to comply with the medical demands indicated by Engelhardt (and such work is often done with little awareness or intentionality). Such a merger is always incomplete. Phenomenologist Havi Carel, who lives with a rare, progressive lung disease, describes this in her book, *Phenomenology of Illness*:

Illness may force us to adopt a reifying and detached view of our own body—this is a shift often required from patients when discussing their disease with health professionals. However, although most of us can momentarily adopt an objective view of our body, we are not able to sustain it; that is existentially unbearable. We cannot actually view ourselves *objectively* in any sustained sense, and it is unrealistic to expect that of others. Health professionals need to be aware of this because of medicine’s privileging of third-person perspectives. Objectivity is seen as an ideal by many professionals, but when subjected to philosophical analysis, it can be seen that merely relying on an objective stance is a naive and non-practicable position that ought to be replaced with a more nuanced understanding of intersubjectivity.26

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25 Toombs, 132, n. 68.
26 Carel, 220.
Insofar as we are a living body, we cannot fully understand ourselves as objectified, as *Körper*, to recall a term from chapter one. We are not the walking dead, for the lived body pushes back against its objectification, struggling against this “existentially unbearable” state. Carel interestingly refers to the concept of “double sensations,” which we explored in chapter one, to make the point that the ill body is not simply touched as an object; it is always touching back. Nevertheless, in certain limit cases the medicalization of our bodies very nearly approaches this reality; we come close to being objects touched and gazed upon, corpses put into motion. These limit cases reveal something crucial about a dominant modern medical imaginary. This is nowhere more so than in the ICU, as we shall see shortly through engaging ethnographic and historical work on the development of its arrangement of distinct discourses, practices, and practitioners.

Before turning to this site, we must consider Toombs’s fourth level of perception, the “disease state,” which is “the meaning of the patient’s illness for the physician.” The “disease state” is the distillation of the how modern medicine sees the body, and it shapes the patient’s understanding of bodily disruption, offering the patient a framework within which they can move from the second stage of uncategorized “suffered illness” to the third stage of “disease.” Here we find the gaze of the “Other” that makes possible the patient’s particular perception of their body as “being-for-others.” But it is important to note that the gaze of this “Other” is a particular medical gaze, and that the process of objectification Toombs describes is objectification in the mode of medicalization. This particular kind of objectification of the body is made complete as it is understood in modern scientific terms, where first-person, “subjective” accounts from the patient are either disregarded or

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27 Toombs, 39.
translated in favor of “objective” medical truths about the body as matter in motion. These truths are revealed most decisively through scientific tests and procedures, such as blood tests, X-Rays, oxygen levels, etc.

Toombs illustrates the close relationship between perception and a certain kind of epistemology in the “disease state” by telling the story of a muscle biopsy that her doctor ran in order to discern why she would be experiencing muscle pain, which is an abnormal symptom for her disease, multiple sclerosis. The pathology report indicated that something was indeed wrong with her muscles, but it gave no clarity about the potential cause or the recommended therapy. Toombs reflects on the follow-up conversation she had with her doctor:

In frustration I commented that, since the biopsy did not indicate what the problem was, nor what to do about it, we seemed to have gained little by performing the procedure. My physician replied, “Oh, but we have! Now we KNOW something is wrong.” For me, as a patient, to know that something was “wrong” was to be acutely aware of my bodily dysfunction and discomfort, and my inability to carry out the most mundane of activities. For the physician, to know that something was “wrong” was to have “objective” evidence in the form of an abnormal pathology report with respect to the muscle tissue removed from my thigh.\footnote{Ibid., 40; emphasis in original.}

All too often, the epistemological criteria that accompany the “disease state” manifest themselves in this kind of blatant disregard for someone's embodied self-understanding. The everyday work of this operation is more subtle, as patients’ descriptions of their suffered illness are transformed into signs that fit within diagnostic frameworks. A pathological and anatomical understanding of the diseased body is created, represented clearly in physicians’ conceptions of a “disease state” and approximated in patients’ understandings of their bodily disruptions as “disease.”
3.2.3 A Contingent Pathway of Perception

Therefore, Toombs, in her description of four distinct levels of bodily meaning in illness, describes one particular pathway for conversion from pre-reflective sensory experience to the “disease state.” Recall from our discussion of conversion in chapter one that conversions from one mode of perception to another are contingent; they are not timeless realities, but instead are bound up with the development of institutional arrangements of discourses, practices, and practitioners that create the conditions and possibilities for distinct pathways of perception. In this chapter, we are particularly focused on the pathway of perception that Toombs describes as the objectification of the body in modern medicine. But where Toombs seems to assume that this may be a given reality, we recognize that it is one among several possible medical imaginaries in the modern hospital, each with its own distinct mode of imagining and engaging the body. In the last chapter, we discerned a medical imaginary that construed the body as enemy, and in the next chapter we will discern one that seeks to enable the patient to befriend her body. In this chapter, in contrast, we are focused on the pathway of perception that Toombs describes, as represented paradigmatically within the ICU. We now turn to ethnographic and then historical investigations of this paradigmatic medical site in order to understand how this perception is made possible. These investigations will uncover the moral conflicts and schema of this medical imaginary in the modern hospital, and so we will be prepared to discern a fitting moral response.

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29 Havi Carel, who follows Toombs’s work closely, notes the contingency of this approach by saying, “Our starting point is therefore to take Toombs’s analysis as part of a phenomenology of illness, but qualify it as applying to Western contemporary culture, rather than revealing essential features of experience, as Toombs suggests.” This project takes Carel’s proviso one step further by arguing that there are at least three distinct modes of imagining and engaging the body in Western culture and medicine. Carel, 67.
3.3 Ethnographic Investigations

3.3.1 “The Most Exciting Part of Medicine”

In her work, Toombs offers a phenomenological account of a particular pathway of conversion, as people move from the pre-reflective sensory experiences of bodily disruption to perceiving their bodies as diseased in ways that approximate physicians’ scientific understanding of the “disease state.” We now turn to offer an account of the institutional arrangement of discourses, practices, and practitioners that create the conditions and possibilities for imagining and engaging the body as object. For the epistemic vulnerability that marks any experience of bodily disruption is intensified within the institution of the hospital, and this is especially true within the Intensive Care Unit (ICU). Here, we can discern the apogee of scientific medicine in which the body is perceived as an object. We can see such an understanding of the ICU and the practice of medicine in the words of Paul Beeson, one of the preeminent physicians of his generation, who said:

In intensive care, which is really the most exciting part of modern medicine, everyone is thrilled about putting catheters in and measuring pressures here and there and measuring blood gases all the time. The talk is of “the numbers”: “What are the numbers on Mrs. Jones this morning?” And you list her oxygen, CO$_2$, sodium, and potassium, and you talk about what you are going to do to correct those. If you go and stand in an intensive care unit, you will see a team of four or five people, usually the specialist and a fellow and the house officer and a couple of students. They come in and stand on both sides of the patient’s bed, and they look across the patient and talk to one another about the numbers. No one puts a hand on the patient. No one engages in visual contact. Often the patient can’t talk if he has assisted respiration. But the patient is listening, and it is so important to put a reassuring hand on the patient’s arm and look him in the eye and say something. Instead of that, they talk about the numbers and then go on to the next patient.\(^{30}\)

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This reflection is both extraordinary in its insight and also quite ordinary in displaying the everyday imaginative power of the ICU. It comes from an interview that medical anthropologist Sharon Kaufman conducted with Beeson as part of an effort to chronicle the stories of those who had been leading figures in medicine as it experienced a series of transformations from World War II through the 1970s. Beeson was a particularly distinguished physician; he often drew comparisons to William Osler, the most prominent physician of the preceding generation. As a living standard of excellence for the practice of medicine, Beeson is clearly enraptured by the power of medicine on display within the ICU, but at the same time he recognizes it as a dehumanizing site in which medical teams stand around a body and “talk to one another about the numbers.”

We see these two impulses reflected in Samuel Shem’s *The House of God*, a classic, dark-humored account of the life of medical trainees in the modern hospital. In it, the narrator, an intern, describes working in the ICU as “different, high-powered, kind of like being part of the manned space program, but that it was also like being in a vegetable garden, only the vegetables were human.” Shem’s account of medical practitioners perceiving the bodies of patients as “vegetables” within the ICU indicates that in this site we find in its purest form what Toombs describes as physicians perceiving the body in the “disease state.” By investigating this paradigmatic medical site, we can discern the medical gaze at work within the modern hospital.

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31 Beeson is one of seven retired physicians interviewed by Kaufman. For more on his importance as a physician, see Kaufman, *The Healer’s Tale*, 27-29. For a recent account of William Osler’s importance and his complex legacy, see Abraham Nussbaum, *The Finest Traditions of My Calling: One Physician’s Search for the Renewal of Medicine* (New Haven: Yale University Press, 2016), 10-51.
3.3.2 Medicalizing the Body in the ICU

In order to give an ethnographic account of the ICU as a paradigmatic medical site, we will further engage the work of Sharon Kaufman. Several years after publishing her interviews with Beeson and others, Kaufman conducted an ethnography of the processes of dying within the modern hospital. Throughout research that occurred in three different hospitals over two years, Kaufman spent half of her time in ICUs. During that time, she investigated what was responsible for creating the conditions and possibilities for the mode of perception described by Beeson. What Beeson observed as turning patients into numbers involved much more than teams of physicians rounding in the morning. Kaufman discerned a constellation of medical practitioners acting and speaking in certain distinct and discernible patterns while in orbit around the patient’s body. Among those that she named, a few are worth highlighting:

In the ICU, nurses monitored machines, gave intravenous medications, never took their eyes off a patient (even while writing in the medical chart), and spoke reassuringly to patients and families. They were a conduit of information to the doctors. They told me how their day-to-day tasks of making patients comfortable and keeping them alive worked as advocacy on behalf of patients….I listened as doctors asked nurses, respiratory therapists, and other hospital staff about patients’ physiological functions and asked nurses and social workers about how families were coping. I watched them do surgical procedures on patients in the ICU….I followed respiratory therapists as they watched mechanical ventilators and adjusted oxygen flow. I stood by bedsides while they worked with doctors to put breathing tubes carefully, correctly, but swiftly down patients’ windpipes. I accompanied them as they calmed patients and tried to make the oxygen masks more comfortable, tested lung capacity, wrote everything into the medical chart.

These nurses, doctors, and respiratory therapists all gather around the intubated body of the patient in the ICU, and through their interventions they work to save life while

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33 In one hospital’s ICU, Kaufman rounded with the medical team several times a week for eighteen months. For more on her methods, see Kaufman, “Introduction” and “Appendix A: About the Research,” And A Time to Die, 1-20; 327-332.

34 Ibid., 5-6.
simultaneously medicalizing it. There are particular practices to notice. Nurses look after machines, administer medications, and speak with patients and families, all the while monitoring the patient’s body. Respiratory therapists oversee the ventilators connected to patients, and they assist in placing breathing tubes, adjusting oxygen flow in order to best meld the workings of machines and bodies. Doctors receive reports from nurses, therapists, and various physiological tests, turning patients into numbers, as Beeson describes. When they judge it necessary, physicians intervene, giving orders to redirect various pathways and processes. These practices and their accompanying discourses create the conditions and possibilities for the pathway of perception leading to what Toombs desires as the perceiving the body in the “disease state.”

Whereas Toombs’s description of the “disease state” flows rather singularly from the physician’s perception, Kaufman makes clear that an entire constellation of practitioners and technologies are at work within the ICU to help create the conditions for a certain form of medicalized life. Yet, the physician’s gaze has a particular primacy that sets the terms of engagement for other practitioners within the ICU. Robert Zussman’s field research in two ICUs makes clear the determinative power of the physician’s gaze in relationship to the practice of nursing. When discussing the intense monitoring and technological interventions that are key to intensive care, one resident told Zussman, “I like the idea that you had real control over the patient, in the sense that you control their respiration, their blood pressure, their heart rates sometimes, and you had information on the pressures in the lungs and everything else and that you really weren’t treating a patient in an unscientific way, which I thought was very fascinating and exciting.”35 Zussman goes on to say that for residents in

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35 Zussman, 58.
medical training “the intensive care unit offers precisely what they had been looking for in medicine.”36 Such a frank recognition of the appeal of the ICU reveals it to be a paradigmatic site for the modern medical imaginary we are examining in this chapter. On this account, in the ICU medicine can be practiced with precision, as it should be, with the medicalized body carefully controlled as an object.

But in order to do these things with the patient’s body, busy physicians need others to carry out their orders. Here we can begin to see how the physician’s gaze sets the terms for other practitioners in the ICU. Nurses are well aware that physicians do little bodily work with the patients. As one nurse put it, according to Zussman, the doctors will say, “‘We’ll do this and we’ll do that,’ but they don’t do anything. They basically sit back there and make the decisions. They basically have no contact with the patient as individuals.”37 Further, even though nurses pride themselves on the kind of care that seeks to resist objectification, their understanding of the duties of care becomes fairly thoroughly medicalized. As Zussman recounts, another ICU nurse put it this way: “Unfortunately, when you are prioritizing, your patient’s needs come first. And around here patient needs means technical first. Then you are allowed to go into more social psychological. Your priorities always have to be square in your mind.”38 In Zussman’s analysis, this prioritization of medicalized need becomes a way, for nurses to become technicians much in the same way that doctors are, but in a subsidiary and more tactile mode. Moreover, there is a crucial feedback loop for this emphasis on technical, objectified skill. As nurses in the ICU become instruments of the will of physicians

36 Ibid.
37 Ibid., 67.
38 Ibid., 73. One nurse, Angela, “speaking for a majority of the ICU nurses, recognizes that she probably should spend more time talking to patients and their families, but acknowledges that the in fact does not: ‘You feel that you’re working a lot, you’re doing all of these technical things, the machines, the respirators, and the family is sort of by the wayside’” (71).
concerned with the medicalized body, they are valued and respected insofar as they become proficient at these specific technical tasks.39 Through this process, Zussman claims, nurses “have become ‘mini-interns’….Like physicians, they have become technicians.”40

Finally, the process by which the person’s lived experience of bodily disruption becomes understood as “disease” is a mutual interplay between patients and practitioners. At the same time the physician’s medical imaginary provides concepts and categories by which someone understand their bodily disruption as disease, the patient is searching for ways to understand the bodily estrangement she is experiencing. Zussman notes that patients, perhaps to the surprise of many patient advocates, seem often to welcome “the predominantly technical orientation of intensive care.”41 But this is not necessarily the case; recall this chapter’s opening story in which the daughter of a patient describes the disorienting and hostile nature of the ICU’s “technical orientation.” Yet even this patient’s daughter recognizes the need to for her family to pattern their lives and understandings around the imaginary offered within the ICU. Therefore, whether willingly, unwillingly, through subconscious processes, or some combination of these processes, the patient’s bodily understanding merges with the doctor’s medical gaze.

3.3.3 The ICU as a “Zone of Indistinction”

By examining this arrangement of discourses, practices, and practitioners, we can better discern the nature of this medical imaginary within the ICU. Kaufman argues that the “on-the-ground organizational activities associated with the intensive care unit,” such as

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39 As Zussman writes, “It is by virtue of their technical skills that nurses win the respect of physicians” (77).
40 Ibid., 80.
41 Ibid., 91. Zussman goes on to say, “For patients and families alike, a transfer to intensive care is a frightening experience….But what is frightening is not so much the unit as the brute facts of acute illness. If anything, the unit, as distinct from the illness that requires transfer to it, is reassuring” (93).
ventilators, feeding tubes, and prolonged comatose states, “have created this zone of indistinction that is now a normal part of the American hospital world and a commonplace creation of medical work.”42 By “zone of indistinction,” Kaufman means a “gray zone between health, awareness, function, and viable life on the one hand, and ‘no longer a person,’ ‘death in life,’ or death on the other hand.”43 In this gray zone between life and death, the medical gaze holds great power. For here we begin to see how the storied, lived body of a person can be thoroughly transformed into the body as an object of medical analysis and intervention, into “numbers,” in Beeson’s words.

In talking with Kaufman, one nurse described her patients as those “sort of trapped in their disease, in their bodies, in the ICU.” This nurse said that her responsibility to these patients was “to just help this purgatory that they are in…to be tolerable, to be somewhat more manageable at some level.”44 Although this nurse thought that she was merely trying to alleviate as much suffering as possible while these patients remain in limbo, such stasis shares similarities with the theological concept of “purgatory,” as both involve a process of transformation. This “zone of indistinction” is not simply a holding pattern between life and death; instead, it represents the emergence of a form of life scripted by these processes of medicalization and objectification. To recall our earlier discussion of conversion in chapter one, here in the ICU we find a metanoia, the mutation of what came before and the birth of a new form of life.

Some might consider this to be a form of life directed towards human flourishing, given that the work in the ICU is ostensibly about the preservation of life and reclamation of

42 Kaufman, …And a Time to Die, 62.
43 Ibid.
44 Ibid., 42.
health. After all, as Zussman notes, is it not “in intensive care that men and women whose hearts have stopped are brought back to life, that machines breathe for those who cannot breathe for themselves, that patients who cannot eat are fed?” He goes on to describe this understanding in biblical terms: “Perhaps Lazarus is not quite raised from the dead, but it is in intensive care that the miracles of modern technology are reenacted routinely and methodically.” Yet, these miracles have a ghastly hue; they remain trapped in logics of death and disease even as they offer seemingly miraculous power to save lives.

Kaufman begins to uncover this dimension of the ICU when she turns to the history of medicalized death. She draws from the work of Michel Foucault in order to understand the historical developments that led to a medical reality in which, as she says, “The dying person was transformed into the patient.” In doing so, Kaufman recognizes that key historical transformations have led to the institutional arrangements of discourses, practices, and practitioners that create the conditions and possibilities for perceiving the body as an object. We now turn to give an account of these developments, drawing from the recent work of Jeffrey Bishop, who himself builds off of the work of Foucault. This historical investigation, when coupled with our ethnographic work above, will provide a thorough understanding of the medical imaginary found paradigmatically within the ICU in order to enable the discernment of a fitting moral response.

3.4 Histories of the Intensive Care Unit

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45 Zussman, 20.
46 Ibid.
47 Kaufman, …And a Time to Die, 63.
When reflecting on his experiences in the ICU in relation to the rest of the hospital, the narrator of Shem’s *The House of God* describes the ICU as “Quintessence. That was it. The Unit was the quintessence. There, after all the sorting had been done, lay the closest representation, in living terms, of death.”\(^{48}\) How did the ICU come to be the quintessence of a medicine and medical gaze centered around death? In *The Anticipatory Corpse*, Jeffrey Bishop attempts to answer this question by providing a genealogy of the medical imaginary found within the ICU. He does so by drawing from and developing Michel Foucault’s argument in *The Birth of the Clinic*, showing lines of connection between the medical transformations during and following the French Revolution and the objective, scientific approach to the body present within today’s ICU. Both Bishop and Foucault’s text are decidedly more complex than what follows, but the particular threads of their arguments foregrounded in what follows provide crucial conceptual resources for understanding the objectification of the body found within the ICU and modern medicine.\(^{49}\) Through examining the historical development of the ICU, we will uncover the theological and philosophical underpinnings for imagining and engaging the body as object, thus enabling us to discern a fitting moral response.

Bishop describes the ICU in ways that comport with our ethnographic investigations above, and we offer a brief overview of his arguments before turning to investigate the historical development of this paradigmatic medical site. In the ICU, Bishop claims, “patient life is reduced to physiological function” and all the technological resources of modern medicine are utilized “to keep life going, where life is defined as nonliving matter in


\(^{49}\) A thorough overview of their arguments would necessarily involve attention to, among other things, Foucault’s claim that certain transformations in French medicine were made possible by a statistics-based focus on public health and Bishop’s related argument about the subtle forms of control found within palliative care.
motion.” The ICU both reflects and instantiates an understanding of life that is thoroughly mechanized: the body is a series of causal chains, matter in motion, and the force of modern medicine can and should be brought to bear to keep this motion going. If death is the cessation of such motion, medicine then relies on death to reveal the processes of life itself. From the vantage point of death, the causes of life can be seen more clearly. From the medical student’s first moments in the anatomy lab to the post-mortem investigative work of the autopsy, medicine’s understanding of life flows from “taking the dead body as epistemologically normative,” a mantra that Bishop repeats throughout his argument. Modern medicine is therefore committed to eliminating discussion of form and purpose and instead focuses on keeping matter in motion through material and efficient causes. The power of “a metaphysics of material and efficient causation” is revealed in the ICU, as a diversity of practitioners and technologies intervene on the patient’s body in order to keep various bodily systems from “shutting down,” or providing a mechanical replacement when they do. These complex efforts to keep this body—this object—in machine-like motion have a history, as do the accompanying medical imaginary and the ICU itself.

3.4.1 Technology and Practice

In order to understand the historical development of “a metaphysics of material and efficient causation” in the ICU, we begin by examining the most recent reasons for its inception before turning to a lengthier historical account. Most immediately, the history of the ICU is bound up with important structural changes within the modern hospital, and these flow in large part from a singular invention: the mechanical ventilator. The ventilator

50 Bishop, The Anticipatory Corpse, 113.
51 Ibid., 22.
“sparked the most significant organizational change in the contemporary hospital.” Into the 1950s, critically ill patients were still treated on the general hospital wards, perhaps with a bit more nursing attention, but “by 1970, every tertiary medical center and many community hospitals had intensive care units (ICUs), in which the great majority of patients were on respirators.” Therefore, the proliferation of the ICU and the medical imaginary found within it is the result of the invention of a new medical technology.

Because of the mechanical ventilator, in the ICU the breath of life itself can be sustained, mimicked, regulated, and restarted. The discourses and practices that accompany the ventilator are formative for the entire team of practitioners trained in various ways to handle this technological intervention. As we saw in Kaufman’s ethnographic account, the physician, the respiratory therapist, and the nurse all have roles to play in maintaining a regular process of inhalation and exhalation. In different but related ways, by means of this technological device and through each other, these practitioners exert their will on the patient’s body.

While “a metaphysics of material and efficient causation” is particularly pronounced with the mechanical ventilator’s role in the formation of the ICU, we also can discern it through a variety of other technological interventions. The drip lines of medications, various monitoring systems, dialysis, and cardiac interventions are all causal interventions in the body’s material pathways. The patient’s body is continually mapped and manipulated.

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53 David Rothman, Beginnings Count (Oxford: Oxford University Press, 1997), 113-114. While this transformation has precursors in both Florence Nightingale’s practice of placing the most seriously ill soldiers nearest to the nursing station and the rise of special postoperative rooms following surgery beginning at Johns Hopkins in 1923, it was not until the rise of the mechanical ventilator and the accompanying need for a team of specialized caregivers that the structural change of the ICU found its way into all major hospitals. See Henrick H. Bendixen and John M. Kinney, “History of Intensive Care,” in Manual of Surgical Intensive Care, ed. The American College of Surgeons’ Committee on Pre and Postoperative Care (Philadelphia: WB Saunders Company, 1977), 3-14; see also Zussman, 17.
through these technologies. The practitioners that exist in a constellation around these devices all help instantiate a mode of imagining and engaging the patient’s body as an object in the ICU.

Bishop also draws attention to the development of cardiopulmonary resuscitation (CPR), a less technologically intensive medical practice that nonetheless contributes in a significant way to the medical imaginary found within the modern ICU. As part of the research that led to CPR, a series of often brutal experiments were conducted in order to revive the cardiac and pulmonary functions of dogs, and the techniques of resuscitation moved rapidly from the lab into the clinic. Bishop is particularly interested in the close connection between the lab bench and the patient’s bedside; the medical techniques of what we now know of as CPR come through the conjoining of the scientist and physician. It is through investigating the causal pathways that lead to the moment of death that the laboratory and hospital are joined. In both its development and its contemporary practice, CPR is an intervention defined by death and designed to redirect a causal pathway away from it.

Therefore, in the development of its current technologies and practices, we can see how “a metaphysics of material and efficient causation” is made possible within the modern ICU. By imagining and engaging the patient’s body as an object, the arrangements of discourses, practices, and practitioners in the modern ICU carry forward a mechanistic approach to life. In the development of the practice of CPR, we see an example of how the physician and the scientist are merged. Bishop explores this connection further by attending to the history of medical education that gives rise to the modern physician-scientist so

closely associated with the modern ICU’s medical imaginary. In particular, Bishop turns to the vision of modern medicine laid out in Abraham Flexner’s 1910 report on medical education, *Medical Education in the United States and Canada*. Flexner’s influential report “both prescribed and articulated the argument for intimately linking medicine with the laboratory.”

Thus, we now turn to the role it, and medical education more generally, has played in the development of the medical imaginary discerned within the modern ICU.

### 3.4.2 Medical Education

Abraham Flexner was an American educator who founded the Institute for Advanced Study at Princeton and reformed our system of medical education. Backed by the Carnegie Foundation, he examined medical education at the turn of the twentieth century and was appalled at the lack of standardized rigor. Flexner found medical training at the time to be largely centered around apprenticeship to a local practicing physician. In his report, he proposed that medical education follow the lead of William Osler, “father of modern medicine” and one of four founders of the Johns Hopkins University School of Medicine. Osler’s institution was for Flexner the leading example of rigorous and scientific medical training, and he recommended that all other American medical schools follow in its path. Because of this, instead of being locally apprenticed under a physician, medical students would travel to elite research universities and teaching hospitals in order to be formed into the right kinds of physician-scientists. Abraham Nussbaum describes a dual legacy of this transformation, saying, “The lasting effects of Flexner’s *Report* include an explosion of

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55 Ibid., 97.
medical knowledge and a series of technical advances, but also a fraying of the ties between physicians and communities. We belong to the hospitals in which we train and practice.\textsuperscript{56}

Therefore, when a person suffering an illness is transformed through an encounter with a physician into a diseased patient, as we saw in Toombs’s account, we should also understand that the physician has also experienced transformation through the process of medical education.\textsuperscript{57} In this conversion of the doctor from a healing member of a local community into an expert physician-scientist fitting in at any teaching hospital, we see the result of a fundamental shift in medical education that has moved from local apprenticeship to standardized expertise. Flexner’s emphasis on the physician-scientist lends itself, as Bishop argues, to the formation of medical practitioners focused on the technical task of keeping matter in motion. Today, the act of becoming a physician involves medical students becoming numbers in a formula in order to be matched with a teaching hospital according to preferences, qualifications, and needs. This process reveals how physicians come to understand their agency in relation to the medical system. This fundamental shift in the way American physicians are trained is a key part of the story of the development of a medical imaginary that construes the body as object.

This transformation in American medical training and practice joined forces with other fundamental changes occurring within the institution of the hospital. As Paul Starr describes it in his influential \textit{The Social Transformation of American Medicine}, “The modern history of the hospital has seen a steady stripping away of its communal relations as it has

\textsuperscript{56} Nussbaum, 15.
\textsuperscript{57} Both of these transformations are, in part, medical manifestations of what Charles Taylor calls “The Great Disembedding,” the process in modernity by which the individual emerges separated from other modes of social belonging that had previously been definitive. See his brief chapter under this name in \textit{A Secular Age}, 146-158. Karl Polanyi draws attention to the phenomenon of “disembedding,” particularly in relation to capitalism’s effects on communal life, in \textit{The Great Transformation: The Political and Economic Origins of Our Time}, 2nd ed. (Boston, MA: Beacon Press, 2001; 1944).
more closely approached the associative structure of business organization.” Therefore, the anonymizing and objectifying forces found in the modern ICU are made possible, in part, by transformations in the training of physicians and the institution of the hospital. These transformations were well underway before Flexner’s report, and they have their origins in the rise of the teaching hospital and its accompanying mode of understanding the body. For an account of this we return to Bishop, who draws from Foucault’s description of the fundamental shifts in medicine and the hospital that occurred in Paris during and after the French Revolution. These historical investigations into the rise of the modern hospital will enable us to understand the theological and philosophical underpinnings of this medical imaginary in order to discern a fitting moral response.

3.4.3 The Institution of the Hospital

Because of its enormous influence within contemporary work in the anthropology, sociology, history, and philosophy of medicine, Michel Foucault’s The Birth of the Clinic is an intellectual catalyst for Bishop’s The Anticipatory Corpse. Bishop’s opening chapter, “Birthing the Clinic,” is primarily a reading of Foucault’s work in a way that sets the terms for Bishop’s sweeping argument about the state of modern medicine. Through a complex argument, Foucault seeks to determine “the conditions of possibility of medical experience in modern times.” As he argues, our modern medical experience has transformed in fundamental ways and these changes are made evident in a seemingly insignificant shift in the clinical encounter.


59 Foucault, The Birth of the Clinic, xix.
This new structure is indicated—but not, of course, exhausted—by the minute but decisive change, whereby the question: “What is the matter with you?”, with which the eighteenth-century dialogue between doctor and patient began (a dialogue possessing its own grammar and style), was replaced by that other question: “Where does it hurt?”, in which we recognize the operation of the clinic and the principle of its entire discourse.60

By shifting away from the question, “What is the matter with you?”, medicine has left behind first-person accounts of illness and any nascent, fragmentary, or even robust patient self-understandings. In its place, medicine’s imagination is shaped by what Toombs calls the “disease state,” as the doctor asks, “Where does it hurt?” This new question involves “the fundamental spatialization and verbalization of the pathological,” in which disease becomes an objectified reality through the measurements and discourse of the doctor.61

At this point it is crucial to remember that “this new structure” that Foucault is describing is not simply the rise of clinical bedside medicine and its accompanying discourses. It is that, of course, but it is also the rise of the modern teaching hospital as a fundamental institution of medicine. The translator of The Birth of the Clinic (published in French as Naissance de la Clinique) begins by noting, “When Foucault speaks of la clinique, he is thinking of both clinical medicine and the teaching hospital.”62 What Foucault describes as emerging during and after the French Revolution is not just a particular kind of medical practice and an accompanying way of knowing; it is the birth of a new institutional form, the teaching hospital, which makes possible and carries forward modern medical practices and epistemologies. It is in both this institution and the kind of clinical medicine it carries forward that we discern the origins of what Bishop describes as medicine’s “metaphysics of

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60 Ibid., xviii.
61 Ibid., xi.
efficient and material causation” along with its “taking the dead body as epistemologically normative.”

In the teaching hospital and clinical medicine, knowledge of health and disease were no longer tied to a medicine of forms, which focused on abstract accounts of a disease whose presence was revealed as physical symptoms emerged over time. Such an account of medicine, contends Foucault, was dominant shortly before the French Revolution, and in many ways this kind of medicine dates back to humoral theory and the origins of the practice of Western medicine. But in the rise of the teaching hospital and clinical medicine, this gap between the apparent symptom and the mysterious workings of the form of the disease is closed. A medicine of forms is no longer required to understand the mechanics of a disease. Instead, in the touch, the hearing, and especially the sight of the physician, the gap between symptom and disease, signifier and signified, was erased. At the patient’s bedside, the doctor’s medical gaze is understood to be capable of making clear all the hidden mysteries of the diseased body; and as the practice and teaching of medicine are joined together, the attending physician creates the truth of the diseased body as his medical gaze is spoken to the physicians-in-training also gathered at the bedside.

This connection between the physician’s sight and voice is key. Foucault describes the epistemological framework implied by this connection as one that makes possible clinical medicine in the teaching hospital. With characteristic flourish, he writes,

Over all of these endeavours on the part of clinical thought to define its methods and scientific norms hovers the great myth of a pure Gaze that would be pure Language: a speaking eye. It would scan the entire hospital field, taking in and gathering together each of the singular events that occurred within it; and as it saw,

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63 Foucault gives a complex account of this transformation, which Bishop follows in detail and then summarizes: “The abstract space of forms gives way to the political space of epidemics. The political space of the Revolution produces a revolutionary medicine, which in turn gives way to the clinical space.” Bishop, The Anticipatory Corpse, 55.
as it saw ever more and more clearly, it would be turned into speech that states and teaches; the truth, which events, in their repetitions and convergence, would outline under its gaze, would, by this same gaze and in the same order, be reserved, in the form of teaching, to those who do not know and have not yet seen. This speaking eye would be the servant of things and the master of truth.  

Foucault then goes on to describe several of the epistemological myths that undergird this “speaking eye,” one of which is that “the clinical gaze effects a nominalist reduction of the essence of the disease.” As we shall see, Bishop argues for the contemporary importance of this nominalist reduction in medicine. But first it is important to note how the production of medical truth is brought together in the act of seeing and speaking in the teaching hospital. The patient’s accounts of their experiences are no longer valued, and neither are abstract general concepts of the essences of disease. Instead, what can be observed and spoken by the medical practitioner is what matters. Foucault’s description of the elimination of formal and final causality in understandings of disease prepares the ground for what Bishop describes as the elimination of formal and final causality within the entirety of medicine. The prominence of efficient and material causality and the powers of medicine’s “speaking eye” are only increased further as anatomy and autopsy make it possible for this penetrating gaze to move more deeply into the body.

For Foucault, the conditions and possibilities for this epistemological transformation were found in the dramatic shifts that occurred in Parisian medicine, education, and hospitals during the French Revolution. These sweeping changes can be partially

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64 Foucault, *The Birth of the Clinic*, 114-115.
65 Ibid., 119.
66 Although these transformations of the hospital and medicine in France occur in a turbulent and brief amount of time, they are preceded and paralleled by more gradual changes at leading institutions of medicine across Europe. Risse’s chapter, “Enlightenment: Medicalization of the Hospital” focuses in on the changes of the Royal Infirmary of Edinburgh and Vienna’s Allgemeines Krankenhaus from 1750-1800 (Risse, *Mending Bodies, Saving Souls*, 231-288). Risse offers a broader overview of parallel transformations in his essay “Clinical Instruction in Hospitals: The Boerhaavian Tradition in Leyden, Edinburgh, Vienna, and Pavia,” *Clio Medica* 21.
illuminated through the story of one particular institution. Within a single Parisian hospital, we can see on display the transformations in how the body is imagined and encountered that find their paradigmatic form in the modern ICU. Through the modernization of this one institution, we can discern the emergence of a foundational element of the modern teaching hospital. Therefore, we turn to an account of the transformations found within Paris’s Hôtel-Dieu.

With a population of nearly 700,000 at the start of the French Revolution, Paris was a medieval city straining under the transformations of urbanization. This reality was particularly present in the Hôtel-Dieu, “God’s Hostel,” which was founded in 651 AD as a charity hospital of the kind we will explore in greater detail in the next chapter. In between its founding and the French Revolution, it had expanded in size and scale, and halting efforts were made to replace its inefficient organization and the patchwork of donations and endowments that funded its operations with a municipally controlled and financed bureaucracy. These were largely ineffectual, and on the eve of the French Revolution the hospital was grossly overcrowded, with over 3,500 patients forced into 1,200 beds. Infection and mortality rates were higher here than in any other Parisian institution, and so the Hôtel-Dieu was held up as a symbol of the inefficient bloat and rot at the heart of the Ancien Régime and French Catholicism. At the same time, it represented an effort by city governments to

use hospitals as “segregation and confinement tools” to deal with the poverty and illness that accompanied population growth.67

In the Hôtel-Dieu we can see how the urbanization of Europe, coupled with what Charles Taylor describes as “the rise of the disciplinary society,” led to growing dissatisfaction with municipal charity institutions, most of which had religious roots. These institutions were increasingly seen as inefficient and holding back societal progress. Taylor, drawing in part from the work of Foucault, investigates the growing expectation of disciplined, orderly lives as part of the story of the rise of modernity.68 In his history of the hospital, Guenter Risse offers a parallel argument to Taylor focused particularly on changes that followed shifts in understanding of charity that both predated the Reformation and were intensified in its wake, particularly in Protestant regions of Europe.69 The transformations of the Hôtel-Dieu in Paris were especially intense given that a characteristically Protestant focus on efficient and deserving care, albeit in a secularized form via the French Revolution, was brought to bear in just a few years upon a historically Catholic institution. We now turn to consider those changes in more detail.

Foucault chronicles how early in the French Revolution, there was a strong push for deinstitutionalization so that the course of a disease could be observed naturally in the home and medicine could assist there in the move toward health.70 However, the numbers and

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67 Risse chronicles the historical development of this understanding and function of the hospital in his chapter, “Hospitals as Segregation and Confinement Tools,” *Mending Bodies, Saving Souls*, 167-229. Risse offers a particular overview of how these transformations affected Paris's Hôtel-Dieu up to the eve of the French Revolution (293-299).
70 Foucault describes this perspective as follows: “The hospital is an anachronistic solution that does not respond to the real needs of the poor and that stigmatizes the sick in a state of penury. There must be an ideal state in which the human being would no longer know exhaustion from hard labour or the hospital that leads to death” (*The Birth of the Clinic*, 44).
needs of the sick poor in Paris quickly made clear the impracticality of this proposal, and so the revolutionary leaders settled for a provisional step in which the inefficient and thoroughly unnatural charity hospitals were to be reconfigured into a “differentiated hospital space.” At the same time, the teaching of theoretical medicine among university faculties was shut down in favor of apprenticeship models that were deemed much more socially useful. A further step towards making French hospitals more efficient was doing away with the “immobilization of wealth” represented by charitable hospital foundations and replacing such inflexible bulwarks with a mobile and responsive “nationalization of hospital funds.” Predictably, such nationalized funds were inadequate to the institutional needs, but a crucial event helped prevent a reversion to the old system of charitable care: injured soldiers returning home from the revolutionary wars replaced the sick poor in hospital beds, and the French army was at least nominally responsible for paying for their care. And so the revolutionary desire to do away with inefficient charitable hospitals like the Hôtel-Dieu in Paris and instead care for the sick in the natural environment of the home was discarded due to pressing on-the-ground needs, and clinical care was firmly entrenched within the existing hospitals.

In the midst of these events of the French Revolution, Foucault argues that a fundamental but almost unseen transformation has occurred. His claim about the nature of these transformations is worth quoting at length:

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This “ideal state” would occur in the natural setting of the home where the physician’s gaze could see the disease most clearly and so intervene most effectively.

71 Ibid., 42.
72 Ibid., 44-52.
73 Ibid., 40, 66.
74 Ibid., 66. This account of the transformations of the hospital during the French Revolution follows Foucault’s argument; for a complementary and more detailed historical overview, see Risse, *Mending Bodies, Saving Souls*, 300-308, which in particular provides more detail on the various financial arrangements.
By a spontaneous convergence of pressures and demands proceeding from social classes, institutional structures, technological or scientific problems of very different kinds, an experience was beginning to be formed by a kind of orthogenesis. To all appearances, it was simply reviving, as the only possible way of salvation, the clinical tradition that had been developed in the eighteenth century. In fact, what was involved was something quite different. In that autonomous movement and the quasi-clandestinity that abetted and protected it, this return to the clinic was in fact the first organization of a medical field that was at once composite and fundamental: composite, because in its everyday practice, hospital experience resembles the general form of a pedagogic system; but fundamental, too, because unlike the eighteenth-century clinic, it is not a question of an encounter, after the event, of a previously formed experience and an ignorance to be dissipated. It is a question, in the absence of any previous structure, of a domain in which truth teaches itself, and, in exactly the same way, offers itself to the gaze of both the experienced observer and the naïve apprentice; for both, there is only one language: the hospital, in which the series of patients examined is itself a school.75

What may have appeared to be *epistrophe*, the revival of an old clinical tradition, was actually *metanoia*, the birth of a new way of knowing, practicing, and learning medicine as the hospital experienced an institutional conversion. According to Foucault, this new approach to medicine was both composite and fundamental: composite because it contained both training and treatment within a single institution, the clinic as teaching hospital, and fundamental because in the act of seeing the sick patient medical truth was constructed (rather than applied) in and through the perception of the patient’s body. Therefore, despite the superficial similarities this institution is now a radical departure from its previous self, and it houses and propagates a new understanding of the body. And although Foucault does not make much of this change, it is crucial to note that the transformations he chronicles are bound up with the victory of the physician’s authority over the (religious) nurse.76

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75 Ibid., 68.
This transformation of the institution of the hospital was accompanied by an epistemological justification for the hospital rather than the home as the primary locus for teaching medicine and treating patients. As “a neutral domain, one that is homogeneous in all its part and in which comparison is possible and open to any form of pathological event,” the hospital clinic “makes possible, therefore, the setting aside of the extrinsic.” As we saw in ethnographic accounts of its arrangements of discourses, practices, and practitioners, such a desire reaches its apogee in the contemporary ICU. Here, interference from the outside world, in all its forms, is resisted in the pursuit of a neutral and homogenous domain. And even though over two hundred years separate today’s medicine and these French transformations, it is hard to overstate the importance of these shifts. In the decades following the French Revolution, generations of students from around the world traveled to Paris to receive medical training, shaping “an anatomical-clinical synthesis soon to become both the hallmark and the shortcoming of modern medicine.” Therefore, the transformations of the institution of the hospital chronicled by Foucault form a foundational part of the modern hospital and practice of medicine.

### 3.4.4 Connecting the Birth of the Clinic and the Modern ICU

In order to connect the transformations of the French hospital with the rise of the physician-scientist in modern medicine, Bishop follows Foucault in offering an intermediary step through the practice of pathological anatomy. The work of Xavier Bichat joins with the transformations occurring in clinical medicine and the teaching hospital in order to produce

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77 Foucault, *The Birth of the Clinic*, 109, 110.
78 Risse, *Mending Bodies, Saving Souls*, 331. Risse also says that following the French Revolution, “the Paris Medical School and its teaching hospitals became the most famous medical-educational institutions in the world, a Mecca for thousands of foreign students anxious to make ward rounds with some of the most distinguished French clinicians and surgeons” (331).
a new mode of imagining and engaging the body in medicine. These transformations continue the institutional trajectory we have been tracing; until his untimely death in 1802, Bichat was chief physician at Paris’s Hôtel-Dieu described above.79 Bishop summarizes the philosophical implications of this alignment between pathological anatomy, clinical medicine, and the teaching hospital by quoting and commenting on *The Birth of the Clinic*.

Foucault claims that the new alignment of anatomy and the clinic allowed for a new way of conceiving time and disease: “The possibility of opening up corpses immediately, thus reducing to a minimum the latency period between death and the autopsy, made it possible for the last stage of pathological time and the first stage of cadaveric time almost to coincide….Death is now no more than the vertical absolutely thin line that joins in dividing them, the series of symptoms and the series of lesions.” The series of symptoms discerned in the clinic concerns time; the series of lesions discerned in pathological anatomy concerns space. Death occupies no space; death sits outside time. Death is medicine’s transcendental. And still death is immanent, for it is also the final point of disease time. Death is both the end of life and the end of disease—in the sense of a terminus, the final effect in the series of causes and effects. And it is from the heights of death itself that both life and disease can be analyzed.80

If the clinical medicine found within the teaching hospital makes possible the verbalization of disease, the integration of pathological anatomy makes possible its spatialization. No longer does the unfolding of the form of a disease towards its *telos* require the progression of time. Instead, from the cessation of life, disease, and time in death we can trace back a series of efficient causes, all materially explainable, so that life, disease, and their temporality become spatialized through these material interactions. Because of the spatialization of disease, we do not need to wait on the unfolding of hidden temporal processes in order to understand these causal pathways. Thus, as Bishop argues, “the dead body thus acts as the epistemological foundation of knowledge because it is the stable ground against which the

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79 For a detailed historical account of Bichat and the rise of pathological anatomy as a framework of understanding for clinical medicine, see Risse, *Mending Bodies, Saving Souls*, 309-314.

flux of life and disease can be known,” which allows “medicine to perfect its language, a language that is diffused throughout the clinic.”

The autopsy sets the epistemological criteria for the practice of medicine. As the work of pathological anatomy merges with physiology, conceptions of life itself begin to be formulated as matter in motion, against the backdrop of the dead body. Consequently, Xavier Bichat can say, “Life consists in the sum of the functions by which death is resisted.” Renowned French physiologist Claude Bernard continues this mechanization of the body, referring to our bodies as “living machines” and shearing away any efforts at explanation that extend beyond those of matter in motion. Bernard goes so far as to say that “the words life, death, health, disease have no objective reality,” for all that we can know is the immediate causes of physical effects.

The work of pathological anatomy is no longer limited to the autopsy; it has been extended into the living patient’s body through a series of technological advances that reveal the hidden secrets of the living body. The body as understood through dissection and anatomy has been mapped upon living bodies through a variety of technological instruments that make visible the body’s interior. From the invention of the stethoscope in a Parisian

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81 Ibid., 56.
84 Bernard, 67; Quoted in Bishop, *The Anticipatory Corpse*, 76. Bishop makes the point that Bichat still professed a form of vitalism whereby a force other than material and efficient causes was involved in making possible life, which opened up the possibility for something like formal and perhaps even final causality to still exist. Following Simon Oliver, Bishop argues that by the time of Bernard a few decades later, vitalism had lost its explanatory force and was unnecessary.
hospital in 1816\textsuperscript{85} to the rise of X-ray imaging and, later, CT-scans, a series of investigative technologies have worked to reveal the inner workings of the body that beforehand were only visible through dissection.\textsuperscript{86} This merging of mapping technologies with the knowledge gained through pathological anatomy makes possible a way of knowing the medicalized body as an object.

In summary, then, a series of interrelated historical developments dating back to the French Revolution have created the conditions and possibilities for the patient’s body to be imagined and engaged as an object. The new teaching hospital’s discourses, practice, and practitioners make possible a distinct mode of perceiving and constructing the body through the clinician’s vision and speech. This medical gaze is extended through pathological anatomy and a variety of new imaging technologies, and at the beginning of the twentieth century the physician-scientist model was firmly established in America through Flexner’s report. From CPR to the mechanical ventilator, the discourses, practices, and practitioners of the modern ICU map and manipulate the patient’s body as an object. This distinct medical imaginary, as found paradigmatically within the modern ICU, is undergirded by a set of philosophical and theological assumptions. In order to discern a fitting moral response to this medical imaginary, we must first give further account of the metaphysical assumptions carried within the historical development of the arrangements of discourses, practices, and practitioners within this paradigmatic medical site.

\textsuperscript{85} Risse, \textit{Mending Bodies, Saving Souls}, 314-316.
\textsuperscript{86} For an ethnographic account of contemporary medical imaging, see Barry F. Saunders, \textit{CT Suite: The Work of Diagnosis in the Age of Noninvasive Cutting} (Durham, NC: Duke University Press, 2008).
3.5 Theological, Philosophical, and Political Underpinnings of the Modern ICU

If in the ICU the body is imagined and engaged as an object, and if the ICU is defined by what Bishop calls “a metaphysics of material and efficient causation,” then what are the theological, philosophical, and political assumptions that undergird this paradigmatic medical site? Recall from earlier that in Sharon Kaufman’s ethnographic examination of the pathways of dying in the modern hospital, she uses the phrase “zone of indistinction” to describe a certain form of life she witnessed in the modern ICU. Kaufman takes this phrase from Giorgio Agamben’s *Homo Sacer*, where he argues that the “zone of indistinction” indicates a “point of intersection at which state politics and biological life converge.” It is worth reflecting on Kaufman’s invocation of Agamben, for through it we can begin to see something of the theological, philosophical, and political assumptions that undergird the ICU.

At the beginning of *Homo Sacer*, Agamben places himself in conversation with the political theorist Carl Schmitt, whose work we engaged in chapter two. But Agamben pushes beyond Schmitt’s thought to conceptualize what modern sovereignty looks like “now that the great State structures have entered into a process of dissolution and the emergency has...become the rule.” Agamben positions himself in relation to Schmitt by declaring that “the fundamental categorical pair of Western politics is not that of friend/enemy but that

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87 Kaufman, *...And a Time to Die*, 344, n. 1. Kaufman is quick to distance herself from Agamben’s argument about modern biopolitical forms of life, claiming that she is merely interested in a state of being where forms of life and death cannot be easily distinguished or separated.

Agamben moves past the sovereign decision over who is friend and who is enemy in order to consider a prior question over which forms of life are deemed to be worthy of political consideration. Schmitt’s conception of the distinction between friend and enemy presumes a world in which people engage one another as political actors; Agamben’s understanding of bare life considers a form of humanity that has been deemed outside the bounds of political existence. And, as we shall see, a distinct set of theological and philosophical assumptions undergird Agamben’s conception of sovereignty in modernity.

Agamben follows the work of Foucault in recognizing that a dissolution of sovereignty into various capillaries of power has occurred in modernity, but he wants to extend Foucault’s analysis into the “hidden point of intersection between the juridic-institutional and the biopolitical models of power.” To do this, he depicts “the life of *homo sacer* (sacred man)” as someone who is included in the political order solely by his exclusion. According to Agamben, the political order has entrapped this form of life by the very act of excluding them from the normal processes of political life. This can be seen through the way in which the *homo sacer* “may be killed and yet not sacrificed.” As Agamben later explains, “The sovereign sphere is the sphere in which it is permitted to kill without committing homicide and without celebrating a sacrifice, and sacred life—that is, life that may be killed but not sacrificed—is the life that has been captured in this sphere.” Denied of political protections and religious significance, *homo sacer* is humanity stripped to what Agamben calls bare life. *Homo sacer*, who was originally an “obscure figure of archaic Roman law,” reveals that the

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89 Ibid., 8.
90 Ibid., 6.
91 Ibid., 8, emphasis in original.
92 Ibid., 83.
political order is able to entrap bare life within its sovereignty in the very act of excluding it as something not worthy of political existence. Agamben goes on to show that these ancient roots come to full fruition in the concentration camp:

Insofar as its inhabitants were stripped of every political status and wholly reduced to bare life, the camp was also the most absolute biopolitical space ever to have been realized, in which power confronts nothing but pure life, without any mediation. This is why the camp is the very paradigm of political space at the point at which politics becomes biopolitics and \textit{homo sacer} is virtually confused with the citizen.\footnote{Ibid., 171.}

According to Agamben, then, in the concentration camp we find the clearest expression of biopolitics, as political life becomes the unmediated control of bare life.

Given this account of bare life and biopolitics, it is crucial for our purposes that Agamben draws attention to the important role that medicine plays within such an account of sovereignty. He does so with reference to the Nazi regime, not to make the often-noted point about the dangers of unbridled medical research, but instead to show that we can find a conceptual echo of the form of life present within the concentration camp in certain medical spaces.\footnote{See Agamben, 139-159, where he discusses the Nazi concentration camps and medical practices in an argument that builds to \textit{“Politicizing Death,”} 160-165, where he discusses the case of Karen Ann Quinlan.} By discussing the case of Karen Ann Quinlan, who existed in a persistent vegetative state for years while legal battles raged over her body, Agamben brings us to the space that Kaufman describes. He says, \textit{“the hospital room”} in which patients \textit{“waver between life and death delimits a space of exception in which a purely bare life, entirely controlled by man and his technology, appears for the first time.”}\footnote{Agamben, 164.} Here we can begin to understand the political differences between the surgical ward and the ICU.

In arguing for a different conceptions of sovereignty and politics than Schmitt’s, Agamben points beyond the delineation of a friend/enemy distinction justifying surgical
violence to a form of life in the ICU that is stripped of all meaning and thoroughly mastered by sovereign technological control. Here, therefore, we see the political and philosophical underpinnings for a medical imaginary that construes the body as an object and what Bishop calls “a metaphysics of material and efficient causation.” On this account, the physician in particular and the medical team more generally is the sovereign, and the patient in the ICU has been reduced to bare life. Crucial for this conception of bodily control is the power of the physician’s will, which, as we saw above, is greatly enhanced by the ICU’s arrangement of discourses, practices, and practitioners.

The conception of sovereignty contained within the physician’s will sits within significant Western political, philosophical, and theological trajectories. By briefly charting these movements, we will finally be prepared to connect the ICU’s medical imaginary with moral theories attempting to provide frameworks for action. Within the ICU, we see a body that is both objectified and malleable. While scientific objectivity and constructivist plasticity may seem to be in some tension, they have been held together since the origins of modern medicine. Recall that Claude Bernard referred to our bodies as “living machines” while also claiming that “the words life, death, health, disease have no objective reality,” for all that we can know is the immediate causes of physical effects. Foucault explains this seeming paradox through what he calls “the speaking eye,” which is able to both see and speak (and so create) the medical realities of bodies in the hospital. This “speaking eye” is both “the servant of things,” fulfilling the role of scientific objectivity, while also being “the master of

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truth,” constructing reality through its speech. Bishop follows Foucault’s explanation and so describes this work in medicine as follows:

Medicine, then, according to Foucault, embraces an epistemology of death such that the dead body is the normative body, and thereby also embraces a nominalism, where the dead body can be mapped over the living reality of the body so that truth claims about living bodies can be made. The diseased and living body as object of the doctor’s gaze is a being that does not exceed the extent to which it is known, and it best known at autopsy….the resulting metaphysics of efficient causation allows mastery over the living body as machine, as dead matter in motion.

Bishop draws from the work of John Milbank in order to denounce the deleterious influence of nominalism on our modern political and moral orders. This invocation of nominalism brings us back to the account of the physician as sovereign implied by Agamben. For in it we see the ways in which the rising importance of the will within modern politics, philosophy, and theology is bound up with modern medical knowledge and practice. For that, we turn to the work of Charles Taylor and Gerald McKenny.

In describing the rising importance of the will as an “epochal change in our understanding of and stance towards nature, within us and without,” Charles Taylor writes in *A Secular Age* that this is “the overdetermined result of a number of independent changes, and cannot be laid at the door of one crucial factor.” Among the causes, the rise of theological voluntarism coupled with the turn to the subject is certainly an important transformation, as is the loss of a sense of innate purpose in creation and the rise of an instrumental approach to nature. Drawing from Charles Taylor’s earlier *Sources of the Self*, Gerald McKenny describes the fruit of this latter transformation as “the Baconian

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98 Foucault, *The Birth of the Clinic*, 115.
100 See, for example, Bishop, *The Anticipatory Corpse*, 80, 212, and 352n.50. Milbank’s specific intellectual genealogy, beginning with *Theology and Social Theory: Beyond Secular Reason*, 2nd ed. (Malden, MA: Blackwell Publishing, 1990, 2006) and extending throughout the movement known as Radical Orthodoxy, is beyond the scope of this project.
According to McKenny, modern medicine follows a trajectory set in part by Francis Bacon and Rene Descartes through seeking “to eliminate suffering and to expand the realm of human choice.” Medicine’s willful control over nature was taken to be divinely ordained.

This impulse to broaden the powers of human choice is particularly relevant to our concerns here, as it represents an emphasis on the centrality of human will and so human control as expressed through medicine. “As a result,” McKenny writes, “medicine is based on practices and techniques of control over the body rather than on traditions of wisdom about the body.” Beyond Bacon and Descartes, other theological and philosophical figures, ranging from Thomas Hobbes to John Locke, were influential in making possible this conceptual transformation.

Moreover, any account of these theological and philosophical shifts without attention to how they are bound up with material and societal changes is woefully insufficient: the rise of capitalism, the nation-state, and modern scientific techniques are all part of the emerging dominance of an instrumentalizing stance towards nature in Western society. Taylor calls this an “overdetermined result” and summarizes some of the shifts we just described as follows:

We see this [epochal change] with the nominalist writers, and later with many of the seventeenth century champions of the new science, e.g., Descartes and Mersenne. If God has a potential absolute over Creation, and this means that he cannot be seen as bound by the inherent bent, even of things he has created in the first place, then reality must be seen as infinitely manipulable by him, and this requirement can best

102 Gerald McKenny, To Relieve the Human Condition, 2.
103 Ibid., 2.
104 Ibid., 20. This shift in medical practice reflects changing theological assumptions about the role of human beings within creation. McKenny follows Taylor in describing the Protestant origins of this change. See Taylor, Sources of the Self, especially 230-233.
105 Milbank, for example, interrogates the legacy of Thomas Hobbes in the opening chapter of Theology and Social Theory, 9-47. For an example of an analysis of Locke’s influence, see the chapter “Locke’s Punctual Self” in Taylor, Sources of the Self, 159-176. In our next section, we shall see how Tristram Engelhardt relies on a Lockean notion of the self in his moral theory.
be met by a view of nature as mechanism, from which all hint of intrinsic teleology has been expelled. But if this is the nature of things, then this has consequences for our stance towards the world as well. Not only must we alter our model of science—no longer the search for Aristotelian or Platonic form, it must search for relations of efficient causality; but the manipulable universe invites us to develop a Leistungswissen, or a science of control.  

According to our argument so far, this science of control described by Taylor achieves its paradigmatic form within the practice of medicine in the ICU. Through our phenomenological, ethnographic, and historical investigations, we have described the development of arrangements of discourses, practices, and practitioners in the ICU that create the conditions and possibilities for imagining and engaging the body as object. Theological, philosophical, and political assumptions undergird the medical imaginary found within the ICU as a paradigmatic medical site. For here, the storied and purposive body is transformed into bare life, mere matter in motion subject to the techniques and wills of physician-scientists and their accompanying medical teams and technologies. The conversion undergone in the ICU involves the loss of final and formal causality, and this is a deeply moral loss for modern medicine. If embodied persons are sundered into objectified bodies and disembodied wills that struggle to resist the surrounding forces, what moral response is fitting for such a medical imaginary? With these phenomenological, ethnographic, historical, political, philosophical, and theological accounts in mind, we turn to consider this pressing moral question.

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106 Taylor, *A Secular Age*, 113. Taylor draws the term “Leistungswissen” from Max Scheler and describes it as “a science in which truth is confirmed by instrumental efficiency.”
3.6 Discerning a Fitting Moral Response

A brief summary of our investigation into how the body becomes imagined and engaged as an object in the ICU in particular and in the hospital more generally is in order. When patients and practitioners encounter each other in the ICU, they do so in a hospital context that has sundered them from their former local communities of meaning. For patients, this occurs in an institution where, in the words of one family member, “everything that happens keeps you off center.” For physicians, this process has occurred and is occurring over a longer period of time of medical education and formation. Physicians’ ties to local communities are frayed and, in the words of one doctor, “we belong to the hospitals in which we train and practice.” Estranged in varying degrees from their previous contexts of meaning, these strangers then meet to interpret and act upon the patient’s bodily estrangement. The disruption of the hospital intensifies the epistemic vulnerability that marks the experience of bodily disruption. Kay Toombs chronicled this conversion as patients learn to understand their bodies as diseased through the vocabulary and concepts of a medical imaginary. According to Jeffrey Bishop, this conversion strips away accounts of form and purpose in order to consider the body strictly in terms of efficient and material causality.

In the ICU, we see the development of arrangements of discourses, practices, and practitioners that create the conditions and possibilities for this pathway of perception. The ICU, that “quintessence” of modern medicine, displays the forces of scientific medicine at work mapping and manipulating the patient’s body as an object. As the ventilator moves a

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107 Sharon Kaufman, …And a Time to Die, 85.
108 Nussbaum, 15.
patient’s chest up and down, we see a clear manifestation of the modern body as bare life, dominated by wills empowered by a variety of technologies. Furthermore, the ICU is housed within the teaching hospital, an institution whose modern form emerged during the French Revolution. The teaching hospital trains medical residents to become physician-scientists, as Flexner’s report envisioned. Medical practitioners are formed within the hospital as moral agents seeking the most efficient and effective means of bodily control. Given the force of these bodily relations, what moral response is fitting? How should we seek to govern the relations between these strangers in the strange context of the modern ICU, where the body is imagined and engaged as an object?

Here we can see the import of this project’s methodological approach. By attending to the medical imaginary paradigmatically found within the modern ICU, we are in a position to make judgments about the fittingness of moral theories as responses to this moral context. In our last chapter, we were able to judge the possibilities and challenges facing a particular moral theory in its responses to two related but distinct medical imaginaries found within the surgical and oncology wards. In this chapter, we seek to judge between the fittingness of two related but distinct moral responses in light of a single medical imaginary found within the ICU. Therefore, we will consider two possible moral responses, both contained within the thought of H. Tristram Engelhardt, Jr. The first is the more explicit moral theory found throughout his work and for which Engelhardt is famous; the second, more implicit option from Engelhardt is developed further within the concluding pages of Bishop’s *The Anticipatory Corpse*. In detailing these responses, we will be able to make judgments about which response is most fitting to the modern medical imaginary explored within this chapter. We begin with an account of the significance of Engelhardt and his work.
3.6.1 Engelhardt in Context: A Contrarian and a Convert

Trained as both a philosopher and a physician, H. Tristram Engelhardt Jr., has been involved in the field of bioethics since some of its earliest days. Along with Edmund Pellegrino, he founded *The Journal of Medicine and Philosophy*, and Engelhardt also co-founded the longstanding *Philosophy and Medicine* book series. He was one of the first Americans to enter into international dialogues in bioethics, and in particular he has maintained a longstanding connection with Chinese bioethics. As we discussed in chapter two, one of his earliest philosophical contributions was to modern bioethics’ foundational document, *The Belmont Report*, along with James Childress. As Albert Jonsen notes in *The Birth of Bioethics*, Engelhardt was one of the select few philosophers and theologians invited to contribute a philosophical essay for the consideration of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. Jonsen, who was a part of this federal Commission, describes their effort to narrow down a set of principles:

We also had in our dossier of philosophical essays H. Tristram Engelhardt’s paper which had suggested three basic principles: “respect for persons as free moral agents, concern to support the best interests of human subjects in research, intent in assuring that the use of human subjects of experimentation will on the sum redound to the benefit of society.” Tom Beauchamp had also contributed a paper entitled “Distributive justice and orally relevant differences.” After much discussion the commissioners took Engelhardt’s first two principles and Beauchamp’s principle of distributive justice and crafted “crisp” principles: respect for persons, beneficence, and justice.

Out of these collaborations, Jonsen writes, *The Belmont Report* was conceived. Engelhardt himself is not particularly proud of the part he played; when referring to this moment, he

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110 As described earlier in chapter two, James Childress was another of the invited intellectual sources.

says that he “must confess the sins of his youth, which include a contribution to the salience of principlism.”\footnote{H. Tristram Engelhardt, Jr., *The Foundations of Christian Bioethics* (Lisse, NL: Swets & Zeitlinger Publishers, 2000), 66n.118. In his own defense, Engelhardt notes that his “first principle was not equivalent to the principle of autonomy” and that “his goal has been to reconstruct the dominant moral visions of the time.”}

This comment draws attention to two important features of Engelhardt and his work.

First, Engelhardt delights in controversial and contrarian philosophical positions. Jonsen captures Engelhardt’s contentious spirit well, saying, “Engelhardt has been the *enfant terrible* of bioethics: irrepressible, irreverent, unpredictable, but ever insightful and brilliant.”\footnote{Jonsen, *The Birth of Bioethics*, 82. Gerald McKenny makes a similar claim about the relationship between Engelhardt and Christian ethics. In describing the scope of Engelhardt’s project, McKenny writes, “Part theology, part moral philosophy, part intellectual history, part cultural criticism, Engelhardt’s project shares the scope and ambition of the projects of thinkers like Alasdair MacIntyre and John Milbank. Like their work, his is both erudite, in a nonspecialist sort of way, and idiosyncratic. Like theirs, his work is at once a moral argument, a genealogy of modern ethics, and the articulation of a concrete ethical vision as an alternative to modern ethics. And like theirs, his work is an audacious indictment against the entirety of modern Western ethics and politics.” See Gerald McKenny, “Desire for the Transcendent: Engelhardt and Christian Ethics,” in *At the Roots of Christian Bioethics: Critical Essays on the Thought of H. Tristram Engelhardt, Jr.*, ed. Ana Smith Iltis and Mark J. Cherry (Salem, MA: M&M Scrivener Press, 2010), 107.}

Second, it is impossible to overstate the importance of Engelhardt’s conversion to Orthodox Christianity for his life and thought.\footnote{For Engelhardt’s own account of his conversion, see his chapter “A Journey to the East: Coming to Right Worship and Right Belief,” in *Turning East: Contemporary Philosophers and the Ancient Christian Faith*, ed. Rico Vitz (Yonkers, NY: St. Vladimir’s Seminary Press, 2012), 211-240.} The contrarian and converted nature of Engelhardt’s thought are on display in a well-known passage at the start of the second edition of *The Foundations of Bioethics*, where he writes,

> If one wants more than secular reason can disclose—and one should want more—then one should join a religion and be careful to choose the right one. Canonical moral content will not be found outside of a particular moral narrative, a view from somewhere….I indeed affirm the canonical, concrete moral narrative, but realize it cannot be given by reason, only by grace. I am, after all, a born-again Texan Orthodox Catholic, a convert by choice and conviction, through grace and in repentance for sins innumerable (including a first edition upon which much improvement was needed). My moral perspective does not lack content. I am of the firm conviction that, save for God’s mercy, those who willfully engage in much that a peaceable fully secular state will permit (e.g., euthanasia and direct abortion on demand) stand in danger of hell’s eternal fires. As a Texan, I puzzle whether these
are kindled with mesquite live oak, or trash cedar. Being schooled in theology, I know that this is a question to be answered only on the Last Day by the Almighty.\footnote{H. Tristram Engelhardt, Jr., The Foundation of Bioethics, 2nd ed. (New York: Oxford University Press, 1986; 1996), xi. In the ten years between the two editions, Engelhardt became Orthodox. The significant rewrite that occurred during those periods indicates that the second edition should be taken to represent his mature philosophical position, particularly when taken in concert with the content-full morality found within The Foundations of Christian Bioethics. Unless otherwise indicated, all references to The Foundations of Bioethics will be to the second edition.}

We will return to the philosophical and theological implications of Engelhardt’s account of his conversion to a content-full Orthodox bioethics. As we shall see, his admonition to “be careful to choose” the right religion is telling for his understanding of theology and the moral life.

But for now, it is worth noting the complexity of this “born-again Texan Orthodox Catholic”: in The Foundations of Bioethics, we find him arguing for the limits of secular reason, often in a fashion that he takes to be a kind of reductio ad absurdum (e.g., content-less secular reason permits euthanasia, abortion, and scores of other actions he finds abhorrent); while in The Foundations of Christian Bioethics he maintains that a true content-full Orthodox morality understands those engaging in such acts to be in danger of the fires of hell. The complexity of Engelhardt’s position presents two possible responses to the moral context we have outlined so far in this chapter. We begin with the bare protections of a permission-based morality, before turning to Engelhardt’s second, more sectarian position.

### 3.6.2 Moral Response 1: Engelhardt as Individualistic Libertarian

The first response, for which Engelhardt is famous, is to decry the moral chaos of modernity and delimit the bare, procedural morality fitting for our fragmented secular context. This is not because Engelhardt believes that the moral life has few demands; rather,
he thinks that the limits of secular reason can only impose a highly limited moral framework. In a typical passage, Engelhardt describes our society’s moral condition as follows:

We find ourselves alone. We are left without ultimate purpose or orientation…..Blind to final purposes, we turn to ourselves for meaning. As moral strangers, within the fabric of secular morality, we confront godlike choices with impoverished human vision, and without ultimate guideposts.\footnote{Engelhardt, \textit{The Foundations of Bioethics}, 411. Engelhardt echoes the apocalyptic moral landscape with which Alasdair MacIntyre begins \textit{After Virtue}, drawing upon MacIntyre’s account of our modern moral condition at several points throughout his work. However, while Engelhardt assumes MacIntyre’s account of our moral devastation, he does not assume MacIntyre’s account of the traditioned nature of moral inquiry.}

Engelhardt envisions a secular world in which content-full morality is unavailable to a society filled with moral strangers. In its place, the best we can secure is “a procedure by which moral strangers can create webs of morally authorized undertakings, including endeavors in health care.”\footnote{Engelhardt, \textit{The Foundations of Bioethics}, x. Engelhardt is very much a binary thinker when it comes to morality. “Morality is available on two levels: the content-full morality of moral friends, and the procedural morality binding moral strangers” 9. For the difference between moral friends and moral strangers and their belonging to communities and society, respectively, see pp. 6-8, with an important proviso on p. 24n.13.} Key to this procedure is the principle of permission, through which moral agents-as-strangers reach something like contractual agreements with one another in the place of shared moral understanding. This emphasis on the importance of granting permission lends itself to the notion of consent in modern medicine, and so perhaps it should come as no surprise that Engelhardt has been influential in the development of this bioethical principle since \textit{The Belmont Report}. However, Engelhardt’s emphasis on permission and thus consent should not be taken as cohering with the approach of Beauchamp and Childress’s \textit{Principles of Biomedical Ethics}, which we briefly engaged in our previous chapter. According to Engelhardt, Beauchamp and Childress do not fully consider the depth of our moral disagreement. To understand why, we must consider Engelhardt’s understanding of the nature of moral disagreement and resolution. This will also make clear the importance of permission within Engelhardt’s moral theory.
Engelhardt begins his chapter, “The Intellectual Bases of Bioethics,” with the claim, “Moral controversies appear irresolvable.”\(^\text{118}\) He then proceeds to argue for the ways in which seven prominent approaches to bioethics fail to resolve moral controversies before finally asserting that “controversies can be resolved on the basis of (1) force, (2) conversion of one party to the other party’s viewpoint, (3) sound rational argument, and (4) agreement,” with agreement referring to mutual consent.\(^\text{119}\) In Engelhardt’s vision of a peaceful society, he wishes to avoid resolving arguments through force at all costs. Engelhardt maintains that something like conversion is presumed by theorists like Rawls and Rorty whose appeals to a societal moral consensus do not fully consider the depth of our moral diversity.\(^\text{120}\) Similarly, the so-called “common morality” of Beauchamp and Childress depends on this illusion of consensus.\(^\text{121}\) Because we come together in society as diverse moral strangers, we do not share the moral premises or moral authorities to resolve moral controversies through sound rational argument. And so we are left with contract-like agreement achieved through permission. As he writes,

> To rephrase the point, because there are no decisive secular arguments to establish that one concrete view of the moral life is better morally than its rivals, and since all have not converted to a single moral viewpoint, secular moral authority is the authority of consent. Authority is not that of coercive power, or of God’s will, or of reason, but simply the authority of the agreement of those who decide to collaborate.\(^\text{122}\)

Here we see Engelhardt display a fundamentally libertarian commitment to protecting the free encounters of consenting adults, and this commitment goes to the heart of his moral

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\(^{119}\) Ibid., 67.

\(^{120}\) Ibid., 67-68.

\(^{121}\) In a reference to Beauchamp and Childress, Engelhardt writes, “If such teleologists and deontologists lived in the same moral lifeworld before their theoretical reconstruction of their morality, it is not at all amazing that their different theoretical apparatuses generally justify the same choices” ibid., 57.

\(^{122}\) Ibid., 68.
theory. As he says at the start of The Foundations of Bioethics, “the morality that binds strangers has an unavoidably libertarian character.”\(^{123}\) In a moment we will return to Engelhardt’s claims about coercion and conversion in light of our understanding of the practices and transformations occurring in the ICU. But for now, we continue to consider what is entailed by Engelhardt’s moral theory and the notion of permission governing the encounter between moral strangers, and whether or not that moral response is fitting for the moral context of the ICU.

Given the multiple modes of estrangement that mark the encounter between patients and healthcare practitioners, Engelhardt’s emphasis on permission as the bedrock moral principle perhaps seems appropriate. After all, if we do not know whom we are meeting in the hospital and if, on top of that, we have little sense of ourselves as we experience bodily disruption, we should be careful to place safeguards around these interactions. As Engelhardt writes,

> Where one in fact does not share the moral presumptions of those with whom one works, one must seek ways of protecting against misunderstanding. Bureaucratic rules and formulations are inevitable in such circumstances. They provide formal guidance where informal agreement cannot be presumed.\(^{124}\)

These rules and regulations around permission (and with it, disclosure and consent) exist “as protections against individuals’ imposing their understandings of the good life on unwilling others.”\(^{125}\) This effort to strengthen persons against the domination of others seems like an appropriate moral response to the moral landscape described by Toombs, Kaufman, and

\(^{123}\) Engelhardt, The Foundations of Bioethics, x. When considering Engelhardt’s libertarian inclinations, it is worth noting that Robert Nozick is the most cited contemporary thinker in The Foundations of Bioethics; the only persons to appear more frequently in Engelhardt’s text are Kant and Hegel.

\(^{124}\) Ibid., 82. As he writes later, “Much of the formal bureaucratic structure for disclosure and consent in countries such as the United States is a function of the fact that in peaceable, secular pluralist societies health professionals and patients recurringly meet as strangers” 297.

\(^{125}\) Ibid., 299.
Bishop. If patients are subject to the willful control of physician-scientists, then perhaps we should focus our moral efforts on promoting the power of the patient’s will through the concept of permission. And yet in light of the forces of bodily formation described above, a focus on consent and permission seems rather insufficient. To understand why, we turn to Engelhardt’s philosophical anthropo-
logy, which is closely connected to his libertarian secular morality.

For Engelhardt, the limits of secular reason are only capable of securing moral standing in secular society for “persons,” not all human beings. Persons are marked by the “four characteristics of self-consciousness, rationality, moral sense, and freedom,” which “identify those entities capable of moral discourse, capable of creating and sustaining a moral community, capable of giving permission.” 126 Only such entities count as persons and are covered under “the principle of permission and its elaboration in the secular morality of mutual respect.” 127 This is, of course, a radically curtailed notion of personhood. As a reminder, this kind of moral reasoning is not what Engelhardt personally believes; instead, it is all he thinks is defensible according to the standards of secular morality.

Engelhardt proceeds to take on several challenges to this account of personhood, using the standards of secular reason. One of these is the question, “What is the secular moral standing of a sleeping person?” 128 After all, the sleeping person does not experience self-consciousness as we normally consider it, and notions of rationality, moral sense, and freedom are hard to defend for those sleeping, except perhaps in the most vivid of dreams. To answer this question, he turns to our embodiment as persons: it is our spatiotemporal

126 Ibid., 138.
127 Ibid.
128 Ibid., 151.
continuity that makes possible personhood over times when, say, we are sleeping and so are
not “persons” in the strict sense. Tellingly, Engelhardt immediately moves from this
discussion of embodiment to offering an account of things that persons own. Drawing from
John Locke for an account of property rights, Engelhardt argues that the body is the
paradigmatic example of something a person owns.

One’s body must be respected as one’s person, for the morality of mutual respect
secures one’s possession of one’s self, and one’s claims against others who would use
one’s body or one’s talents without one’s permission. Again, since spatiotemporally
extended persons must occupy a space, to act against that space or place is to act
against such persons themselves. Such unconsented-to interference would be an
action against the very notion of mutual respect and the peaceable community.\(^1\)

Persons and the things persons own—including and especially their bodies—are subject to
the respect afforded by the principle of permission. This means that permission is the
defining moral standard by which any encroachment upon one’s personhood is judged. If
this sounds like a particularly libertarian conception of the moral life, that should come as no
surprise; recall that Engelhardt claims that “the morality that binds strangers has an
unavoidably libertarian character.”\(^2\) In moral encounters, then, “persons can convey
authority over themselves to others and in doing so convey authority over their bodies.”\(^3\)

Is this principle of permission governing authority over one’s body as one’s property a
fitting response to the medical imaginary revealed paradigmatically in the ICU? For
Engelhardt, the implications for the practice of medicine are straightforward:

It is around various expressions of the principle of permission that relations between
patients, physicians, and other health care workers take shape….In health care men
and women create a web of expectations and permissions through agreements to
being touched and explored by others, through commitments to confidentiality and

\(^1\) Ibid., 155.
\(^2\) Ibid., x.
\(^3\) Ibid., 155.
the keeping of special trusts, and by fashioning common understandings of goals to be jointly pursued.132

These relations take shape in order to resolve controversies that accompany the intimate, bodily nature of medical practice, but, as we have seen, they are anything but straightforward. As we saw in our phenomenological and ethnographic explorations, the “web of expectations and permissions” created between practitioners and patients is not a value-free procedural enterprise of giving and receiving permission and authority. Instead, the agents involved are transformed as the patient’s body is medicalized.

The moral formation undergone within the ICU raises at least two issues for Engelhardt’s account of how to resolve ethical questions, both of which are connected to a deeper conceptual problem. First, recall Bishop’s argument, drawn from Foucault, that modern medicine strips away final and formal causality, leaving efficient and material causes to govern the body. How is that not, on Engelhardt’s terms, a form of “force” or “coercive power”?133 And second, following Toombs’s phenomenology, patients undergo a conversion of perception and self-understanding as they move from the lived experience of bodily disruption to perceiving this experience through the descriptive categories of disease. How is such a movement not the resolution of moral controversy through what Engelhardt refers to as the “conversion of one party to the other party’s viewpoint” rather than the granting of permission?134

Within the context of Engelhardt’s understanding of how moral controversies can be resolved, these two objections point to a key conceptual question about how permission is

132 Ibid., 289.
133 Ibid., 67
134 Ibid.
defined in contrast to coercion and conversion. When engaging Engelhardt, McKenny raises this question pointedly in regards to coercion, writing,

> Any answer to this question [of what counts as permission] will have to formulate criteria to distinguish permission from coercion and to determine to what extent one must know what one is permitting. There are thin notions of permission that require minimal thresholds of knowledge…and of non-coercion….There are also thick notions of permission that set more robust requirements for knowledge…and for non-coercion….And, of course, there are many degrees of thinness and thickness. ¹³⁵

This claim about differing ways to differentiate between permission and coercion matters directly for the bodily forces described by Bishop and Foucault, and it applies analogously to the question of conversion raised by Toombs’s phenomenological account. And so contrary to Engelhardt’s efforts to offer a secular morality available to all moral strangers, McKenny says, “There is no concept of permission which itself is purely procedural, lacking content, and therefore available as a default position when all substantive conceptions turn out to have relied on a particular moral sense.” ¹³⁶ If this is the case, then Engelhardt’s response to the moral context paradigmatically represented by the ICU fails on his own terms; his moral theory’s emphasis on permission is unable to address the questions of coercion and conversion that arise in the practices and discourses that are brought to bear on patients in the modern hospital.

Engelhardt responds to McKenny by claiming that the question of whether or not permission has been given is “a dispute about a bare fact of the matter, though surely a fact overlain with moral significance.” Engelhardt goes on to explain:

> The question as to whether permission has been given by one person to another particular person without coercion by the permission receiver is not necessarily a moral question. It can be a factual question as to whether the persons in question have entered into the practice of resolving controversies on the basis of agreement.

¹³⁶ Ibid., 113.
This is not to deny that various moral and other normative commitments frame the context of discovery, thus shaping the facts one perceives to be facts of the matter.\footnote{H. Tristram Engelhardt, Jr., “Re-reading Re-reading Engelhardt,” in \textit{At the Roots of Christian Bioethics: Critical Essays on the Thought of H. Tristram Engelhardt, Jr.}, ed. by Ana Smith Iltis and Mark J. Cherry (Salem, MA: M&M Scrivener Press, 2010), 295-296.} Despite the last sentence’s qualification about the formation of perception, Engelhardt’s response falls prey to a problematic fact-value divide. Any effort to answer the “factual question” of whether persons are in the process of “resolving controversies on the basis of agreement” will be subject to disputes over the nature of such a practice, as McKenny argues.\footnote{Although Engelhardt draws from MacIntyre at several points, he considers his supposedly content-less concept of permission to escape MacIntyre’s critique of “the Enlightenment dream” (\textit{Foundations of Bioethics}, 92, n. 73). In \textit{Whose Justice? Which Rationality?}, MacIntyre’s offers a pithy response to appeals to “bare facts of the matter,” like Engelhardt’s, saying, “Facts, like telescopes and wigs for gentlemen, were a seventeenth-century invention” 357.} What one doctor considers mutual agreement may well be conversion or coercion, and Engelhardt gives little guidance for how to distinguish between the three.

Engelhardt seems to undercut his own response to McKenny in a chapter, “The Languages of Medicalization,” that stands out as not quite fitting in with the approach found in the rest of \textit{The Foundations of Bioethics}.\footnote{It is perhaps telling that this chapter is the only part of \textit{The Foundations of Bioethics} that was not significantly rewritten for the second edition. Engelhardt, \textit{The Foundations of Bioethics}, xii.} In it, he goes much further in recognizing the formative power of medicine to shape our field of perception than in the brief qualification he offers in response to McKenny. He begins the chapter by stating,

\begin{quote}
Medicine medicalizes reality. It creates a world. It translates sets of problems into its own terms. Medicine molds the ways in which the world of experience takes shape; it conditions reality for us. The difficulties people have are then appreciated as illnesses, diseases, deformities, and medical abnormalities, rather than as innocent vexations, normal pains, or possession by the devil.\footnote{Ibid., 189.}
\end{quote}

Such an account of how medicine “creates a world” undercuts the fact-value distinction that Engelhardt invokes to defend his notion of a content-less permission. Engelhardt’s account here actually seems to comport with much of the phenomenological work we did at the
beginning of this chapter. Recall that Kay Toombs draws from Engelhardt’s early essay, “Illnesses, Diseases, and Sicknesses,” to support her own phenomenological account. In “The Languages of Medicalization,” Engelhardt continues his work in phenomenology in ways that stand in strong continuity with the approach of this chapter, pointing to the ways that perception is formed in medical encounters. But this account stands in contrast to Engelhardt’s own proposal for a content-less morality based upon the giving and receiving of permission.

As we have explored throughout this chapter, drawing from the work of Kaufman, Bishop, and Foucault, the phenomenological appearance of the body as an object before a medical gaze has a history. Engelhardt agrees, arguing, “All knowledge is historically and culturally conditioned, and the influence of history and culture is often, as we shall see, particularly marked in medicine.”\footnote{Ibid., 190.} He then goes on to describe these influences, even drawing briefly from Foucault and Bichat to describe the transformations in knowing and practice brought about by the anatomical and physiological turn.\footnote{Ibid., 214-217.} Engelhardt concludes this examination by noting the great power of medical naming to shape the world of practitioners and patients alike, and compares such formative power to the ability of other major social institutions like religion and law to create social worlds through acts like excommunication and judicial verdicts.\footnote{Ibid., 222.} Because of this, Engelhardt proposes,
It is therefore important to decide how a problem will be understood. In deciding where to place a problem, one changes the frame of reference for interventions. In medicalizing a set of problems, one may relieve afflicted individuals of one set of disvaluations and encumber them with another.\textsuperscript{144}

This claim by Engelhardt is in fundamental agreement with the approach of this dissertation: how we perceive and speak the world shapes our actions within it. For bioethics, moral theory must be constructed in response to the problems of action that arise from the ways in which the body is imagined and engaged in healthcare.

The account of scientific medicine’s objectification of the body chronicled throughout their chapter presents moral difficulties that the giving and receiving of permission is inadequate to resolve. The shaping of perception through the formational arrangements of discourses, practices, and practitioners that have developed in the ICU means that no account of permission stands alone apart from questions of coercion and conversion. While he cannot admit as much, Engelhardt’s argument in “The Languages of Medicalization” points toward the same conclusion. He is unable to conclude the chapter by strictly appealing to a secular morality of permission, the concept that frames the rest of his moral theory. Instead, after noting the importance of informed consent, he is forced to recognize that “the very characterization of reality can thus become a moral issue,”\textsuperscript{145} and because of this he draws the chapter to a close by turning to alternate communities of description. “The issue of who decides,” he argues, “is thus moved from the area of individual free and informed consent to a communal area of negotiations regarding construals of reality.”\textsuperscript{146}

There is a major conceptual shift contained within this one chapter of \textit{The Foundations of

\textsuperscript{144} Ibid., 224.
\textsuperscript{145} Ibid., 225.
\textsuperscript{146} Ibid., 226.
By following it, we move from Engelhardt’s individualistic libertarianism to a second strand found within his thought.

3.6.3 Moral Response 2A: Engelhardt as Communal Libertarian

Engelhardt claims that the libertarianism that marks the morality of strangers is hospitable to communities of robust moral commitments where one can find what he calls the morality of friends. In Engelhardt’s account, secular morality opens up space for both individuals and communities of “consenting collaborators” to coexist peaceably. This requires attention to more than individual encounters between two persons who give and receive permission. Within medicine, this means that “communities of physicians, insurers, and the various publics will need to negotiate regarding the characterization they will employ when they collaborate.”

This recognition of communal contexts of meaning entails a rather radical claim near the end of Engelhardt’s chapter on medicalization in *The Foundations of Bioethics*: because “the medicalization of reality will vary from community to community,” then medical choices are preceded by choices about the community of interpretation to which one belongs.

A traditional Roman Catholic community is likely to have understandings of health, disease, disorder, deviance, and disability quite different from those of a community of secularized cosmopolitans. Their different constructions of medical reality can then be embedded in alternative health care systems, which carry with them quite different understandings of what should count as a disease to be treated and of what treatment expenses should be sustained by the community.

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147 As Engelhardt writes in his “Preface” to *The Foundations of Bioethics*, “This libertarian character of a defensible general secular morality is not antagonistic to the moralities of concrete moral communities whose peaceable commitments may be far from libertarian (e.g., the communism of monasteries). In actual communities framed around content-full moralities, liberty is usually far from the most important good….The arguments in *The Foundations of Bioethics* are not opposed to such sentiments within particular, peaceable, moral communities. Strictly, with respect to such sentiments, the agreements are neutral” (x). However, as we will see at the conclusion of this chapter, the notion of the church as a community of “consenting collaborators” (227) is one that Christians should reject.

148 Ibid., 227.

149 Ibid., 227.
Engelhardt does not pursue this line of inquiry further in *The Foundations of Bioethics*, which is a work overwhelmingly concerned with individual morality according to the standards of secular reason. However, Engelhardt’s libertarianism refracted through the choice of moral communities raises a second potential response to the medical imaginary discerned paradigmatically within the ICU. Rather than focusing on consent between strangers, the fitting moral response to medicine’s objectification of the body is a focus on communal formation that ultimately may demand a kind of separatism.

In *The Foundations of Christian Bioethics*, Engelhardt offers his own thick conception of a morality of friends, based upon the teachings of Orthodox Christianity as found within its first thousand years. In it we can discern more clearly this second, more communal strand of libertarian thinking within Engelhardt’s thought, but even here he maintains a theoretical framework that strongly privileges an individualistic libertarian morality within secular society. He offers a conceptual account of the existence of a community of friends within a society of strangers as his effort to carve out space for religious communities in a society governed by secular reason. And so he says,

> A libertarian cosmopolitan ethic will not impose a particular moral vision, but allow communities to pursue with consenting collaborators their own understanding of human flourishing. Thus, traditional Christian communities would be free to regulate themselves and to pursue freely and peaceably their understanding of salvation.”

Engelhardt later references John Locke on “the voluntary nature of ecclesial bodies” in an effort to justify religious communities as “deriving their moral authority from the consent of those who participate.” On this account of a libertarianism open to voluntary communal associations, Engelhardt argues that “non-geographically located religious communities

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151 Ibid., 136, where he draws from John Locke’s *A Letter Concerning Toleration*. 249
could offer the possibility of numerous parallel, even international, religious health care networks, each with its own bioethics. Religious and other communities could maintain their own moralities in their various religious, educational, and health care institutions.”152 This is the institutional manifestation of Engelhardt’s comment that one should be careful to “choose” the right religion.

After detailing how the recovery of an Orthodox bioethics would approach moral questions at the beginning and end of life, Engelhardt returns to these institutional concerns at the very end of the last substantive chapter in *The Foundations of Christian Bioethics*, which closes with a section on “The Integrity of Christian Health Care Institutions.”153 In order to resist the “the intrusion of all-encompassing secular health care systems,” Engelhardt proposes the creation of separate institutional networks devoted to various forms of Christian care for the sick.154 He then briefly describes two possible ways this could occur through global Roman Catholic and Orthodox Christian healthcare systems. Ever the contrarian, Engelhardt cannot end his chapter with a parallel description of these two traditions as offering distinct but compelling Christian options for healthcare. Instead, he concludes by declaring the superiority of Orthodox Christianity over Roman Catholic approaches to moral reasoning, a perpetual theme of his writing over the last two decades. It should come as no surprise that he does so in a libertarian way, through an extended quotation from Friedrich Hayek that dismisses the Catholic desire for “social justice” as an overly immanent concern. According to Engelhardt, Catholics easily lose sight of the pursuit

152 Ibid., 136-137.
153 Ibid., 379-383.
154 Ibid., 380.
of salvation and holiness that is central for Orthodox Christians and their practice of healthcare.\textsuperscript{155}

Because his libertarian commitments center on the individual giving and receiving permission, Engelhardt’s effort to make conceptual space for separate religious communities of health care can be easily missed, especially in his earlier writings. Engelhardt’s individualistic libertarianism often occludes his descriptions of a more communal libertarianism, in which agents can choose to locate themselves within various institutional options that carry substantive moral commitments. But as we have noted, the moral concerns arising within the modern ICU and the medicalization and objectification of the body are not well met by individualistic notions of permission. Instead, these concerns point to the need for alternate modes of imagining, practicing, and housing medicine. Exchanges of individual consent are at best secondary, and a structural response is required, reversing the emphases within Engelhardt’s thought. Just such a response can be discerned under the surface of the closing chapter of Jeffrey Bishop’s \textit{The Anticipatory Corpse}. Bishop’s theoretical framework, built upon the work of Michel Foucault and further developed in his closing chapter through dialogue with Alasdair MacIntyre, is much more amenable to describing the need for institutional and structural responses than Engelhardt’s moral approach, which, as we saw, is steeped in the individualistic libertarian impulses of John Locke and Robert Nozick. In response to the medical imaginary found within the modern ICU, we turn now to describing the separatist impulses within Bishop’s closing chapter as the most fitting expression of this communal strand in Engelhardt’s thought.

\textsuperscript{155} Ibid., 383.
3.6.4 Moral Response 2B: Jeffrey Bishop as Separatist

Bishop’s argument in *The Anticipatory Corpse*, beginning with the French Revolution and culminating in the modern ICU, claims that modern medicine is a *metanoia*, a mutation in the practice of medicine that has resulted in the emergence of something radically new and different. Within the teaching hospital in general and the ICU in particular, we discern a new form of medicine that is wholly captive to the logics of efficient and material causality. If this is true, then the modern hospital, as represented paradigmatically by the ICU, is a distinct community of moral formation that may be incommensurable with other communities committed to the practice of healthcare. Such an understanding requires a radical moral response. The final chapter of *The Anticipatory Corpse* hints at just such an intervention, though this constructive turn is brief and given with “hesitation,” for “diagnosis is easy; therapy is difficult.” And yet in Bishop’s constructive proposal we can discern an intensification of the communal libertarian line found within Engelhardt.

Bishop argues that medicine should be housed within separate “local communities of robust metaphysical commitments.” It is “there,” he claims, “in living traditions informed by a different understanding of space and time … [that] we will find a unity of material, function, form, and purpose.” Although Bishop refuses to offer a detailed course of treatment, his closing therapeutic turn warrants serious examination as a response to the medical imaginary found paradigmatically within the modern ICU—especially because of its implicit separatist impulse. For if modern medicine represents a rupture in the practice of medicine, then in response Bishop can be read as proposing *epistrophe*, conversion via return

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157 Ibid., 311.
158 Ibid., 313.
to an ancient moral vision housed within traditional forms of life, and with it alternate and separate institutional homes for the practice of medicine.

As detailed above, The Anticipatory Corpse carefully attends to the formative power of practices and discourses, drawing from and developing the work of Foucault. As we have seen, the concept of permission does not carry the moral weight necessary to respond to the forces of coercion and conversion found within the modern ICU. In light of this intense moral formation, the influence of MacIntyre on Bishop’s work emerges more fully in the book’s closing pages. Here we can begin to discern the moral response to modern medicine taking on institutional form, as Bishop describes an alternative social space in which the goods of medicine can be properly instantiated and pursued. Bishop closes by “tentatively” suggesting further exploration into

the ways in which local communities of robust metaphysical commitments are necessary to the discernment of what counts as a call from a suffering other, of how one might rightly receive that call, and of what a proper response to a call might look like. To do so, one would have to be immersed in and to believe in the metaphysical commitments of a particular community at a given time and place.159

While it is left unclear whether these local communities must provide virtuous formation for medical practitioners working within the current world of medicine or whether these communities must form their own alternate medical institutions for training practitioners and practicing medicine, a separatist preference can be unearthed by examining Bishop’s analysis alongside a particular reading of MacIntyre.

By reading these final passages from The Anticipatory Corpse as a meditation on the closing words of MacIntyre’s After Virtue, we may begin to discern an implicit therapeutic plan within Bishop’s account. As MacIntyre famously states:

159 Ibid., 311-312.
If my account of our moral condition is correct, we ought also to conclude that for some time now we too have reached [a] turning point. What matters at this stage is the construction of local forms of community within which civility and the intellectual and moral life can be sustained through the new dark ages which are already upon us. And if the tradition of the virtues was able to survive the horrors of the last dark ages, we are not entirely without grounds for hope. This time however the barbarians are not waiting beyond the frontiers; they have already been governing us for quite some time. And it is our lack of consciousness of this that constitutes part of our predicament. We are waiting not for a Godot, but for another—doubtless very different—St. Benedict.\footnote{MacIntyre, \textit{After Virtue}, 263.}

Bishop himself invokes this passage from MacIntyre in his essay, “Waiting for St. Benedict among the Ruins: MacIntyre and Medical Practice,” published the same year as \textit{The Anticipatory Corpse}.\footnote{Jeffrey Bishop, “Waiting for St. Benedict among the Ruins: MacIntyre and Medical Practice,” \textit{Journal of Medicine and Philosophy} 36 (2011): 107-113. The essay introduces a special issue of the \textit{Journal of Medicine and Philosophy} devoted to MacIntyrean accounts and critiques of modern medical practice.} Here Bishop situates his account of modern medicine within MacIntyre’s conceptual schema, saying, “The incoherence of many of medicine’s practices arises from the ruins of a predecessor culture to which medicine…denies any relationship.”\footnote{Ibid., 113.} His final word is an admonition to hope, not despair, but it is a hope couched within the yearning for the instantiation of a new, separate practice of medicine: “for there is work to be done amongst the ruins, even while we await the next St. Benedict.”\footnote{Ibid.}

MacIntyre’s closing words in \textit{After Virtue}, when coupled with both Bishop’s invocation of MacIntyre in “Waiting for St. Benedict among the Ruins” and the powerful critique of modern medicine in \textit{The Anticipatory Corpse}, make it possible to understand Bishop’s work as a cry of apocalyptic alarm meant to rouse people of good will in medicine from their slumber. As MacIntyre argues, such people should no longer engage in the modern equivalent of “shoring up the Roman imperium,” and they must cease identifying “the
continuation of civility and moral community with the maintenance of that imperium.”

On Bishop’s account, this may mean that medical practitioners concerned about the future of medicine must stop devoting their energies to malformed institutions and their arrangements of discourses, practices, and practitioners that are incapable of attending to the form and purpose of human life. Instead, they must begin to construct alternate and separate communities, following the way of St. Benedict—or St. Basil, given that both Bishop and Engelhardt are Orthodox Christian converts.

Thus, when Bishop concludes his book by asking, “Might it not be that only theology can save medicine?,” we should hear in his question a call for the creation of separate institutions housing different theological commitments to healthcare, much like these two saints did fifteen hundred years ago.

Given that we live on the other side of the transformations made possible by these two saints, we will consider their legacies for healthcare in our next chapter.

3.7 Conclusion: Trapped in Modernity?

In this chapter, we have traced the objectification of the body in modern medicine, as seen paradigmatically in the ICU. Through Kay Toombs’s work in phenomenology, we described a process of conversion by which a person whose body has been made strange through bodily disruption learns to perceive their body as an object through the

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164 MacIntyre, *After Virtue*, 263.
165 As we shall see in the next chapter, we must take seriously what it means to live on the other side of the innovations and influence of St. Benedict and St. Basil. For more on the influence of Eastern Orthodoxy on Bishop, see his autobiographical essay, “Orthodox Journey,” where Bishop describes how his “life has been a preparation for [his] conversion” to the Orthodox Church, a conversion that was both historically prepared and at the same time freely his “choice.” Jeffrey Bishop, “Orthodox Journey,” in *Turning East: Contemporary Philosophers and the Ancient Christian Faith*, ed. Rico Vitz (Yonkers: St. Vladimir’s Seminary Press, 2012), 364. In this essay, Bishop names his friendship with Engelhardt as the impetus of his conversion, culminated when Engelhardt became his godfather in 2010 (361). For Engelhardt’s conversion, see his essay from that volume, “A Journey to the East.”
166 Bishop, *The Anticipatory Corpse*, 313.
understanding offered by medical discourse. Following Sharon Kaufman and Jeffrey Bishop, the conditions and possibilities of this pathway of perception were explored through ethnographic and historical work on the development of a distinct arrangement of discourses, practices, and practitioners in the modern ICU. Here a medical imaginary construes the body as an object to be known and controlled, and the roots of this medical gaze can be traced back to transformations in the institution of the hospital that occurred during and after the French Revolution. With the rise of the teaching hospital and clinical medicine came the ideal of the physician-scientist, wearing a lab coat while knowing and controlling the body as matter in motion. The physician-scientist’s medical imaginary, as seen paradigmatically in the ICU, has theological, philosophical, and political underpinnings that reduce the person to bare life willfully controlled through these arrangements of discourses, practices, and practitioners. In response to this objectification of the body within the ICU, we traced out two major kinds of moral response, and we attempted to discern which response offered a more fitting bioethics in light of the medical imaginary at hand.

The first moral response is found within Tristram Engelhardt’s work on a morality justifiable by secular reason and capable of governing interactions between moral strangers in a secular society. For Engelhardt, coercion, conversion, and sound rational argument are either unacceptable or impossible in a society of moral strangers, and so he turns to the concept of permission to provide moral guidance. Within the world of healthcare, this means that the giving and receiving of permission to act on the body is the crucial moral act. However, the accounts of formation given by Toombs, Kaufman, Bishop, and others do not support the notion of permission offered by Engelhardt; instead, as we see in the modern ICU, coercion and/or conversion seem much more likely to govern the bodies and
imaginations of those within this paradigmatic medical site. Consequently, we turned to a second mode of moral response, offered first by Engelhardt and then expanded by Bishop. When Engelhardt does acknowledge the importance of formation within modern healthcare, he turns to a more communal libertarianism, which forms a secondary strand within his thought. But he does not pursue this line of reasoning very far, aside from acknowledging that different communities of moral friends should be able to coexist peaceably as alternate options within a secular society. However, Bishop takes this communal concern very seriously, as seen in his constructive response outlined at the close of his book. Here, Bishop interprets Alasdair MacIntyre’s call for a new St. Benedict to mean that the practice of medicine must be founded within alternate communities of robust metaphysical commitments. If the modern hospital is defined throughout by the medical imaginary found within the ICU, then Bishop’s call for a new communal housing for medicine is the most fitting response to the moral issues found within this medical site. Therefore, among the moral responses considered, Bishop’s therapeutic recommendation follows the most accurate diagnosis of the moral problems accompanying the paradigmatic medical imaginary discerned within the modern ICU. If the modern hospital is thoroughly an institution of metanoia, of radical mutation from the past, then Bishop’s moral response is one of institutional epistrope, returning the hospital to its pre-modern roots.

But here we must consider whether, in their desire for separate and pure institutions, Engelhardt and Bishop are still trapped within the logics they are looking to escape. In particular, if the objectification of the body in modern medicine traces its roots back to transformations during and after the French Revolution, that quintessential modern event, then do the therapeutic recommendations offered by Engelhardt and Bishop still channel the
modern assumptions they seek to escape? Recall from our opening discussion of Engelhardt the striking passage from the beginning of his second edition of *The Foundations of Bioethics*, where he declares, “If one wants more than secular reason can disclose—and one should want more—then one should join a religion and be careful to choose the right one.”

Engelhardt then goes on to proclaim himself “a born-again Texan Orthodox Catholic, a convert by choice and conviction.” We conclude by considering the philosophical and theological implications of Engelhardt’s account of his conversion to a content-full Orthodox bioethics. In light of Engelhardt and Bishop’s responses to modern medicine, we can understand the admonition to “be careful to choose” the right religion as a revealingly modern exhortation.

Stanley Hauerwas, like Engelhardt, is a Texan Christian whose work in bioethics carries with it a contrarian streak. In responding to Engelhardt, Hauerwas claims that “the deepest difference” between Engelhardt and himself is their “understanding of Christianity.” But this difference in understanding is not rooted in a theological divide between Orthodoxy and Methodism. “Rather,” Hauerwas says, “our difference is quite simply I think being Christian is more like being Texan than [Engelhardt] does.” Though couched as a friendly provocation, Hauerwas’s claim is a serious one. For Engelhardt’s advice to choose carefully the right religion betrays his modernist framework. While secular liberals may consider Christian lives as constituted by a religious choice, Hauerwas counters, “To be baptized in Christ’s death and resurrection is to be made part of a people, part of

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168 Ibid.
170 Ibid., 34.
God’s life, rendering the language of choice facile.”¹⁷¹ Engelhardt wisely does not use the
language of “choice” to describe his existence as a Texan, for “such language is surely a
distortion of the great and good reality that comes from finding one’s life constituted by
such a land and people.”¹⁷² But when he uses the language of choice to describe belonging to
a religious community, Engelhardt is still trapped within the modern framework that he
desires to escape.

The problems with Engelhardt’s emphasis on choice for religion also apply to his
desire for separate healthcare institutions. We have already considered ways in which the
concept of permission is not a fitting moral and philosophical response to the modes of
bodily formation found within the modern ICU. But in light of Hauerwas’s response to
Engelhardt, we can also understand the language of choice as a theologically and
philosophically problematic way of understanding the institutional arrangements of
discourses, practices, and practitioners in modern healthcare. By considering various
religious and secular approaches to medicine as options to choose from, Engelhardt and
Bishop reproduce the modern assumptions they are attempting to escape.¹⁷³ As Hauerwas
argues,

The great challenge before Christians in Engelhardt’s world, and I believe it is in fact
the world in which we exist, is how our lives as Christians can be as involuntarily
constituted as being Texan. To be Christian means that we must be embedded in
practices so materially constitutive of our communities that we are not tempted to

¹⁷¹ Ibid., 35.
¹⁷² Ibid.
¹⁷³ A similar modernist presumption sits at the heart of “the Benedict Option,” a proposal put forward by
conservative American commentator Rod Dreher. In response to conservative Christians losing the culture
wars, Dreher advocates a retreat from public life and engagement in an effort to preserve a Christianity he fears
is in danger of disappearing. A thoroughgoing analysis of Dreher’s proposal is beyond the scope of this project,
but it is worth noting that his advocacy for a separatist “option” is quite similar to Engelhardt and Bishop’s
proposals. Moreover, Benedict, Bishop, and Engelhardt are all adult converts to Orthodoxy. See Rod Dreher,
describe our lives in the language offered by the world, that is, the language of choice.\textsuperscript{174}

Within the world of healthcare, Hauerwas’s understanding of the challenge facing Christians today points to an understanding of the hospital as a site of Christian formation.

In response, however, Bishop argues that modern medicine is so corrupted by an objectifying medical imaginary that there may be no ways to consider the practices of medicine as “materially constitutive” of Christian identity. Given the ways we have discerned the body rendered as a medicalized object in the modern ICU, this may indeed be a fair and fitting response. In order to display the conditions and possibilities for faithful Christian moral agency in modern medicine, we must take Bishop’s concerns seriously. To do so would require an account of a medical imaginary in the modern hospital that is “embedded in practices so materially constitutive” of Christian existence and moral agency that we would not feel the need to escape and be tempted by the language of choice. For this, we turn now to an account of the hospital that predates the French Revolution, an account of the development of an institutional arrangement of discourses, practices, and practitioners that does not take the dead body as epistemologically normative but instead anticipates life through hospitable bodily care.

At the end of the first part of \textit{The Anticipatory Corpse}, Bishop asks, “Is it possible to conceive of a nonviolent form of knowledge and, therefore, of a nonviolent form of medicine? Or is violence a basic feature of reality? In other words, can the physician heal

\textsuperscript{174} Hauweras, “Not All Peace Is Peace” 37. Hauweras concludes his response to Engelhardt in language that may seem shocking to those who expect him to represent a sectarian and separatist politics. He says, “Our task as Christians is not to make such a world more terrible than it has a tendency to be, but to survive in and for such a world—not because survival is itself a virtue, but because we have been called by God for whom our survival is a witness and a sign of God’s grace” (122).
without transgression?175 To answer these questions, we must leave behind a theologically
distorted form of bodily control predicated on willful and violent forces being fundamental
to the nature of reality. We must turn from a primary focus on the ICU and the hospital’s
transformation in the French Revolution and instead turn to an alternate medical imaginary
expressed in labor and delivery and the Christian roots of the hospital. In doing so, we can
begin consider what it might mean for medicine to participate in the nonviolent work of the
Spirit, the giver of life, as the Spirit seeks to befriend our bodies, drawing them into the life
of God in Christ.

175 Bishop, *The Anticipatory Corpse*, 95.
Chapter 4
The Body as Friend: Bodily Care in Labor and Delivery and a Hospitable Bioethics

How have women given birth, who has helped them, and how, and why? These are not simply questions of the history of midwifery and obstetrics: they are political questions.

—Adrienne Rich, *Of Woman Born*¹

4.1 Introduction

No blood. No cramps. Is something wrong or is something right?

Just vomit. And nausea, waves and waves of nausea. Is something wrong or is something right?

These questions have no clear answers.

Pregnancy is a bodily disruption that means profoundly different things to different people. This is in part because of fraught questions surrounding “wanted” and “unwanted” pregnancies, and while these questions are particularly pressing after the advent of legalized contraception and abortion, similar questions are voiced by women throughout history. But if it is possible to set aside the debates surrounding contraception and abortion, then we are still confounded by epistemic uncertainty. “What does this mean?” is always a difficult question for someone experiencing bodily disruption, and we can see how this is the case by examining the experience of pregnancy.

The signs are hard to read in even the most straightforward of pregnancies, and they can be complicated in seemingly innumerable ways. Spotting can signal menstruation, miscarriage, or the implantation of an embryo. The same goes for cramping. Intense

vomiting can mark both healthy and ectopic pregnancies. Do these disruptions indicate a new and welcome guest, or a hostile invader? It’s hard to tell during pregnancy, and this uncertainty only intensifies in childbirth.

The uncertainty surrounding this bodily experience contributes to pregnancy being an epistemically underdetermined phenomenon. By describing pregnancy as an “epistemically underdetermined” phenomenon, I am drawing loosely from the thought of Willard van Orman Quine, who argued in various ways over his career that the same empirical observations can be explained by equally tenable theories of meaning. While Quine was primarily working on underdetermination within the philosophy of science, his work has implications for alternate modes of describing bodily disruption. So far in this project, we have described how the body is imagined and engaged as an enemy in the surgical ward and as an object in the ICU. The epistemically underdetermined estrangement experienced by the lived pregnant body can result in the pregnant woman perceiving her body as either an enemy or an object, but a third medical imaginary is also present and possible: the body as friend.

In this chapter, we consider how the body is perceived in our third medical site, the labor and delivery ward. In doing so, we turn to primarily focus on how bodily disruption

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2 For an overview of Quine’s varying descriptions of his underdetermination thesis, see Lars Bergström, “Quine on Underdetermination,” in Perspectives on Quine, eds. R. Barrett and R. Gibson (Cambridge: Blackwell, 1990), 38-52. In a late work, Quine describes underdetermination as follows, “What the empirical underdetermination of global science shows is that there are various defensible ways of conceiving the world.” W.V.O. Quine, Pursuit of Truth (Cambridge, MA: Harvard University Press, 1990), 102. Bergsöm later offers a synthesis of Quine’s differing descriptions of the underdetermination thesis as follows:

In sum, then, the indetermination thesis says that our global system of the world (at any given time) has some, probably unknown, empirically equivalent but irreducible rival, which is equally good as our system. This rival system may even by logically incompatible with ours. Some subtheories of our global system may also be underdetermined in either of both of the two senses just indicated. But the underdetermination thesis should not, or need not, be taken to imply that every subtheory of our global theory is underdetermined. As far as I can tell, this formulation of the thesis may well be in accordance with Quine’s intentions.

can eventually result in the body being viewed as a friend, while also taking seriously the ways in which the body can be perceived and engaged as an enemy and an object. As in previous chapters, we begin with phenomenology, since our actions occur within the world that we perceive. This phenomenological inquiry then will be paired with work in medical anthropology and history in order to discern the arrangements and histories of practices, discourses, and practitioners that result in recognizably distinct modes of perceiving and engaging the body in the modern labor and delivery ward.

From this work in depicting the medical imaginaries at work in the modern labor and delivery ward, we will turn to fitting moral responses. The focus will be on a moral approach that seeks to foster the conditions and possibilities of befriending estranged flesh, and to do so we will draw together work on care with the work of Stanley Hauerwas. This focus on practices of hospitable bodily care flows from a theological imagination of welcoming the stranger that dates back to the earliest roots of the hospital as a Christian institution.

There is no objective guarantee that a medical imaginary centered on befriending estranged flesh will be found more effective or compelling than those grounded in perceiving and engaging the body as an object or as an enemy. But by making clear the commitments to hospitality latent within healthcare, this witness is at least able to stand as a substantive alternate medical imaginary. Additionally, articulating these commitments makes possible an account of how they may be both instantiated and nurtured. Because the practices that mark these three medical imaginaries are not necessarily mutually exclusive, we will seek to understand how they can be ordered through an overarching commitment to hospitable care. Furthermore, through the work of Luke Bretherton, we can better understand how to nurture the conditions and possibilities for this medical imaginary’s
sustained presence within the modern hospital. This will require, in part, fostering the presence within the hospital of diverse moral communities that share commitments to hospitable bodily care.

Before proceeding, it is worth acknowledging that some might take labor and delivery to be a side project within the modern hospital, a site for feel-good stories and not the real work of saving lives found in sites like the surgical ward and the ICU. If labor and delivery is such a side project, however, it is a rather large and important one. As Anne Lyerly writes in *A Good Birth*:

There are 4.3 million births per year in the United States, and their impact on the health care system is significant: 23 percent of all women discharged from hospitals have just given birth; six of the fifteen most common hospital procedures involve childbirth; and more than a quarter of all procedures performed on women are obstetrical. Maternal and newborn hospital charges were $86 billion in 2006, far exceeding those of any other condition.\(^3\)

In other words, it is difficult to overstate the importance of the labor and delivery ward for the modern hospital and our healthcare system.

And this importance is not simply numerical; work in the labor and delivery ward provides us with a clear glimpse of the purposes of healthcare for patients and practitioners. Here, more than perhaps anywhere else in the hospital, we see the patient centered as the key agent in healthcare. Moreover, in the labor and delivery ward the patient is surrounded by a constellation of caregivers that can serve as morally paradigmatic medical practitioners. If the hospital is a world often dominated by the prestige and egos of physicians and surgeons, the messy work of bodily care in labor and delivery provides an alternate witness, both to the proper goal of healthcare and also to how a moral agent may work within the

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hospital as a morally complex institution. Thus, we will focus on the work of the patient as attended to by the work of nurses, midwives, nurse-midwives, therapists, and others as paradigmatic for healthcare. To do so, we begin with a phenomenology of the body as perceived in pregnancy and birth.

4.2 Phenomenology of Pregnancy and Birth

“Myself in the mode of not being myself.” So Iris Marion Young describes the experience of pregnancy in her influential essay, “Pregnant Embodiment: Subjectivity and Alienation.” Young claims that reflecting on pregnancy “reveals a body subjectivity that is decentered.” In this section on the phenomenology of pregnancy and birth we follow Young’s work in order to understand how this phenomenon involves a particularly intense form of bodily estrangement. In her essay, Young argues that “the pregnant subject...is decentered, split, or doubled in several ways. She experiences her body as herself and not herself.” The estrangement entailed by this decentering, splitting, and doubling peaks in labor; in the words of another feminist phenomenologist, all of pregnancy can be understood as a “gradual crescendo” towards labor as the “culmination of nine months of physical and psychological preparation and anticipation.” How, then, is this “redoubling up of the body” perceived throughout pregnancy and birth?

5 Ibid.
6 Ibid., 46.
For both phenomenological and moral reasons, it is crucial that the reality of this “redoubling up of the body” be described through the first person perception of the pregnant subject. Young makes this point forcefully:

Only I have access to these movements from their origin, as it were. For months only I can witness this life within me, and it is only under my direction of where to put their hands that others can feel these movements. I have a privileged relation to this other life, not unlike that which I have to my dreams and thoughts, which I can tell someone but which cannot be an object for both of us in the same way.8

We will return later to the privileging of the tactile over the visual implied by Young’s account. For now, it is important to note that the pregnant subject’s “privileged relation” with her body entails an ability to “witness” in a way that other forms of knowing cannot replace. Commenting on this passage from Young, James Mumford argues that she is describing “something more profound than simply acquiring an information premium.”9

Mumford turns to Julia Kristeva to explain the nature of this “privileged relation,” saying “any investigation of initial human appearance will be phenomenological only to the extent that it is, in Kristeva’s words, ‘concerned with the subject, the mother as the site of her proceedings.’”10 And so, phenomenologically, it is crucial to center the perceptions of the

8 Young, “Pregnant Embodiment” 49.
9 James Mumford, 18.

Mumford goes on to say, “Ruled out from the start, then, is any resort to a purely scientific approach purporting to describe the new one ‘objectively,’ as suspended before our gaze.” Mumford seems to rule out the possibility that a pregnant subject could perceive her body as an object and later does the same with the possibility that she could perceive her body as an enemy. Yet, as we have seen throughout this project, in moments of intense bodily disruption we can be converted to a mode of perception offered by another, especially if the other is a medical practitioner supported by arrangements of practices, discourses, and institutions. This could transform our perception of the body in any number of ways; as we explored in chapter two, we could perceive the body as enemy, and as explored in chapter three, we could perceive the body as object. Such perceptions may legitimately belong to the pregnant subject; this is what it means to say that these bodily disruptions are epistemically underdetermined. We will engage Young and Mumford further on this issue below.
pregnant subject. Morally, the importance of such a focus is made clear by the slogan popularized by the disability rights movement, “Nothing about us without us!”11

With this “privileged relation” in mind, we can now turn to Young’s phenomenological description. She takes as her “starting point” Julia Kristeva’s remarks on pregnancy: “Pregnancy seems to be experienced as the radical ordeal of the splitting of the subject: redoubling up of the body, separation and coexistence of the self and another, of nature and consciousness, of physiology and speech.”12 Young affirms the validity of this claim outside of Kristeva’s psychoanalytic framework by describing the experience of pregnancy as revealing “myself in the mode of not being myself.”13 As Naomi Wolf describes in her influential book, Misconceptions, “this sense of slowly being doubled was like my spirit cleaving into two.”14 A sense of bodily estrangement marks the phenomenon of pregnancy and birth.

Young goes on to offer more detailed phenomenological description of how this phenomenon appears and unfold over the first months of pregnancy:

As my pregnancy begins, I experience it as a change in my body; I become different from what I have been. My nipples become reddened and tender; my belly swells into a pear. I feel this elastic around my waist, itching, this round, hard middle replacing the doughy belly with which I still identify. Then I feel a little tickle, a little gurgle in my belly. It is my feeling, my insides, and it feels somewhat like a gas bubble, but it is not; it is different, in another place, belonging to another, another that is nevertheless my body.”15

11 This moral concern is never far from me as I write about the experiences of pregnancy and birth, as expressed in both the sources I use and the colleagues I consult while writing.
13 Ibid.
15 Young, 49.
Young describes here the process of the pregnant body becoming strange; she experiences pregnancy “as a change in my body.” And such changes are not necessarily the prominent ones we discussed earlier, as Young does not discuss nausea or bleeding in her phenomenological analysis. Instead, Young’s focus is on more gradual processes: her nipples change and her belly swells, itches, and becomes hard. Through these bodily disruptions, Young says, “My automatic body habits become dislodged; the continuity between my customary body and my body at this moment is broken.”16

A clear example of the pregnant body becoming strange is in the changing ways one inhabits and perceives space as the “belly swells.” Moving through chairs and crowds, Young finds “my way blocked by my own body sticking out in front of me—but yet not me, since I did not expect it to block my passage.” Leaning over to tie her shoe, she is “surprised by the graze of this hard belly on my thigh.” Her habits no longer befit her body’s changing boundaries, and she feels this acutely when she least expects it: “I do not anticipate my body touching myself.” As she discusses tying her shoe, Young deliberately invokes Merleau-Ponty on bodily touch and double sensations, saying, “In the ambiguity of bodily touch, I feel myself being touched and touching simultaneously, both on my knee and my belly. The belly is other, since I did not expect it there, but since I feel the touch upon it, it is me.”17 These surprising touches both render the body strange and invite Young to attend to its changes, to develop new modes of being embodied in space.

Here Young addresses a debate discussed earlier in this project. Recall that in the work of Kay Toombs and others, being made aware of the body indicates a problem with our body and our embodied projects. In reference to similar approaches, Young says,

16 Ibid., 50.
17 Ibid.
Thus the dichotomy of subject and object appears anew in the conceptualization of the body itself. These thinkers tend to assume that awareness of my body in its weight, massiveness, and balance is always an alienated objectification of my body, in which I am not my body and my body imprisons me. They also tend to assume that such awareness of my body must cut me off from the enactment of my projects; I cannot be attending to the physicality of my body and using it as the means to the accomplishment of my aims.\(^\text{18}\)

Daily pregnant experience—the touch of belly to knee or the surprise of bumping another in a crowded space—“calls me back to the matter of my body even as I move about accomplishing my aims.”\(^\text{19}\) Such bodily awareness is not a problem, but instead becomes the occasion of a continual tacit reconciliation, as “the unity of the self is itself a project.”\(^\text{20}\)

As we noted in chapter one, the experience of attending to one’s own body does not necessarily indicate illness or disease.\(^\text{21}\) Instead, the pregnant subject “often experiences her ordinary walking, turning, sitting as a kind of dance, movement that not only gets her where she is going, but also in which she glides through space in an immediate openness.”\(^\text{22}\)

Young’s phenomenology of pregnancy and birth is echoed by that of Louise Levesque-Lopman, who also refused the idea that attention to the body is necessarily an impediment: “My awareness of my body did not impede the accomplishment of my aims...My body was attending to itself at the same time that it was enacting its project that was also my project.”\(^\text{23}\)

As we have seen throughout this project on bioethics and the body, here Levesque-Lopman

\(^{18}\) Ibid., 51. Young is directly referring to work from Hans Plugge and Erwin Straus, but her analysis applies to the phenomenological approaches of Toombs, Carel, and others like them.

\(^{19}\) Ibid., 48.

\(^{20}\) Ibid., 48.

\(^{21}\) As we noted there, Kristin Zeiler draws from the work of Young to explore the “eu-appearance” of the body in some cases of pregnancy. See Kristin Zeiler, “A Phenomenological Analysis of Bodily Self-Awareness in the Experience of Pain and Pleasure: On Dys-appearance and Eu-appearance,” *Medicine, Health Care and Philosophy* 13, no. 4 (2010): 333-342.

\(^{22}\) Young, 52. Young draws from Sally Gadow’s argument for an “aesthetic mode” of embodied experience in order to counter philosophical trends that see attention to the body as indicating a problem. Sally Gadow, “Body and Self: A Dialectic,” *Journal of Medicine and Philosophy* 5, no. 3 (1980): 172-185.

runs up against the barriers of our language; to say “my body and its projects” is the same thing as saying “me and my projects.”

Young describes pregnancy as “rendering fluid the boundary between what is within, myself, and what is outside, separate,” and she goes on to claim “the birthing process entails the most extreme suspension of the bodily distinction between inner and outer.”

Throughout her pregnancy, Young experiences “my insides as the space of another, yet my own body.” Over time, the pregnant subject “increasingly” feels her insides “strained and pressed,” and she also “feels the movement of a body inside me.” This body inside her is both “another, yet my own body.” We have already seen one way in which pregnant subjects conceive what Merleau-Ponty refers to as double sensations, and in this touching and being touched in the womb we find perhaps the most primordial form of this phenomenon where the body “attempts to touch itself touching.”

Recall from chapter one that Merleau-Ponty goes on to say that in this phenomenon we “glimpse momentarily...the incarnation of this other right hand.” Given the not insignificant association in Western thought between ensoulment and the first signs of movement (the ‘quickening’), Young’s experience of “another, yet my own body” points very directly to something like incarnation, at least in a phenomenological sense if not in a more explicitly theological register. Recall also that Merleau-Ponty, when describing the phenomenon of “double sensation” and the reversibility of touch it entails, asks, “Now why would this generality, which constitutes the unity of my

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24 Young, 49, 50. Levesque-Lopman describes labor as “a culmination of nine months of physical and psychological preparation and anticipation.” Levesque-Lopman, Claiming Reality, 125.
23 Young, 49.
26 Merleau-Ponty, Phenomenology of Perception, 95.
27 Ibid.
29 As Simone de Beauvoir says, “In one sense the mystery of incarnation is repeated in each woman.” Simone de Beauvoir, The Second Sex, trans. Constance Borde and Sheila Malovany-Chevallier (London: Jonathan Cape, 2009), 553.
body, not open it to other bodies?" Merleau-Ponty never considered the pregnant body as perhaps the original site of both double sensations and their extension to other bodies reflects how phenomenology has historically privileged the male perceiver. Here we see another way that phenomenological focus on the pregnant subject builds off of themes found throughout this project.

Young’s investigation of the blurring of distinctions between bodies and inside and outside culminates in the very moment of birth: “Through pain and blood and water this inside thing emerges between my legs, for a short while both inside and outside me.” In the words of Simone de Beauvoir, “It is a strange miracle to see, to hold a living being formed in and coming out of one’s self.” This moment of “pain and blood and water” is a miracle, a separation, a conversion. Kristeva claims “a mother is a continuous separation, a division of the very flesh. And consequently a division of language.” In the moment of birth, one person very visibly becomes two, and the cries of the infant demand that our language change to reflect this reality. Recall Elaine Scarry’s argument that intense pain creates the conditions and possibilities for a conversion of the self. Naomi Wolf focuses her inquiry in

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31 Merleau-Ponty was certainly guilty of this tendency, though he also has proven to be a more productive thinker for feminist theorists than most other phenomenologists. As Elizabeth Grosz says, Many feminists have found support for their various projects in Merleau-Ponty’s particular brand of phenomenology, but it is significant that of all the feminist writings on his works with which I am familiar, even those feminists strongly influenced by him remain, if not openly critical, then at least suspicious of his avoidance of the question of sexual difference and specificity, wary of his apparent generalizations regarding subjectivity which in fact tend to take men’s experiences for human ones. Elizabeth Grosz, *Volatile Bodies: Toward a Corporeal Feminism* (Bloomington, IN: Indiana University Press, 1994), 103. For further on this, see *Feminist Interpretations of Maurice Merleau-Ponty*, eds. Dorothea Olkowski and Gail Weiss (University Park, PA: The Pennsylvania State University Press, 2006); several essays in *Feminist Phenomenology*, eds. Linda Fisher and Lester Embrue (Dordrecht, NL: Kluwer Academic Publishers, 2000); and Lisa Guenther, “The Birth of Sexual Difference: A Feminist Response to Merleau-Ponty,” in *Coming to Life: Philosophies of Pregnancy, Childbirth and Mothering*, eds. Sarah LaChance Adams and Caroline R. Lundquist (New York: Fordham University Press, 2013), 88-105.
32 Young, 50.
33 Beauvoir, 563.
Misconceptions on “the death of the old identity...and its rebirth into that hard-won, messier, more interdependent new maternal self and new love.” Margaret Atwood’s story, “Giving Birth,” describes this process with Jeanie, who finds herself and her language dissolving in the pain of labor. After “the disappearance of language” in the agony of birth, “in the days that follow Jeanie herself becomes drifted over with new words, her hair slowly darkens, she ceases to be what she was and is replaced, gradually, by someone else.” This sense of conversion into a new person is found throughout literature on pregnancy and birth, but how exactly one “becomes drifted over with new words” deserves further examination. In order to give an account of the modes of conversion that may accompany pregnancy and birth, we turn to the different pathways of perception that mark these phenomena.

In her phenomenology of pregnancy and birth, Young recognizes that her positive account of continual self-integration is not shared by all. In fact, she begins her essay by particularizing her phenomenological account, saying that she speaks “for those pregnant women who have been able to take up their situation as their own.” In other words, Young’s phenomenological inquiry leaves open the possibility that other pathways of perception exist for those experiencing pregnancy and birth. So while Young describes the basic phenomenological structure of the bodily disruption perceived during pregnancy and birth, we must recognize that her fundamentally constructive account of pregnancy’s bodily disruptions is contingent. Therefore, when Young says “we can become aware of ourselves as body and take an interest in its sensations and limitations for their own sake, experiencing

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35 Wolf, 8.
37 Young, 47.
them as a fullness rather than a lack,” we must be quick to say that not all pregnant subjects experience their body as a friend. As Beauvoir notes, “birth may take many different forms.”

What does it mean to take seriously the reality that phenomenological variance marks the “immense psychic and physical tremor that is pregnancy and birth”? Naomi Wolf indicates this ambivalence by describing her experience of nausea as “a sickness in the gut” that “had a richness to it, as if I had gotten ill by ingesting pure gold.” Wolf later describes lying in bed near the end of her pregnancy:

> I feared I would be chained forever to our bilious couch...like Prometheus chained to a rock. Alternating with this sense of dread was a calm equally deep. I would lie in bed, on my side, with my hands on the baby, and feel drawn into a field of unbearable sweetness.

Wolf’s ambivalent account allows us to see Young’s analysis as one pathway of perception available for pregnancy and birth, recognizing that the same basic phenomenological structures of pregnancy and birth could be perceived in radically different ways due to this being an epistemically underdetermined phenomenon. The two other pathways of perception that we will consider are those we investigated at length in our previous two chapters, where the body is perceived either as an object or as an enemy.

Young herself describes the first of these alternate pathways of perception in the second half of her essay. Here she discusses how “the pregnant subject’s encounter with obstetrical medicine in the United States” lends itself to “the objectification or appropriation by one subject of another subject’s body, action, or product of action.” For Young, this involves obstetrical medicine “defin[ing] or control[ling]” the pregnant subject’s experience

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38 Ibid., 51.
39 Beauvoir, 561.
40 Wolf, 9.
41 Ibid., 131.
such that she “does not recognize that objectification as having its origins” in her experience. Here Young slightly overstates her phenomenological case, for as we saw in Kay Toombs’s work, the subject’s own perception of bodily disruption can move, through a series of steps, towards the “disease state” understanding offered by the physician. So where Young claims that medicalization is “the conversion of this subjective experience into objective entities that can be observed by anyone with the proper instruments,” we must insist that this medical imaginary’s construal of the body as object can also involve a conversion of the pregnant subject’s perception of her own body. That said, Young’s attention to the ways in which modern medicine can structure the pregnant subject’s experience rightly renders the contingency of the pathway of perception that, as we noted earlier, Toombs assumes as a given.

Young argues that there are three major factors that contribute to this objectification of the pregnant subject’s body:

First, the normal procedures of the American hospital birthing setting render the woman considerably more passive than she need be. Second, the use of instruments provides a means of objectifying the pregnancy and birth that alienates a woman because it negates or devalues her own experience of those processes. There is a final alienation the woman experiences in the medical setting, which drives from the relations of authority and subordination that usually structure the doctor-patient relation in contemporary medical practice.

Young’s account of “alienation” comports with this project’s understanding of the bodily estrangement that forms the conditions of possibility for a conversion into a form of life that perceives the body as an object. While the pregnant subject’s experiences may be devalued, they are not necessarily negated; instead, they may be translated and transformed

42 Young, 55.
43 Ibid., 61.
44 Ibid., 58-59.
into a mode of imagining the body as an object. In this way, we are able to see that her
description of medicalization in the second half of the essay is a genuine pathway of
perception available to the pregnant subject, but one that is not necessary and preordained
because it is contingent upon the institutional arrangements of practices, discourses, and
practitioners that she describes here. In other words, we find here a pathway of perception
that corresponds with our work in chapter three on the body as object. These contingent,
formative realities will be further explored in our next section, but we must first discern a
final pathway of perception for the pregnant subject.

The final mode of perceiving pregnancy and birth explored here is one of assault, in
which an enemy has invaded and taken abode in one’s own body. Questions of sexual
violence, coercion, and rape often surround this mode of perception, but it is certainly not
limited to these contexts. Caroline Lundquist explores this pathway of perception in
dialogue with Young’s work, recognizing that the same phenomenological structure of
bodily disruption can be perceived in radically different ways:

For the pregnant subject who never positively accepts her pregnancy, the sense of
splitting subjectivity can be radically unlike the experiential mother-child
differentiation of chosen pregnancy Young describes; a chiasm not of two subjects,
but rather of a subject and some unwanted or menacing object, some less than
human, perhaps monstrous creature, or the embodiment of the aggressor, in
pregnancies resulting from rape. Women whose unwanted pregnancies must be
carried to term may undergo the same basic biological processes as willing mothers,
but these processes are yet perceived or interpreted in substantially different ways.\(^\text{45}\)

Lindquist draws from Croatian journalist Slavenka Drakulić’s fictionalized account of the
lives of the women she interviewed following the Bosnian Civil War. Drakulić’s character
“S.” stands in for the women who had been raped during the conflict and then experienced

the resultant pregnancies. S.’s perception of pregnancy is fundamentally marked by this violence. Lundquist echoes the language of Young and Kristeva when she says, “S. feels herself torn in two,” but that experience of splitting is immediately described as “her own body [becoming] the battlefield of herself and her aggressors.” 46 Drakulić’s character S. describes the experience as “war, inside her, in her own womb.” 47 In light of this perception of her pregnancy, “S. fought this alien body, the sick cells that multiplied inside her against her will....When she shut her eyes she saw the foreign cells quite clearly, multiplying, occupying her from within.” 48 In this way, then, Lundquist argues that the same phenomenological structures given by Young can be perceived in radically different ways; bodily disruption becomes an assault instead of a befriending.

Although Lundquist focuses on an account of pregnancy and birth following sexual violence, this mode of imagining the changing body as a hostile enemy is not only found in those circumstances, nor do they necessitate perceiving pregnancy in this way. In her influential book, Of Woman Born, Adrienne Rich says as much in describing pregnancy and birth within our patriarchal world, a world she calls, “The Kingdom of the Fathers”:

Without doubt, in certain situations the child in one’s body can only feel like a foreign body introduced from without: an alien....Yet even women who have been raped seem often to assimilate that germ of being, created in violence, not as something introduced from without but as nascent from within. 49

The complicated ways in which pregnancy can be perceived both as “a foreign body introduced from without” and also as “nascent from within” displays how imagining the body as both enemy and friend can occur at the same time. Beauvoir directly addresses this

46 Ibid., 142.
48 Ibid., 6-7.
49 Rich, 64.
ambiguity when she says that the pregnant subject experiences pregnancy “both as an enrichment and a mutilation; the fetus is part of her body, and it is a parasite exploiting her; she possesses it, and she is possessed by it.”\(^{50}\) Such a perception by the pregnant subject flows from many of the same phenomenological structures that Young describes, though they are given different valences in this mode of description. So where Young describes the pregnant subject as “located in the eyes and the trunk,” moving through the world in “a kind of dance,”\(^{51}\) others describe that phenomenon in much less positive terms. For example, although Young draws heavily from Kristeva’s account of the pregnant subject, Kristeva is far more ambiguous about the experience than Young. We can see this in her alternate description of what it means to perceive through “eyes and trunk”:

On the one hand—the pelvis: centre of gravity, unchanging ground, solid pedestal, heaviness and weight to which the thighs adhere, with no promise of agility on that score. On the other—the torso, arms, neck, head, face, calves, feet: unbounded liveliness, rhythm and mask, which furiously attempt to compensate for the immutability of the central tree. We live on that border, crossroads beings, crucified beings.\(^{52}\)

Kristeva is engaging the same phenomenon as Young, but she describes it as a crucifixion, not as “a kind of dance.” As we have seen in Margaret Atwood’s work, the cruciform existence of the pregnant subject reaches its culmination at the moment of giving birth, when something like a death and rebirth occurs in the conversion of the pregnant subject. Given the pathway of perception just examined, this process of conversion could culminate in the pregnant body seeing both her own body and the body of her newly born child as enemies to herself.\(^{53}\)

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\(^{50}\) Beauvoir, 551-552.

\(^{51}\) Young, 52.

\(^{52}\) Kristeva, “Stabat Mater,” 178.

\(^{53}\) Lundquist examines this some with “S.”, who sees birth as the expulsion of “something radically other from her own flesh.” See p. 143.
Modern healthcare’s practices, discourses, and practitioners can lend themselves to perceiving the act of giving birth as a kind of deliverance from an enemy’s assault. Such an approach is deeply rooted in the realities of childbirth, which has been a leading cause of women’s death throughout history. As we will see, the language and practices of risk and risk management become medicine’s way of forming and responding to the very real fear of death. Emergency caesarean sections, which have delivered the lives of innumerable infants and mothers, both represent and form this medical imaginary within the labor and delivery ward. In other words, we find here a pathway of perception that corresponds with our work in chapter two on the body as enemy.

In summary, then, this phenomenological account of pregnancy and birth shows that the phenomena are epistemically underdetermined. The bodily disruptions experienced by pregnant and laboring subjects provide the conditions and possibilities for multiple pathways of perception. We have traced three such pathways through phenomenological accounts of the ways in which pregnant and laboring subjects perceive their bodies as friend, as object, and as enemy. In doing so, we have begun to connect these modes of perceptions with a variety of practices, discourses, and practitioners. We must better attend to the contexts and pathways of perception before we can begin the work of discerning a fitting moral response. Because any moral response must take seriously the arrangements of discourses, practices, and practitioners within which action occurs, we turn now to offer such an account through the resources of ethnographic work.

4.3 Ethnographic Understandings of Labor and Delivery
In her classic text, *Of Woman Born*, Adrienne Rich explores the question, “How have women given birth, who has helped them, and how, and why?” She does so not simply out of historical curiosity, for “these are not simply questions of the history of midwifery and obstetrics: they are political questions.” In this section, we turn to turn to ethnographic accounts of pregnancy and birth in order to discern the institutional arrangements that make possible the pathways of perception chronicled above. This move is essential in order to understand the conditions and possibilities of the pathways of perception we chronicled above via phenomenological accounts of pregnancy and birth. As Deborah Lupton and Virginia Schmied argue, “The circumstances in which women give birth are pivotal to how they experience the process of coming to terms with the Other body that was once inside them emerging to the outside.”

Ethnographical inquiries will bring to light some of the contrasting epistemological and metaphysical understandings of the pregnant body in labor and delivery. Here, Rich’s claim is key, as we must attend to the politics of encounters that the pregnant subject experiences within the modern research hospital.

In accordance with the three pathways of perception described above, we will give accounts of three ideal types of encounters in labor and delivery. Each entails a certain arrangement of discourses, practices, and practitioners that create the conditions and possibilities for perceiving the laboring body as enemy, object, and friend. As we will see, these distinctions are somewhat artificial, as any particular experience of labor and delivery will involve all three types to varying degrees. But by clearly delineating each of these three paradigmatic medical imaginaries as found within the labor and delivery ward, we will be

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54 Rich, 128.
positioned to discern the diverse histories that have led to the current configuration of the labor and delivery ward in the modern hospital. In other words, these ethnographic and historical investigations will enable us to understand labor and delivery as a contested site of encounter. Through them, we can draw out the theological commitments at work within the modern labor and delivery ward in particular, and in the hospital more generally. By considering this ethnographic work in conjunction with a historical understanding of this paradigmatic medical site, we will be in position to offer a theological account of labor and delivery before we turn to fitting moral responses.

The first two ideal types of encounter within the labor and delivery ward pair with our medical imaginaries of the body as object and the body as enemy. To recall a point made in chapter one, these two imaginaries instantiate states of emergency and exception as fundamental modes of imagining and encountering the patient. These two imaginaries understand healthcare as crisis care, and the discourses, practices, and practitioners in labor and delivery reflect such an understanding. Naomi Wolf describes this in her own reflections on giving birth, saying, “Once in the delivery room, the seemingly inevitable high-tech intervention took place. What might have been a normal birth became an emergency.”

Within the labor and delivery ward we can more clearly see both the reality and the contingency of these politics of emergency in the hospital. Through doing so, we will be in a better position to see the ways in which the slower work of hospitably caring for and befriending the body is perhaps the fundamental medical imaginary for both labor and delivery and the hospital as an institution. We will follow the lead of Wolf, who describes practices of objectification in labor and delivery before turning to a more hostile encounter.

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56 Wolf, 136.
Though this reverses the order of the first two chapters in this project, such a move may be more representative of the rhythms of the labor and delivery ward itself.

4.3.1 Body as Object in Labor and Delivery

We first attend to the way in which a constellation of discourses, practices, and practitioners transformed Naomi Wolf’s experience of labor and delivery into an “emergency” by imagining and engaging her body as an object. Wolf describes this process through a series of events in the delivery room. Her description is worth considering at length:

I was hooked up to a fetal monitor...The monitor kept me flat on my side and immobilized. I was told by my entire team that, given my present “inadequate” degree of dilation, and given that my waters had broken, they wanted to give me Pitocin to increase dilation....But since the Pitocin would make for stronger contractions, they advised me that, in their opinion, the pain would be too intense to bear. They wanted to give me an epidural....I had now been flat on my side, scared, for an hour or so, without “making progress,” as they put it....I was starting to feel uncertain about my abilities to labor well, and of course we worried above all about the baby. I hadn't been given a chance to dilate naturally, to acclimatize to the pain gradually. The stronger contractions from the “pit drip” made me feel as if someone were plunging a sword into the ganglia of my spin. I readily accepted the epidural....I was given an IV drip and became a prisoner of the delivery room...There was no longer any question of my walking around to encourage dilation or use gravity. The fetal monitor, which was strapped around my belly, became the center of activity in the birthing room....The baby and I seemed less real in that room than did the machine. At that point the birthing process was so technologized that the notion that “I” was there to give “birth” seemed like sort of a virtual aside.57

Wolf’s narration of this experience describes the ways in which particular practices and discourses transformed her laboring body into a medicalized object, and we can understand this conversion through the medical imaginary we explored in chapter three. Her body was mapped by a fetal monitor and regular cervix checks, which translated tactile contractions, heart rates, and dilation into images and measurements that could be seen and counted as

57 Wolf, 136-137.
real. Wolf’s first-person report of her laboring body became unnecessary, as this work of mapping gave the medical team all the information they needed. When this mapping revealed the body as a network of efficient and material causes in need of intervention, a “pit drip” was started in order to intensify contractions. An epidural was given in order to mute the intense pain that Wolf experienced as the body’s response to induced labor. In other words, the body in pain was met with a pharmacological response instead of hospitable practices of care and attention. As Wolf’s body was mapped and manipulated, any of its resistances were rendered docile through this work of medicalization. Wolf was acted upon as she lay passive and prone in the lithotomy position. To say that she was “laboring” is to imply more agency than she had; she concludes her reflection by saying, “In my delivery, I was an adjunct; I had almost no role.”

A decade prior to Wolf’s account, anthropologist Robbie Davis-Floyd offered a similar analysis of the modern hospital’s labor and delivery ward. Her book, *Birth as an American Rite of Passage*, is based upon ethnographic work that revealed a set of basic rituals within the hospital’s labor and delivery ward that largely align with Wolf’s first person narration. As Davis-Floyd describes it, “Through hospital ritual procedures, obstetrics deconstructs birth, then inverts and reconstructs it as a technocratic process.” Davis-Floyd argues that this “technocratic” model need not be, and she contrasts it with a more holistic model, which is reflected in what we will describe as how the body can be imagined and encountered as a friend. But in rendering this medical imaginary contingent, Davis-Floyd reinforces a claim we made in our above account of different pathways of perceiving pregnancy and birth. She

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58 Ibid., 137.
argues that “hospital procedures take advantage” of the ways in which the “physiological process of labor itself transports the birthing woman into a naturally liminal situation that carries its own affectivity.” To translate this into the framework we used above, the epistemically underdetermined nature of pregnancy and birth leave the laboring subject vulnerable to a conversion in which her body is imagined as an object.

Davis-Floyd wrote in 1992, when the processes of medicalization were in many ways even more pronounced in transforming the laboring body into an object. Thus, although her account is slightly dated, referring as it does to defunct practices “such as handstrapping, the exclusion of fathers, and the use of ‘twilight sleep’ for labor,” it nevertheless gives insight into the ideal type we are exploring. Davis-Floyd begins with how the laboring woman is put in a wheelchair upon entering the hospital, rendering her even more passive. Upon donning a hospital gown, the laboring subject’s “pubic hair is shaved” and “she is given an enema.” Davis-Floyd suggests that the gown marks the laboring subject becoming a patient “belonging to a total institution,” and “the ritual shaving of her pubic hair further intensifies the institutional marking of the laboring woman as hospital property.” The enema is an even more pronounced form of social control, as it serves to make the body incapable even of the involuntary bowel movements that often accompany birth.

After describing these additional earlier rituals marking the laboring body as an object upon entry to the hospital, Davis-Floyd’s account follows much of Wolf’s from above. These practices shape the practitioners and the patient in labor and delivery in valuing “the

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60 Ibid.
61 Ibid., 74.
62 Ibid., 73.
63 Ibid., 82, 83. In describing the hospital as a “total institution,” Davis-Floyd notes the work of Erving Goffman’s *Asylums: Essays on the Social Situations of Mental Patients and Other Inmates* (New York: Anchor Books, 1961). Goffman’s work was referenced by numerous authors discussed in chapter three.
importance of on-time production."\textsuperscript{64} Another ethnography of labor and delivery chronicles the way that a “Journey Board” charts the “progress” of labor throughout the ward, and in so doing creates “institutional demands and a focus on linear time…sparking a tendency to value being ‘on time,’ according to the institutional rhythm, rather than ‘in time,’ or spending relational time with women.”\textsuperscript{65} As part of this “technocratic process,” Davis-Floyd sees the same practices described by Wolf as instilling a sense “the inherent defectiveness of the female birth machine.”\textsuperscript{66} To use language from chapter three, once the body has been mapped as an object, it must be manipulated in order to function in ways that stave off entropy and death.

Davis-Floyd argues that these practices “transform the obstetrical resident who is taught to do birth in no other way” than as a technocratic technician.\textsuperscript{67} Such residency training occurs within the modern research hospital, where “a woman’s reproductive tract is treated like a birthing machine by skilled technicians working under semi-flexible timetables to meet production and quality-control demands.” Davis-Floyd found support for this understanding of the formation of obstetricians in one resident’s description of the work of labor and delivery:

We shave ‘em, we prep ‘em, we hook ‘em up to the IV and administer sedation. We deliver the baby, it goes to the nursery and the mother goes to her room. There’s no room for niceties around here. We just move ‘em right on through. It’s hard not to see it like an assembly line.\textsuperscript{68}

\textsuperscript{64} Davis-Floyd, 130.
\textsuperscript{66} Davis-Floyd, 130.
\textsuperscript{67} Ibid., 153. For more on this formation of the obstetrician, see Davis-Floyd’s later chapter, “Obstetric Training as a Rite of Passage,” 252-280.
\textsuperscript{68} Ibid., 55.
While they may at times use the language of mechanization more than medicalization, we can find in these accounts of the formation of the obstetrician strong echoes of our argument in chapter three that technology and the rise of the clinical gaze worked together to transform the patient’s body into an object. In other words, it should not surprise us that the obstetrician is trained in medical care and so often instantiates the same mode of medicalized perception.

However, obstetricians are complicated figures; they combine both medical and surgical training, and so can move between imagining and engaging the body as an object and as an enemy. Here it is important to note how the same practices might participate in multiple medical imaginaries. For, according to Davis-Floyd, the message that childbirth is a technocratic process is “reinforced if the baby is pulled out with forceps. The application of forceps shows the mother beyond all doubt that her machine is indeed defective, and brings home the message that the lives of the mother and her baby are truly dependent on the institution and its technology.”69 Similarly, Adrienne Rich sees forceps—the obstetrician’s “masculine ‘hands of iron’”—as a technology “often used with mechanistic brutality and unconcern to hasten a normal labor.”70 Rich argues that the forceps are a “quick-delivery trick” and so represent how the obstetrician developed as “a technician rather than a counselor, guide, and source of morale; he worked “on” rather than “with” the mother.”71 But forceps can also be understood as a forceful intervention seeking to prevent deadly harm in the face of bodily threat, so participating in a construal of the body as an enemy. In other words, in some hands the forceps encounter the body as enemy; in others, they

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69 Ibid., 130.
70 Rich, 142.
71 Ibid., 149, 150.
participate in imagining the body as object. Perhaps it is fitting, then, that, as one medical
textbook put it in 1956, “The obstetric forceps, more than any other instrument, symbolizes
the art of the obstetrician.”72 This equivocal account of the forceps points us to the second
medical imaginary present within labor and delivery: the body as enemy.

4.3.2 Body as Enemy in Labor and Delivery

Just as we saw with how the body is imagined as an object, the labor and delivery ward
can also become the site of an emergency politics in medicine as it imagines and encounters
the body as enemy. In this case, a constellation of discourses, practices, and practitioners
create the conditions and possibilities for the laboring subject to perceive her body as an
enemy. Here, as medical anthropologist and obstetrician Claire Wendland notes, the laboring
subject’s “body becomes the site of risk: risk to herself and risk to her fetus.”73 Because of
this, medical practitioners, especially obstetricians, “depict labor and birth as hazardous
proceedings requiring expert surveillance and vigilant supervision at all times.”74 Perhaps the
primary way in which we imagine, in Wolf’s words, a “normal birth” becoming an
“emergency” is in an emergency cesarean section. At this moment, the body is engaged as a
threat, though our language struggles to describe the different ways in which this bodily
threat is perceived. There are no clear ways to differentiate the laboring body and the new
life both belonging to it and seeking to emerge from within it, and so the laboring body can
threaten the fetus or itself, the fetus can threaten the laboring body or itself, or the bodily
threat can be some complicated combination of these possibilities. A particular constellation

73 Claire L. Wendland, “The Vanishing Mother: Cesarean Section and ‘Evidence-Based Obstetrics,’” Medical
74 Ibid., 227.
of practices, discourses, and practitioners then engage the body as enemy in an emergency cesarean section, as we see in Naomi Wolf’s story, to which we now return.

After twenty-four hours of labor in the hospital, Wolf underwent a cesarean section due to the perceived increase risk of infection. The fact that Wolf’s story contains instances of her body imagined as an object and as an enemy is indicative of how these medical imaginaries are interwoven within the labor and delivery ward. However, Wolf’s movement from a delivery room to a surgery room signaled a clear shift in these two medical imaginaries. Her description is once again worth considering at length:

I am wheeled into the surgery room. I am anesthetized and strapped down as if on a crucifix. My husband is seated at my head...the surgeon makes his incision....I feel a violent but numb tugging, like someone ripping soft dough. I start to retch.....There is a cry. I do not recognize it....I want only to be closed up again and rescued from this cold, bone-hard place....My teeth chatter so loudly I can hardly speak. I start to vomit. “Can you stop that?” says the surgeon, irritable or alarmed, I can't tell which. “I need to get this small intestine back in.” I believe I am dying. “Here she is, a gorgeous baby girl,” calls someone, caught up in festivities far away. My husband turns in joy while my body remains half-submerged in cold, like the cold of a newly turned grave....“Her eyes are wide open,” says my husband. He takes her in his arms and brings her down to show to me, but I am frightened. With my abdomen still split open, I want only not to die....Seven men and women, in plastic goggles and pale green cotton suits, are working. Their gloves are bathed up to the elbow, and their busy instruments are messy, with streaks of bright red. The locus of their full attention is down where my stomach should be. No one notices that I see what their hands are dipped in: my center, an open cauldron of blood.55

Wolf perceives the practices inherent in a cesarean section as a kind of death she endures “as if on a crucifix” with her body “half-submerged in cold, like the cold of a newly turned grave.” She simply says, “I believe I am dying.” Here Kristeva’s account of pregnant and laboring subjects as “crucified beings” is given shape and form in a surgery room.56 Wolf’s husband sits beside her head, supporting the half of her embodied self that has not been

55 Wolf, 138-140.
engaged as a threat. Below the curtain, a surgical team is gathered around Wolf’s “split open” abdomen, an “open cauldron of blood.” Wolf’s bodily activities above the drape—her teeth chattering and her vomiting—are nuisances for the surgeon’s work within this sterile field. The surgical team isolates and removes the infant, severing the connections that are the precondition for the bodily threat that led to this emergency surgery.

The “violent but numb tugging” that Wolf experienced has become, by the standards of surgery, a very disciplined and controlled operation. This was not always the case, but the modern cesarean section is, according to surgeon Atul Gawande, “one of the most straightforward” operations done today. In its current form, the cesarean section looms as the “safest” option under conditions of perceived bodily threat. Obstetrician and medical anthropologist Claire Wendland offers a succinct clinical summary of the procedure:

In a cesarean section, the surgeon cuts through the skin and fat of the lower abdomen, slices through the tough underlying fascia, and pulls apart the muscles of the abdominal wall. Opening the peritoneum, a thin sac that encases the abdominal and pelvic organs, the surgeon peels the bladder away from the uterus, cuts open the uterus itself, and pulls out the baby and placenta. All of this can usually be done in a minute or two; the remainder of the operation consists of suturing or stapling together the layers previously cut.

This controlled and clinical language belies the state of emergency that precipitates the operation. In his account of modern labor and delivery, Atul Gawande reveals how the threat of bodily harm and death hovers over this medical site. “At almost any step,” Gawande says, the birthing “process can go wrong.” Gawande proceeds to offer a litany of ways that bodily harm could occur during labor, ranging from uncontrollable bleeding to

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77 Atul Gawande, “The Score,” The New Yorker 82, no. 32 (2006): 58-67, 66. Here we should note that the same plasticity of practice found in the forceps can also be present in the cesarean section. Although its roots are firmly within a surgical mindset, the rise of elective cesareans and a rote focus on the procedure’s efficient production of consistent outcomes means that it too can participate in construing the body as an object.

78 Wendland, 219.

raging infection to unyielding obstruction of labor. For Gawande and for the modern labor and delivery ward, the threat of death as the ultimate enemy looms large. Given that obstetricians are surgeons, they are prepared to meet these bodily threats with surgical force. Recalling our arguments from chapter two, we can see how surgeons could justify cutting in order to save lives.

Given the current practice and the history of labor delivery, it is important to consider the racialized nature of the perception of bodily threat in this site. An Amnesty International report on the dangers of childbirth in the U.S. explains that African-American women are almost four times more likely than white women to die from pregnancy-related complications. To exemplify this reality, the report chronicles the story of Ingmarie Stith-Rouse, a thirty-three year-old black woman who died following an emergency cesarean section. As her husband, Andre Rouse, recalls, “when they tried telling staff that she was distressed and struggling to breathe, they were told it was ‘no big deal’ and that they were ‘too emotional.’” Wealth and celebrity do not necessarily overcome this lack of trust in black women’s own understandings of their bodies and the threats they face. Following giving birth via emergency cesarean section, tennis star Serena Williams, who has a history of blood clots, experienced a pulmonary embolism and demanded medical attention. Williams “told the nearest nurse, between gasps, that she needed a CT scan with contrast and IV heparin (a blood thinner) right away. The nurse thought her pain medicine might be making her confused.” After not being taken seriously by a series of medical practitioners, Williams’s demands to be recognized resulted in her eventually receiving the care she needed.

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80 Ibid., 60-61.
81 Amnesty International, *Deadly Delivery: The Maternal Health Care Crisis in the USA* (Amnesty International Secretariat, 2010), 2. The Amnesty International report reflects the medical imaginary we are describing, as it describes the labor and delivery ward as a site of bodily threat.
82 Rob Haskell, “Love All,” *Vogue* (February 2018), 111.
The stories of Williams and Stith-Rouse indicate that racialized perceptions of pain among medical practitioners affect the care offered to women of color, and research on the formation of medical trainees details this reality further.

In a recent study of one leading medical school, many medical students and residents were more likely to underreport the severity of the pain experienced by black women and men, and so offer less treatment than is needed. This problem is widely known within the African-American community, and as we will see it has deep roots in the practice of obstetrics in particular. Because of it, black women and men often demand the highest levels of interventions in order to guard against any potential complications that may otherwise be disregarded by medical practitioners. In other words, they have to demand the most forceful responses to perceived bodily threats because the institution of the hospital is inhospitable to their bodies. Such a hostile environment is partly responsible for black laboring subjects undergoing cesarean sections at higher rates than their white counterparts. And such hostility has traumatic effects; in one study, black women were significantly more likely to screen for post-traumatic stress disorder (PTSD) following birth than their white counterparts. The racialized dimensions of bodily threat in labor and delivery cannot be ignored.

While a cesarean section may be paradigmatic for the way that the body is engaged as an enemy in labor and delivery, it is by no means the only way this occurs. Aside from that

operation, one of the most common surgical procedures performed on the laboring body is the episiotomy, an incision made in order to enlarge the vaginal opening for birth. Surgical force is used on the laboring body in order to prevent harm either to the potentially obstructed emerging life or to the laboring subject, who is perceived to be at risk of an even greater tear of her perineum. And as we noted above, the use of forceps in labor and delivery involves the use of disciplined and controlled force on the body. Great care has to be taken in order to use enough force to overcome an obstruction without using too much force and potentially crushing the skull. Invoking the imaginary we saw in chapter two, these practices involve the use of controlled force in hopes of preventing greater harm. Therefore, in the labor and delivery ward the body can be imagined and engaged as an enemy, whether in a surgical suite or in a delivery room.

4.3.3 Body as Friend in Labor and Delivery

As we have seen so far, in the labor and delivery ward the body can be imagined and engaged as an object or as an enemy, and sometimes a single laboring subject, like Naomi Wolf, experiences both of these medical imaginaries in very distinct ways. This reveals to us that the labor and delivery ward is not dominated by a single medical imaginary, as might be the case within the surgical ward or the ICU. As such a complex medical site, the labor and delivery ward is illuminative in important ways for the entire institution of the hospital. Most importantly, however, is the way in which this site reveals a third medical imaginary that has deep roots in both the labor and delivery ward and the hospital more broadly: the body as friend. Here we can discern a mode of imagining and engaging the body that is often disregarded in modern healthcare, even though it is, arguably, the hospital’s most fundamental medical imaginary.
The craft that has most vocally maintained an understanding of the body as friend in labor and delivery is midwifery. We begin with a lengthy, representative quotation from Ina May Gaskin—the most well-known midwife in America and perhaps the world—as it summarizes the medical imaginaries we explored above while transitioning to an understanding of the laboring body as friend.

The problem is that doctors today often assume that something mysterious and unidentified has gone wrong with labor or that the woman’s body is somehow “inadequate”—what I call the “woman’s body as a lemon” assumption. For a variety of reasons, a lot of women have also come to believe that nature made a serious mistake with their bodies. This belief has become so strong in many that they give in to pharmaceutical or surgical treatments when patience and recognition of the normality and harmlessness of the situation would make for better health for them and their babies and less surgery and technological intervention in birth. Most women need encouragement and companionship more than they need drugs. Remember this, for it is as true as true gets: Your body is not a lemon. You are not a machine. The Creator is not a careless mechanic. Human female bodies have the same potential to give birth well as aardvarks, lions, rhinoceri, elephants, moose, and water buffalo. Even if it has not been your habit throughout your life so far, I recommend that you learn to think positively about your body. 86

Here we see Gaskin contrasting medical and surgical interventions and imaginaries with practices of patience, encouragement, and companionship. Admonitions to “listen to your body,” “trust your body,” and “work with, not against, your body” fill midwifery literature. Through these discourses and the practices and practitioners that accompany them, we can discern a model of imagining and engaging bodily disruption that seeks to befriend estranged flesh.

A point of clarification is immediately in order. When we speak of the laboring body as a friend, we may be quick to associate such talk with a “natural” birth experienced by candlelight at home with the guidance of a long-haired and free-spirited midwife. Indeed, we find several such scenes in a documentary following the work of Ina May Gaskin as she has

promoted midwifery and “natural” home births throughout her career.\textsuperscript{37} Although the influence of home births and midwives are significant—in fact, what follows in this section would not be possible without the work of midwives—any reification of the “natural” when it comes to birth is problematic on a variety of fronts: first, it may shame women whose birth experiences do not conform to this cultural image (i.e., they did not “think positively” enough about their bodies); second, it may occlude the very real threat of harm that can come through birth; and third, it may undermine the responsibility to care for those experiencing bodily disruption. Moreover, an emphasis on “natural” childbirth may reflect a privileged social location, as much of that discourse comes from relatively wealthy and well-educated white women.\textsuperscript{38} Finally, such yearning for a “natural” home birth can blind us to the real commitments to hospitality built within the institution of the hospital and in particular the labor and delivery ward as it has developed in the past few decades.

The work of befriending our estranged flesh is not a return to Edenic conditions. Following Naomi Wolf, in our desire to avoid “the controlled nature of high-tech mechanized labor,” we also must refuse “romanticizing...the culture of alternative birth.”\textsuperscript{39} Such a third way is hard, messy, and marked by failure. But in the complex coordination of institutional discourses, practices, and practitioners that create conditions and possibilities for the laboring subject to befriend her estranged flesh, we can see how such pathways might be available throughout the modern hospital. In naming the body as friend as an “ideal type” found within labor and delivery, we are not looking to some idealized conditions in which

\textsuperscript{37} For an overview, see the documentary \textit{Birth Story: Ina May Gaskin and the Farm Midwives}, directed by Sara Lamm and Mary Wigmore (New York: Ghost Robot, 2013).
\textsuperscript{39} Wolf, 203.
the disruptions of finite bodies are easily reconciled. Instead, this “ideal type” emerges from having the capacity to go on befriending the body in ways recognizable as one’s own when idealized conditions fail to appear. So although this medical imaginary is indebted in significant ways to the work of midwifery over the centuries, its presence is not limited to situations in which midwives are involved.

In order to understand how the body can be befriended in the labor and delivery ward, we draw in part from the work of Anne Lyerly, and in particular her book, A Good Birth, which is the fruit of interview work she conducted with over one hundred women who had recently given birth. Lyerly also draws from her own experience as someone who has given birth four times, and also as an obstetrician who is able to say, “Every woman does deserve a midwife.” In Lyerly, therefore, we find a practitioner who has learned from midwifery, an investigator who seeks to articulate the wisdom of those she interviewed, and an author willing to speak in the first person about her own experiences as a laboring subject. Even more importantly, in her account we can discern the contours of a medical imaginary in which the laboring body is imagined and engaged as a friend.

Early on in her book, Lyerly recognizes what we named above in our engagement with phenomenology, that giving birth is also a kind of death in which the laboring subject is fundamentally transformed and converted. “But,” Lyerly says,

[It is not a bad kind of loss, necessarily. We lose our former self, and in its place we become mothers; we lose the ideal baby we’d imagined, and in its place we get the baby we will love; we lose an idealized birth experience, and in its place we get something real, something full of beauty, something that is our very own.]

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90 Lyerly, A Good Birth, 235.
91 Ibid., 23-24, emphasis added.
We saw above the ways in which birth as a conversion could involve a “bad kind of loss.” Lyerly argues, however, that the women she spoke with agreed that it need not be that way, and in fact the new self that emerges can be “something that is our very own.” Lyerly devotes her work to understanding and describing this pathway of perception.

At the heart of Lyerly’s argument is that the nature of a good birth is necessarily particular to the laboring subject. As she says, “What makes birth manageable and meaningful—indeed, what makes it good—will relate in a substantial way to the person or people who have experienced it. A good birth has very much to do with the lives that precede it and the lives that follow.”

Similarly, Adrienne Rich stresses “the process of childbirth as a continuum, interwoven inextricably with the entire spectrum of a woman’s life.” Such attention to the story of a woman’s life means that befriending the body in labor and delivery requires a narrative structure, and with it the time necessary for such a story to unfold.

Lyerly takes there to be five key elements to the story of a good birth: “agency, personal security, connectedness, respect, and knowledge.” While a full description of these elements is beyond the scope of this project, we will explore her discussion of agency in detail, followed by a few key aspects of the other elements. In doing so, we will gain a clearer sense of the arrangement of discourses, practices, and practitioners that create the conditions and possibilities for imagining and encountering the laboring body as friend.

For her notion of agency, Lyerly readily admits that midwives have led the way. In emphasizing that the laboring subject is the “agent in the process...the one who gives birth,”

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92 Ibid., 223.
93 Rich, 180.
95 Lyerly, A Good Birth, 2.
Lyerly aligns with midwifery’s emphasis on supporting and enabling the laboring subject.\footnote{Ibid., 59.} Adrienne Rich argues that a midwife’s patience, presence, and assistance makes her a “friend and teacher in the birth-chamber,” but not the central agent.\footnote{Ibid., 151.} The midwife’s focus on the laboring subject is accompanied by a shift in language. Midwifery resists obstetrics’ discourse of “delivering” babies, a shift which Lyerly supports. As an obstetrician, she has “attended” hundreds of births, but she has only “delivered” four children, her own.\footnote{Ibid., 60.} This focus on the laboring subject as the one delivering entails a conception of finite, embodied agency. In giving birth the laboring subject should be “able to make choices,” even while recognizing that these “choices are bounded.”\footnote{Ibid., 58.} Lyerly therefore draws from the discourses of midwifery to offer a way to speak about the agency of a finite body giving birth in a modern labor and delivery ward. Midwives, nurses, and doulas all can enable this commitment to the agency of the laboring subject, and Lyerly’s testimony indicates that obstetricians can follow their leads. Through their work of attending a birth, these medical practitioners, along with supportive partners, family members, and friends, help make possible the laboring subject’s agency as the deliverer. In this discussion of agency, then, we see how the discourses and practitioners surrounding the laboring subject matter for enabling a birth befitting her and her story.

Along with this attention to discourses and practitioners, we also must attend to how particular practices and institutional arrangements are key in offering laboring subjects the opportunity to express their agency in childbirth.\footnote{This is my way of narrating what Lyerly refers to as “choice among options” as a key element of agency. See Lyerly, \textit{A Good Birth}, 51-58.} Just as certain medical practices more easily lend themselves to imagining the body as enemy or as object, so too other practices

\begin{footnotes}
\item[96] Ibid., 59.
\item[97] Ibid., 151.
\item[98] Ibid., 60.
\item[99] Ibid., 58.
\item[100] This is my way of narrating what Lyerly refers to as “choice among options” as a key element of agency. See Lyerly, \textit{A Good Birth}, 51-58.
\end{footnotes}
better create the conditions and possibilities for laboring subjects to befriend their bodies. Women who have given birth report that they received significant pain relief by being able to walk around, immerse in a tub, receive a massage, and/or use a birthing ball. And yet the institutional provision of these resources often falls far behind access to an epidural.\(^\text{101}\)

Thankfully, the rise of new forms of labor and delivery wards within hospitals means that these practices are being emphasized in ways that provide women with the conditions and possibilities for choices that lead to better births.\(^\text{102}\) These reconfigured labor and delivery wards emphasize creating a homelike quality in which the laboring subject and her needs are central.\(^\text{103}\) This arrangement has profound implications for transforming guest/host relations

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\(^\text{103}\) For more on this, Shannon Gedey offers best practices for designing a labor and delivery room in her article, “Labor-Delivery-Recovery Room Design that Facilitates Non-Pharmacological Reduction of Labor Pain: A Model LDR Room Plan and Recommended Best Practices,” *Perkins+Will Research Journal*. 6, no. 1 (2014): 127-139. She says,

*LDR rooms should be designed to meet standards that incorporate best practices to ensure that laboring women are able to be relaxed and comfortable, that their movement is not restricted, and that their privacy is guarded. Women should have every opportunity to ease the pain of contractions without using an epidural analgesia as a first resort because pharmacological methods of pain relief carry additional risks and adverse effects for the baby and mother. Specifically, an LDR room should include:

* An ensuite toilet and shower with dimmable lighting
* Access to a permanently-installed labor/birthing pool
* Sufficient space to accommodate medical equipment, a variety of labor aids, and staff, while leaving room for the woman to walk and try various labor positions
* Attractive, home-like finishes, artwork in a soothing palette, and adjustable lighting
* Privacy features including curtained doors and windows and walls that do not transmit sound
* Access to positive distractions including food, drink, television, and items from home
* Access to comfort items such as warm towels, clean linens, and aromatherapy/massage oils
* Support for birth partners including food and drink, comfortable seating, and dry space in toilet rooms
* Abundant windows with refuge and prospect nature imagery, and room darkening shades (135).*
within the hospital as an institution ostensibly devoted to hospitality, a point to which we will return.

The final aspect of agency that Lyerly highlights is the laboring subject’s “need to be present” in birth.\textsuperscript{104} Such presence is a good in and of itself, as it enables the laboring subject to “bear witness” at the very moment that the bodily estrangement described above reaches its peak.\textsuperscript{105} This presence comes with an awareness that what is happening is part of one’s self, not an external event that happens to someone. Through attending to one’s embodied experience, the laboring subject is able to do the work of “making meaning” of the experience, even as much of that work is done in retrospect.\textsuperscript{106} Bearing witness to birth is a fundamental precondition for reconciliation following bodily disruption and estrangement; it makes possible a narrative in which the person who emerges following the conversion of birth maintains a deep sense of continuity with her past self. This need to be present provides a way of discerning between various responses to pain; for some women, an epidural might make presence impossible, and for others, an epidural seems necessary for them to bear witness during birth. Those attending to the laboring subject can use the goal of fostering bodily presence to discern how to arrange the particular practices, discourses, and practitioners in any given birth. In other words, the medical practitioner’s work of attending in labor and delivery is in service to enabling the laboring subject’s more fundamental work of attending childbirth in a way that makes it her own.

Lyerly then moves on to the other key elements of the story of a good birth: security, connectedness, respect, and knowledge. For the women Lyerly interviewed, security best

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\textsuperscript{104} Lyerly, \textit{A Good Birth}, 66.  \\
\textsuperscript{105} Ibid., 67.  \\
\textsuperscript{106} Ibid., 70. 
\end{flushleft}
comes not through battle but through “partnership and peace,” thus reinforcing our argument that in the hospital the work of befriending the body is more fundamental than relationships of hostility or force.107 Next, Lyerly’s discussion of connectedness builds conceptually off of the need for bearing witness during birth. In order to remain connected to one’s body and to the body emerging from it, Lyerly emphasizes the need for connectedness with family and friends, with medical practitioners, and with further communities of support outside of the hospital. Because childbirth involves “a pulling apart and coming together, a sequential rending and re-forming of one of life’s most intimate connections,” then connection with others is necessary to create an environment for a peaceable bodily connection with one’s self and the emerging life.108 Practices of laboring such as breathing together and “communal pushing” enable interconnectedness in ways that overcomes clear dualisms between the body and the self and between the self and others.109

Lyerly also emphasizes the importance of “respect” for the narrative of a good birth, but not the “respect for autonomy” that medical ethicists continually promote. As she reflects on a cesarean section, such respect for autonomy was certainly present, “but the way things went, I could just as well have been having an appendectomy.”110 Such respect for autonomy reflects the medical imaginary in the surgical ward and James Childress’s moral response that we explored in chapter two. In contrast, Lyerly emphasizes respect that dignifies both the event of birth itself and the childbearing woman and her baby, and a respect that refuses the shame that comes with births that fail to meet certain idealized

107 Ibid., 109.
108 Ibid., 126.
standards. Such a connection between respect and dignity reinforces the inherently constructive and caring nature of Lyerly’s project, and of all efforts to attend and enable a good birth.

Finally, Lyerly’s account shows us the ways in which knowledge is an important element of preparing for befriending the body in childbirth. This is true both in attaining the right kinds of knowledge and in recognizing the limits of knowledge. In many ways, Lyerly’s entire project in knowing more about good births is a recognition of the goodness that comes with finitude, the finitude of knowing and acting in our particular embodied contexts. She concludes,

The experience of giving birth changes us; it changes what we value in birth and in life. It teaches us about ambivalence and uncertainty. It is a lesson in control and its limits. If we strive to be agents of our births, we come to recognize that something profound is happening to us—something we cannot orchestrate. If we strive to feel safe and secure in the context of birth, we come to recognize that risk is unavoidable in birth no less than in life. If we strive to feel connected in birth, we come to realize that birth is both a pulling apart and coming together, a challenge to the notion of an independent self. If we strive to become wiser through birth, we come to recognize that there will always be things we cannot know.

The “ambivalence and uncertainty” that mark labor and delivery means that good births are marked by both the laboring subject and her medical practitioners ceding control without wavering in attending to the laboring body. As Lyerly argues, the agency, security, connectedness, respect, and knowledge that are all part of the narrative of a good birth cannot be willfully imposed, neither through forceful interventions on the body as enemy nor through mapping and manipulating the body as an object. Instead, the work of befriending the body requires both patients and practitioners attending carefully to bodily

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111 Ibid., 157-158.
estrangement while relinquishing the desire to master the body. The conditions and possibilities for such attention can be found in the constellation of discourses, practices, and practitioners in the labor and delivery, and perhaps throughout the institution of the hospital itself.

So far, we have seen that the labor and delivery ward contains modes of imagining and engaging the laboring body as enemy, object, and friend. These medical imaginaries and the institutional arrangements that make them possible all developed over time; they have histories. And it is to those histories we now turn in order to understand more fully both how the labor and delivery ward and the institution of the modern hospital took shape.

### 4.4 Histories

Through tracing the pathways of perception revealed in phenomenological accounts of pregnancy and birth, we have discerned three medical imaginaries within the modern labor and delivery ward. The first two are manifestations of the medical imaginaries we explored in chapters two and three: the body as enemy and the body as object. And, as we shall see, the histories of how these medical imaginaries became present within the labor and delivery ward is bound up with the histories we traced in those two chapters. Our phenomenological and ethnographic investigations of the laboring subject also reveal a third medical imaginary in which the estranged body is imagined and engaged as friend. By exploring the history of this medical imaginary, we will be able to better understand both the moral questions and the moral resources at hand in any effort to befriend the body within labor and delivery. In other words, engaging the history of a medical site better reveals to us the possibilities for moral action within it. This is especially the case because the medical
imaginary that engages the body as friend, though often disregarded, actually is able to lay claim to an older history within the hospital than either of the other two medical imaginaries we have considered. We begin with the particular histories that bring each laboring subject to the labor and delivery ward before turning to the broader histories of this medical site and the institution of the hospital itself.

4.4.1 Histories of the Laboring Subject

The most immediate history of how the body is imagined and encountered in the modern labor and delivery ward is the continuum of care that the pregnant subject received before she arrived at the hospital. Labor and delivery is one of the few sites within the modern hospital in which a medical practitioner still attends a patient as they move from care in the outpatient setting to care in the inpatient setting. It is still possible to catch a glimpse in the labor and delivery ward of the older model of a primary care physician serving as the patient’s attending doctor upon their admission into the hospital. This continuity of care makes possible attending to the laboring subject in a way that befits their own narrative and their particular embodied history. That said, such a narrative may still involve imagining the body as enemy, as object, or as friend; the medical imaginaries found within labor and delivery also shape how the pregnant body is imagined and encountered in care before childbirth. We offer a brief sketch of these personal histories before moving to a broader history of the institution of the hospital.

As Robert Root and Carole Browner argue, there are “practices of the pregnant self” that are “an effort to manage the physical, social, and psychological changes incumbent upon
pregnancy.” In the different arrangements of these practices, we can discern distinct medical imaginaries. So, for example, in the discourses, practices, and practitioners that surround “high-risk pregnancies,” we see clearly ways in which the body is imagined and engaged as a threat and an enemy. Ultrasounds, blood pressure checks, and urine samples can all become ways of evaluating potential bodily threat, and the pregnant subject permits her medical practitioner to respond with force where appropriate.

These same practices, however, can be used to objectify the pregnant body, placing the body on a statistical continuum from normal to abnormal. This is true for blood pressure checks and blood tests as they convert the pregnant body into statistics, and it is especially true for the ultrasound. The movements of emerging life are normally tactile and only accessible to the pregnant subject and those whom she guides to feel the presence of this quickening life. But sonography converts the tactile, first-person understanding to a visual knowledge accessible to all in the third-person via an ultrasound. Here we see the clinical gaze of medicalization in full force, as the pregnant subject relies on a medical practitioner to inform her about her own body as technology makes it visible to all in real time. As a

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113 Robin Root and Carole Browner, “Practices of the Pregnant Self: Compliance with and Resistance to Prenatal Norms,” *Culture, Medicine and Psychiatry* 25, no. 2 (2001): 218. For Root and Browner, these range on a continuum from “absolute compliance” to “open resistance” to the biomedical model. This project adds the body as enemy as a potential imaginary, transforming Root and Browner’s linear continuum to something more like a plane.


115 As Rayna Rapp argues, “Sonography bypasses women’s multifaceted embodiment and consciousness, providing independent medical knowledge of the fetus. Moreover, the technological framework reduces the range of relevant clues for whose interpretation women act as gatekeepers.” Rayna Rapp, “Real-Time Fetus: The Role of the Sonogram in the Age of Monitored Reproduction,” in *Cyborgs & Citadels: Anthropological Interventions in Emerging Sciences and Technologies*, eds. Gary Lee Downey and Joseph Dumit (Santa Fe, NM: School of American Research Press, 1998), 39.

Also, it is important to note that the visualization of the fetus occurs by making the rest of the pregnant body invisible. For more on this, see Margarete Sandelowski, “Separate, but Less Unequal: Fetal Ultrasonography and the Transformation of Expectant Mother/Fatherhood,” *Gender & Society* 8, no. 2 (1994): 230-245.
result, pregnant subjects are trained to perceive and speak in certain ways: “If I want an honest opinion, closest to the truth as you can get, I ask the doctor.” Medical practitioners are not the only ones shaping how the pregnant subject perceives her body as an object; *What to Expect When You’re Expecting* is a massively popular publication that reinforces a medicalized view of the pregnant body.

But just as the pregnant body is epistemically underdetermined, so too these practices of health care do not necessitate that the body is imagined and engaged as an enemy or as an object. That this is the case should be evident when the same practice can be used either to ascertain bodily threat or to map the body as an object. But it is also true that these medical practices can enable imagining the body as friend, though they certainly do not necessitate such an understanding. Even as an ultrasound makes possible medicalizing the pregnant body, it also can enable partners and other loved ones to better understand and support the pregnant subject. Great care has to be taken to continue privileging the pregnant subject’s perspective over the clinical gaze. But enabling a pregnant subject to learn the sex and see images of the life emerging inside her can empower her to befriend her own flesh, as seen in patterns of perception such as “she has my nose.” Similarly, Doppler monitors are used to hear fetal heartbeats; the same practice that places a developing life on a statistical spectrum

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116 This quotation from an interviewed pregnant subject represents someone who is in a state of “absolute compliance” with biomedical ways of knowing. Root and Browner, “Practices of the Pregnant Self,” 208.

117 As Margarete Sandelowski writes, “The democratization of fetal experience that ultrasonography can engender, by providing access to the fetus even to people who are not or can never be pregnant, has enhanced the experiences of men by enlarging their vision. It has also enhanced the experience of women by permitting them to realize their desire to share pregnancy; but, it may also trivialize the experiences women alone have.” Sandelowski, “Separate, but Less Unequal,” 242.
also enables a pregnant subject to hear that her body contains another heartbeat and that it sounds beautiful.\textsuperscript{118}

Beyond these more overtly technological health care practices there are innumerable moments in which practitioners accompany the pregnant subject as she experiences bodily disruption. Good health care for the pregnant subject is filled with a variety of moments in which a medical practitioner can serve as “friend and teacher,” in the words of Adrienne Rich.\textsuperscript{119} This can look like a late night phone call to after-hours care in which a nurse assures the pregnant woman that a particular strange bodily sensation is healthy and to be embraced. At other times, medical practitioners can recognize that a particular bodily disruption must be endured before the body can be embraced, and so they offer ways of actively working to soothe a body in the throes of nausea or back pain. In their work of befriending and guiding the pregnant subject, medical practitioners make it possible for her to experiences bodily disruption throughout pregnancy “as a fullness rather than a lack,” in the words of Young.\textsuperscript{120}

\textbf{4.4.2 Histories of Labor and Delivery}

These histories of care for a particular pregnant subject are themselves embedded in lengthier histories of the institution of the hospital and often competing guilds of care. By engaging these histories of the labor and delivery ward and of the hospital, we will better be able to perceive the possibilities for moral action within them. As we shall see, the development of the labor and delivery ward is fundamentally connected to the histories chronicled in our previous two chapters. For the American histories of how the body

\textsuperscript{118} The audible nature of this practice makes it more easily amenable to the tactile mode of knowing primarily experienced by the pregnant subject, even as the sound becomes visible to the medical practitioner when it is converted into the numbers of a heart rate.

\textsuperscript{119} Rich, 151. Although Rich was referring to the work of midwifery in “the birth-chamber,” the argument here is that such work extends throughout pregnancy and is not limited to midwives.

\textsuperscript{120} Young, 51.
became imagined as enemy and as object in labor and delivery, we take as our guide Richard and Dorothy Wertz’s *Lying-In: A History of Childbirth in America.*\(^{121}\) In it, they chronicle how childbirth in America became “viewed as a potentially diseased condition that *routinely* requires the arts of medicine to overcome the processes of nature.”\(^{122}\) Crucial to their story is how “the exclusion of women from midwifery and obstetrics had profound effects upon the practice.” According to Wertz and Wertz, this masculinization of the care of the laboring subject involved “a confusion of the need to be masterful and even male with the need for intervention.”\(^{123}\) With these shifts in the gender landscape of childbirth care in mind, we focus in on two key historical strands of thought that made possible this transformation in American approaches to childbirth.

According to Wertz and Wertz, two of the earliest roots of this transformation are a French tradition of scientific medicine and an English tradition of barber-surgeons. The French tradition was housed in “the hospital-schools established in Paris” where beginning in the sixteenth century midwives and surgeons “developed a new rational view of birth processes and a number of techniques to aid them.”\(^{124}\) In a move that predated and prefigured what Foucault chronicled as the birth of the clinic, these hospital-schools engaged in a “rationalizing of birth processes” that “led them to call their new midwifery a science.” In the discourse of this scientific midwifery, “surgeons and midwives spoke of the womb and birth canal as though they formed a mechanical pump that in particular instances


\(^{122}\) Ibid., xvi.

\(^{123}\) Ibid., 72. Interestingly, they theorize that the training of obstetricians fit better with the mobile nature of American society; in contrast, the lack of stable communities meant that “networks of women to support midwives were more often broken.” In other words, the formation of a medical resident into a replaceable cog untethered to particular places, which we explored in chapter three, may be connected to the masculinization of American medicine in general and obstetrics in particular. Again, this masculinization of the field is much more pronounced in America than elsewhere.

\(^{124}\) Ibid., 31.
was more or less adequate to expel the fetus.” Here we see the beginnings of a process that we documented at length in chapter three, and it culminates in what Davis-Floyd referred to as the “technocratic” model of labor and delivery where the body is imagined and engaged as an object.\textsuperscript{126}

In contrast, the English tradition was not originally housed in hospital-schools but instead developed through “the often desperate struggles of poorly educated medical empirics, the barber-surgeons, to save the life of the mother by extracting the child with whatever tools they could devise.”\textsuperscript{127} To do this, the barber-surgeons had an “armamentarium” of instruments designed “to extract the fetus, living or dead.” “Most often,” Wertz and Wertz state, “the surgeons had to kill the impacted child in order to save the mother’s life.”\textsuperscript{128} Out of these often deadly interventions emerged the forceps, an instrument through which the surgeons controlled their force in an effort to do minimal harm.\textsuperscript{129} These “desperate struggles” parallel the efforts of military surgeons whose violent interventions on the battlefield involved amputations and often resulted in the deaths of those were trying to save. As a surgical discipline, anesthetics and antisepsis were particularly influential for obstetrics, as the pain of childbirth and the deadly contagion of puerperal fever were both transformed in the nineteenth and twentieth century.\textsuperscript{130} In these ways and

\textsuperscript{125} Ibid., 32.
\textsuperscript{126} Wertz and Wertz argue that the masculinization of obstetrics matters in a particular way for this medical imaginary. They claim that “the male doctor-female patient relation” furthered “the process whereby the female body became an object to medicine and to women themselves.” See p. 104.
\textsuperscript{127} Ibid., 34.
\textsuperscript{128} Ibid., 34.
\textsuperscript{129} The history of the development of forceps is particularly controversial, as its inventor, Peter Chamberlen, and his family profited off of them as a proprietary secret for over a century. In her commentary on this episode, Adrienne Rich combines several prominent critiques of obstetrics: she describes it as over-reliant upon both force and technology, as more concerned with money than the welfare of women, and as a masculine discipline seeking to displace women midwives. Rich, 142-151.
\textsuperscript{130} The history of puerperal fever in childbirth is another area of important critique for obstetrics, as evidence of the means of transmitting the contagion was available to the field for decades before meaningful change was
others, then, historical transformations in childbirth participate in the rise of imagining and engaging the body as an enemy.

Before turning to the institutional history of the labor and delivery ward, it is important to remember that historically these medical imaginaries have been racialized in crucial ways. In an infamous moment in the history of obstetrics and gynecology, J. Marion Sims bought female slaves in order to develop a surgical procedure for the repair of vaginal fistulas, tears from obstructed childbirth that led to urine involuntarily releasing through the vagina. Sims purchased these black women with fistulas, treating them as objects, and he refused to provide them with anesthesia as he experimented on his technique, maintaining that they had a higher tolerance for pain. Sims believed that the bodily threat of his new procedure was too great for white women to undergo until it was perfected, and even then they were given ether anesthesia. The experiences of Ingmarie Stith-Rouse and Serena Williams, chronicled above, have a deep and racialized history in the development of the modern labor and delivery ward.\(^{131}\)

The earliest American institutional predecessors to the modern labor and delivery ward were freestanding maternity hospitals. In the nineteenth century, these “urban asylums” existed to offer charity care to “poor, homeless, or working-class married women who could not deliver at home,” and after the Civil War these patients began to include “unmarried

expectant women.”¹³² Most immediately, these institutions were offering charity care in
response to the problems of urbanization, and they also attempted, in the spirit of the age,
to offer moral reform to their patients. In many ways, then, they represented a
Protestantization of an older institutional model of charity care, to which we will turn
momentarily.¹³³ First, however, we must note the significant institutional changes that came
in the latter half of the nineteenth and the beginning half of the twentieth centuries.

Following the Civil War, maternity hospitals experienced the same institutional
transformations we chronicled in chapter two, as disciplined regimens were instituted in
order to fight contagion. Wertz and Wertz make this connection explicitly, saying that
maternity hospitals drew “from practices in military hospitals during the Civil War” in order
to instill a “medical posture...of manipulation, intervention, and active combat.”¹³⁴ Each
woman was treated “as if she was diseased,” and so practices of “cleaning, shaving, and
purging the patient” instilled an ordered cleanliness that sought to aggressively ward off
infection.¹³⁵ Wertz and Wertz use the example of Sloane Maternity Hospital in New York to
describe the results of this disciplining of care in the maternity hospital:

In 1900 each patient at Sloane received an enema immediately upon admission and
then a vaginal douche with dichloride of mercury, the favored antiseptic. Nurses then
washed the woman’s head with kerosene, ether, and ammonia, her nipples and
umbilicus with ether; they shaved the pubic hair of charity patients, assuming that
poor people harbored more germs, and clipped it for private patients. They gave
women in labor an enema every twelve hours and continued to douche the vagina
during and after labor with saline solutions to which whisky or dichloride of mercury
was added.¹³⁶

¹³² Wertz and Wertz, 132.
¹³³ As we noted in chapter three, these kinds of urban institutions followed shifts in understanding of charity
that both predated the Reformation and were intensified in its wake, particularly in Protestant regions of
Europe. See Risse, Mending Bodies, Saving Souls, 216-219.
¹³⁴ Wertz and Wertz, 137.
¹³⁵ Ibid.
¹³⁶ Ibid., 138.
Here we see the instillation of a controlled regimen designed to combat threats, and it participates in the same transformations described in chapter two. In ways directly tied to our description of Nightingale’s influence, nurses played a crucial role in instantiating this medical imaginary within the maternity hospital. The transformation of the maternity hospital by this surgical imagination culminates in the incorporation of the cesarean section as an operation designed to save the lives of both the laboring subject and her emerging child.

Therefore, this disciplining of care in the maternity hospital follows the disciplining of surgery as it was incorporated into the modern hospital at the end of the nineteenth and the beginning of the twentieth century. Like the surgical ward, the labor and delivery ward became a part of the modern hospital in the first decades of the twentieth century, and this transformation was accelerated by the Great Depression. Along with appendectomies, which we examined in chapter two, obstetrical deliveries were a major driving force in the growth of the American hospital. Wertz and Wertz describe how these transformations were captured in a 1939 *Atlantic* article, which “argued that, just as no one would have an appendectomy performed on the kitchen table, so no woman should have her delivery there.” Delivery, too, was “a surgical procedure.”

Alongside the disciplining of labor and delivery according to the surgical imagination, we also see the rise of “scientific medicine” within obstetrics. Key to this imaginary was transforming the hospital into “a laboratory and school around which the profession of obstetrics might be upgraded and organized.” This scientific approach to obstetrics

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138 Ibid., 105.
139 Wertz and Wertz, 159.
140 Ibid., 145.
parallels what we chronicled in chapter three as the rise of imagining the body as an object, including the labor and delivery ward becoming a “clinic” for teaching and research. J. Whitridge Williams, Professor of Obstetrics at Johns Hopkins, led the charge for many of these transformations. He sought to reform the maternity hospital into a space of scientific control over childbirth. To that end, he pushed for all births to occur in the hospital, where the best obstetricians would be training their students, and he also urged the abolition of midwifery in America, as it led to far too many homebirths. Williams’s reforms eventually did for obstetrics what the Flexner Report did for much of medicine, and it is no coincidence that both had their origins at Johns Hopkins.¹⁴¹

We can see a clear example of obstetrical care as “scientific medicine” in the example of “Twilight Sleep,” which was an influential medical practice for much of the twentieth century even though it receives little attention today. The practice of “Twilight Sleep” was imported from scientifically advanced Germany. As Wertz and Wertz explain,

This technique involved injecting the woman with morphine at the beginning of labor and then giving her a dose of an amnesiac drug, called scopolamine, which caused her to forget what was happening; once the fetus entered the birth canal, the doctor gave ether or chloroform to relieve the pain caused by the birth of the head. Altogether, the procedure dulled awareness of pain and, perhaps more important, removed the memory of it.¹⁴²

During delivery, the laboring subject’s arms were often strapped down and her legs were strapped into stirrups. A variety of technological interventions continually manipulated her body in an effort to control the processes of birth.¹⁴³ This control of the objectified body was part of scientific obstetrics, but it must be noted that “women with feminist and suffragist sympathies spearheaded this drive” for “Twilight Sleep.” These women argued that

¹⁴¹ Ibid., 145-147.
¹⁴² Ibid., 150.
¹⁴³ Ibid., 165.
medicine ignored the pain of childbirth and “they would not get relief unless they
demanded it.”¹⁴⁴ In this way, the control of scientific obstetrics and the control of pain
sought by these women dovetailed in creating the conditions and possibilities for the
laboring body to be perceived as an object in the labor and delivery ward. The rise of
“Twilight Sleep” was crucial for drawing more wealthy pregnant women into the hospital.¹⁴⁵

By the middle of the twentieth century, then, labor and delivery wards had been
incorporated into hospitals in ways that combined these surgical and scientific imaginaries. Hospitals recognized the importance of this achievement; their promotional material was filled with smiling mothers and newborns, promising the safest and most advanced care.¹⁴⁶

But discontents began to emerge: “What had begun in the 1920s as a pursuit of safety, comfort and efficiency, a shared effort by doctors and patients to have the “best” for birth, had become by the 1950s and 1960s an unpleasant and alienating experience for many women.”¹⁴⁷ Adrienne Rich’s reflections in *Of Woman Born* begin with her own experience of “Twilight Sleep”:

> The experience of lying half awake in a barred crib, in a labor room with other women moaning in a drugged condition, where “no one comes” except to do a pelvic examination or give an injection, is a classic experience of alienated childbirth. The loneliness, the sense of abandonment, of being imprisoned, powerless, and depersonalyzed is the chief collective memory of women who have given birth in American hospitals.¹⁴⁸

In response to labor and delivery being construed as an “emergency,” as Naomi Wolf later said, Rich and others have criticized childbirth in the American hospital in the ways we examined above. In their search for more hospitable conditions for birth, they have often

¹⁴⁴ Ibid., 150.
¹⁴⁵ Ibid., 154.
¹⁴⁶ For more on this mid-century understanding of hospitals, see Risse, “Main Street’s Civic Pride: The American General Hospital as Professional Workshop,” in *Mending Bodies, Saving Souls*, 463-512.
¹⁴⁸ Ibid., 176.
turned to the home or to freestanding birth centers. But in doing so they and others have overlooked a key strand in the history of the hospital, one that emphasizes practices of hospitality and that makes possible the charitable institutions of the Hôtel-Dieu, as we saw in chapter three, and the early nineteenth century maternity hospital we explored above. To discover the roots of this institution and its corresponding medical imaginary, we turn to an unexpected source: fourth century Cappadocia.

4.4.3 The Hospital as a Christian Institution

The nineteenth century maternity hospital was one of the last modern iterations of an ancient Christian innovation: the charity hospital. In the history of this institution we discover transformations that have fundamentally altered the moral landscape of healthcare and the hospital. By investigating the history of the charity hospital, we will be in a position to understand the moral questions and the moral resources at hand within the modern labor and delivery ward and the hospital more broadly. We will move from a set of broader transformations within Greco-Roman society as Christianity rose to prominence to how those transformations were instantiated in the institution of the hospital in fourth century Cappadocia.

To understand the roots of the charity hospital, we must first begin with a fundamental transformation that occurred in late antiquity: the rise of “the poor” as a category of people deserving special consideration. As Peter Brown chronicles in Poverty and Leadership in the Later Roman Empire, philanthropy for wealthy Greco-Roman elites involved generosity bestowed upon their particular cities and civic communities. Before the conversions wrought by the rise of Christianity, a “rich man,” according to Brown, was
honored for being a “lover of his home city,” never for being a “lover of the poor.” Their gifts were often grand municipal buildings or some other sort of beneficence for the city’s citizens. And even the infamous “bread and circuses” were gifts given from the emperors to the plebeian *citizens* of Rome. An entire political cosmology existed around the citizen’s duty to bring glory to his city; non-citizens did not even register on that cosmological landscape. In contrast, the Christian bishop became known as the “lover of the poor” *par excellence.* Steeped in Jewish concern for the poor, Christian charity “was a new departure” in the wider Greco-Roman world. By rejecting a model in which “only fellow-citizens needed to be clearly visible,” Christian concern for the poor brought into relief those who were simply not seen according to the political logic of the day. According to Brown, Christian love for the poor “threw open the horizons of society,” and made possible a new social order:

This more comprehensive community was presented now as frankly divided between the rich and the poor, with the rich having a duty to support the poor...The rich, therefore, were encouraged to look through the many intermediate layers of society...to focus, as in a dramatic close-up, on those who lay at the very bottom. Their relation to the poor acted, as it were, as a symbolic clamp. It bracketed and held in place an entire society. To act as a “lover of the poor” was to make an assertion, heavy with symbolic meaning, of one’s acknowledgement of the ultimate cohesion of the entire human community.

This radical reordering of societal norms was a true innovation. “To put it bluntly,” Brown says, “in a sense, it was the Christian bishops who invented the poor.”

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150 This was true for slaves, immigrants, poor non-citizens, and, in many ways, for women. For more on the threat of Christian celibacy to the cosmology of the Greco-Roman city, see Peter Brown, *The Body and Society: Men, Women, and Sexual Renunciation in Early Christianity*, 20th anniversary edition (New York: Columbia University Press, 2008).
151 Peter Brown, *Poverty and Leadership*, 1.
152 Ibid., 6.
153 Ibid., 8.
Such a social innovation transformed the moral landscape, providing a new way of speaking, perceiving, and acting in the world. Brown cites a well-known letter from Julian, the last pagan emperor, in which he creates a system of poor relief in Galatia modeled on Jewish and Christian charity:

In every city establish frequent hostels in order that strangers [in fact, the wandering poor] may benefit from our benevolence...I order that one-fifth of this be used for the poor who serve the priests, and the remainder be distributed by us to strangers and beggars. For it is disgraceful that, when no Jew ever has to beg, and the impious Galileans [the Christians] support not only their own poor but ours as well, all men see that our people lack aid from us [that is, from the pagan priesthood].

Julian’s order to create a network of hostels was meant to emulate already existing Christian institutions, the *xenodocheia*. These “houses for strangers” sheltered poor travelers, and they were sometimes known as *ptōchotropheia*, places for the “nourishing of the poor.” Julian recognized that Jewish and Christian “love for the poor” had changed the moral calculus by which he must operate, and he responded accordingly. We will return to the importance of this fundamental challenge to the Greco-Roman city and political cosmology. With this conception of charity in mind, however, we must first describe the charity hospital, that institution that served as a precursor for the Hôtel-Dieu and the nineteenth century maternity hospital.

A few years after Julian gave this order, Basil of Caesarea founded the first charity hospital by combining the hospitality to strangers found in the *xenodocheia* with the inpatient

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medical care offered within monastic communities.\textsuperscript{156} By attending to this institutional innovation, we will be in a position to understand the theological commitments to hospitality that undergird the institutional arrangements that create the conditions for befriending estranged flesh. Historian Andrew Crislip defines the ancient hospital as an institution that shared a set of three basic features, “inpatient facilities, professional medical care, and charity,” and he argues that Basil founded the first structure to include all three of these features.\textsuperscript{157} Basil’s institution was complex, including “hospital facilities for the sick, a hospice for lepers, a poorhouse for the indigent and elderly, and a hostel for travelers and the homeless.”\textsuperscript{158} The institution was most well-known for its charitable inpatient healthcare. Although Basil himself referred to using a variety of terms, including \textit{xenodocheion} and \textit{ptôchotropheion}, others named it after him, calling it the Basileias. The staff included doctors and nurses; alongside medical care patients received food, moral instruction, and training in crafts. Crislip summarizes the institution as “a charitable hospital, in which the poor could receive treatment from monastics, nurses, and doctors. They were prepared for their discharge and for reintegration into healthy society, not only physically but also morally and economically.”\textsuperscript{159}

In order to prove that Basil’s hospital was a true innovation, Crislip compares it to two institutions we discussed briefly in chapter two: the Greek \textit{asclepeion} and the Roman...


\textsuperscript{157} Crislip, 102.

\textsuperscript{158} Ibid., 104.

\textsuperscript{159} Ibid., 118.
The temple of Asclepius, the *asclepeion*, met two of Crislip’s criteria, as it provided lodging without ostensibly charging a fee, though a donation to the temple of some kind was generally expected. Because, however, it did not include trained medical practitioners, instead largely relying on priests interpreting the dreams of the sick, the *asclepeion* failed to meet Crislip’s definition of an ancient hospital. The Roman *valetudinarium* was an institution that either cared exclusively for soldiers or for slaves, and so it was not a facility of charitable care open to all. Crislip also judges three other potential predecessors—doctors’ clinics, public physicians, and Arian Christian charities—as all lacking at least one key element of an ancient hospital, whether inpatient facilities, trained medical practitioners, or charitable care. In this way, then, Crislip argues that Basil’s hospital ushered in a new institutional form.

Where Crislip focuses on Basil’s institutional innovation, Peter Brown draws our attention to the events immediately leading up to it. Sometime between 368 and 370 CE, when Basil was a young priest preparing to become a bishop, a famine struck Cappadocia. A massive food shortage was “caused by the panic of the rich,” who were unwilling to open up their stores of grain in the face of a famine with no end in sight. Basil’s city, Caesarea, was isolated, and “the threat of famine brought the destitute of an entire region to the gates of the city.” In response, Basil preached a series of sermons in which he implored the rich to be generous to the poor. In one striking example, he criticized the city’s elites as more concerned with achieving immortality through civic monuments, “great cliffs of stone and

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161 Crislip, 120-123.
162 Ibid., 125-127.
163 Ibid., 123-125, 127-133.
marble,” than with caring for the poor. In response, they eventually opened their storehouses, and Basil was able to found his hospital in part due to their generosity. In this example we see clearly the transition between one social and moral order, “love for the city,” to another, “love for the poor.”

Following Basil’s death, Gregory of Nazianzus made clear the power of this transformation as he eulogized his friend and fellow Cappadocian. A decade prior, Basil implored his listeners to shift their concern toward the poor and away from the glory of their city, Caesarea. The fruit of that work was, according to Gregory, a “new city,” the Basileias. In his eulogy, Gregory says,

Go a little outside the city, and gaze on the new city: the storehouse of piety, the common treasury for those with possessions, where the superfluities of wealth as well as the necessities lie stored away because of [Basil’s] persuasion—shaking off moths, giving no joy to thieves, escaping struggles with envy and the onrush of time—where disease is treated by philosophy, where misfortunes are called blessed, where compassion is held in real esteem.

The transformation wrought by Basil became a “new city,” one that stood in stark contrast with the decaying glory of imperial Caesarea. In it, disease is treated philosophically, charity is valued, and bodily “misfortunes” are transformed through hospitality and care to become “blessed.” We will return to the changes in bodily perception made possible by hospitable practices of care later in the chapter. First, though, we must fully appreciate the achievement of the Basileias. As Brian Daley says,

[T]hat large and complex welfare institution on the outskirts of the Cappadocia metropolis that came to be known as the “Basileias” represented a new and

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165 Brown, Ibid., 40.
increasingly intentional drive on the part of these highly cultivated bishops and some of their Christian contemporaries to reconstruct Greek culture and society along Christian lines, in a way that both absorbed its traditional shape and radically reoriented it.  

In founding the first charity hospital, Basil offered an institutional witness as part of the argument that we traced above; in the Basileias we see the transition from a social and moral order determined by love for the Greco-Roman city and its glory to an order structured by “love for the poor.” By doing so, Basil gave birth to a medical institution in which trained practices of bodily care were offered in the context of hospitality to the stranger.

Basil’s achievement was not created in a vacuum, with no intermingling with prior forms or contemporary politics. Daley indicates as much when he says that the Basileias represents Christian work to both absorb and radically reorient traditional Greco-Roman society. Peter Brown investigates this further, arguing that Basil’s sermons and founding of the hospital have to be considered in light of complex relationships with the emperor and his officials. First, the charitable care offered by the church was part of the a delicate dance with the empire in which the church’s privileged status with the Christian emperor was justified in part by the church’s services for the poor. Because of this, Brown argues,

Basil’s activities in relieving Caesarea at a time of famine are best seen as the actions of a man acting quickly and with maximum publicity in order to justify the privileges of his church. Beneath the gaze of an emperor and his highly placed officials, he created a publicly acclaimed system of poor relief that showed that the wealth and tax exemptions of the church in Caesarea were being used to good effect.

Here we see the pressures placed upon the bishop as “lover of the poor” in a society reordered around the “ultimate cohesion of the entire human community.” Brown goes on to suggest that Basil’s efforts also may have been in response to the Roman emperor,

167 Daley, 432.
168 Peter Brown, Poverty and Leadership, 39.
169 Ibid., 6.
Valens, traveling to the east in 370 CE. Both Basil and Valens knew that the famine in Caesarea was going to be compounded by an imperial court that “intended, in the near future, to eat its way through Cappadocia.” Because “both men were committed to maintaining the social fabric of a crucial region,” they struck “a strange alliance.” Therefore, according to Brown, the founding of the Basileias was both a remarkable moral achievement and “a striking outcome of the Constantinian settlement, by which the church was granted its privileges in return for a fully public commitment to the care of the poor.” In the founding of the Christian hospital, therefore, we see a willingness to work with unlikely allies in the work of securing the local common good. This work is woven into the foundation of this transformational institution, and as we shall see this has implications for considering the theological legacy present within the hospital today.

Alongside transforming Greco-Roman society, Basil’s hospital was also an innovation of the monastic model of care. Crislip argues that monastic communities already contained trained inpatient care available to all members of the community. Basil’s contribution was to incorporate this institution into the Christian practices of charity, and so place hospitality to the stranger at the heart of inpatient medical care. In turn, Basil’s model influenced future monastic communities. As Guenter Risse argues, “The foundation of *xenodocheia* in the West had followed St. Basil’s model of community sponsorship of a “new city” capable of  

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170 Ibid., 41.
171 Ibid., 42. For later proof of this transformation of the social order, Brown points to a mosaic placed at the entrance of a hospital found in modern day Syria. Laid in 511 CE, the mosaic contains the classic Roman image of Romulus and Remus being suckled by a wolf. This “unexpected echo in a distant eastern province of the legend of the founding of Rome” has been stripped of its traditional “imperial associations” of an “Unconquered Rome.” “In a Christian hospital,” Brown says, “the suckling wolf of Rome has been transmuted, rather touchingly, into an emblem of care for the helpless” (35).
172 Crislip, 138-142.
receiving people in need.”\textsuperscript{173} The Western Roman Empire never developed as extensive of a network of hostels and hospitals as that found within the Byzantine Empire. Instead, in the West, “monasteries rather than decaying episcopal cities assumed the greater role in dispensing welfare.”\textsuperscript{174} Western monasteries “gradually became the providers of organized medical care not available elsewhere in Europe for several centuries.”\textsuperscript{175}

These institutions contained, at their core, the commitments to hospitality and care for the sick that animated the Basileias. Risse quotes two key passages from the influential Rule of St. Benedict. In regards to care for the sick, chapter thirty-six of the rule proclaims:

\[\text{B}\]efore all things and above all things (\textit{ante omnia et super omnia}) special care must be taken of the sick or infirm so that they may be served as if they were Christ in person; for He himself said “I was sick and you visited me,” and “what you have done for the least of mine, you have done for me.”\textsuperscript{176}

In care for the sick and the least of these, then, monastic communities considered themselves to be caring for Jesus himself. They went further to instill the logic of Matthew 25, quoted in the passage above, into their form of life, as hospitality to strangers was considered hospitality to Jesus. The Rule also quotes Matt. 25:35, “I was a stranger and you welcomed me,” adding, “in the reception of the poor and of pilgrims the greatest care and solicitude should be shown because it is especially in them that Christ is received.”\textsuperscript{177}

These practices of care for the sick and hospitality to the stranger carry forward theological commitments that became engrained into the institution of the charity hospital. We have noted the influence of this institution on the modern hospital already, as we

\textsuperscript{173} Risse, \textit{Mending Bodies, Saving Souls}, 94.
\textsuperscript{174} Ibid., 95.
\textsuperscript{175} Ibid.
\textsuperscript{176} Benedict of Nursia, \textit{The Rule of St. Benedict: In Latin and English with Notes}, ed. Timothy Fry (Collegeville, MN: The Liturgical Press, 1981), 54; quoted in Risse, \textit{Mending Bodies, Saving Souls}, 96. Benedict is quoting from Matt. 25:36 and Matt. 25:40 where Jesus says that care for the sick and the least of these is care for Jesus himself.
\textsuperscript{177} Risse, \textit{Mending Bodies, Saving Souls}, 99; quoting Benedict of Nursia, \textit{The Rule of St. Benedict}, chap. 53, 72-73.
explored the Hôtel-Dieu at the start of the French Revolution in chapter three and the nineteenth century maternity charity hospital above. These commitments to hospitable health care for the poor help explain a key component in the formation of the modern hospital. With Basil’s institutional innovation and its Western monastic legacy in mind, we now pause to take account of the moral and theological foundations that create conditions and possibilities for the befriending of estranged flesh in the modern hospital.

4.5 Hospitable Bodily Care as a Theological Practice

In each of our previous chapters, we have taken stock of the theological vision embedded within the medical imaginary at hand. For the surgical ward, we turned to Carl Schmitt’s conception of friend/enemy distinctions to reveal the ways in which medical authority is construed and the body imagined and encountered as an enemy. The theological backdrop for this imaginary is a Pauline strand of thought that mutated within medicine into a commitment to fighting death as the ultimate enemy, with the patient’s body as a proxy war for this ultimate conflict. For the Intensive Care Unit (ICU), we turned to Giorgio Agamben, whose understanding of bare life points beyond the friend/enemy distinction that justifies surgical violence to a form of life in the ICU stripped of all meaning. Here, the patient’s body as bare life is thoroughly mastered by sovereign technological control. The theological backdrop for this imaginary is in part understood through the work of Francis Bacon, who seeks to relieve suffering and expand human choice through the mastery of nature.

According to Gerald McKenny, the “Baconian project” seeks to utilize the power of medicine as a mechanism of human control over the contingencies of nature. This results, according to McKenny, in a medicine that is “based on practices and techniques of control
over the body rather than on traditions of wisdom about the body.” These two theological visions are also at work in the ways in which the body is imagined and encountered as enemy and as object in the labor and delivery ward.

With this in view, we turn to give an account of the theological vision at work within the Christian charity hospital. Recall that this institution, as inaugurated in fourth century Cappadocia, serves as the historical backdrop for the freestanding charity maternity hospital, which was incorporated into the modern hospital as the labor and delivery ward. Within the Christian charity hospital, the practice of hospitality reflects a core theological commitment to welcoming the stranger as Christ, as made explicit in *The Rule of St. Benedict*. To fully understand this commitment, we will draw again from Basil and his Cappadocian contemporaries, Gregory of Nyssa and Gregory of Nazianzus, pairing their work with Luke Bretherton’s contemporary theological account of hospitality.

We will examine these theological and institutional commitments to hospitable practices of bodily care in light of the roles guest/host relations and anchor institutions play in shaping moral agency that we considered in chapter one. We begin with how Basil’s approach to hospitality and care in the charity hospital responds to the new guest/host dynamics that mark inpatient care. We then turn to how these practices of hospitality and care shape the modern hospital as an anchor institution.

Recall that the Hippocratic Oath’s prohibited the practice of “all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons.” It also demanded strict confidentiality regarding everything the physician learned. We argued that these prohibitions make sense as moral efforts to navigate the dynamics of physicians

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178 McKenny, *To Relieve the Human Condition*, 20.
entering their patient’s homes as guests. They lay out boundaries that mark physicians
comporting themselves as good guests in the home of their hosts, the patients. As we asked
in chapter one, key questions for bioethics today are “who is the guest?” and “who is the
host?” when a medical practitioner enters a patient’s hospital room. In the Christian charity
hospital, guest/host relations are reconfigured so that interactions between patient and
practitioners are Christologically charged in important ways.

As we discussed above, Basil’s work in founding the hospital and exhorting the rich to
care for the poor was a part of reordering the connections and commitments that shaped
society. In Basil’s sermons, we can detect “hints of a larger scheme for the Christian,
philosophical reshaping of his city.” And according to Brian Daley, what became known as
the Basileias was “the practical realization of that scheme, in institutional terms.”
Daley goes on to argue that this work was supported by the sermons on loving the poor delivered
by Gregory of Nyssa and Gregory of Nazianzus around the time of the founding of the
Basileias. These sermons “seem unquestionably to belong to the same project of “building a
new city.” In one, Gregory of Nyssa offered a remarkably strong identification of the
sick poor and the person of Jesus Christ:

Do not look down on those who lie at your feet, as if you judged them worthless.
Consider who they are, and you will discover their dignity: they have put on the
figure (πρόσωπον) of our Savior; for the one who loves humanity (ὁ φιλανθρωπία)
has lent them his own figure, so that through it they might shame those who lack
compassion and hate the poor.

181 Ibid., 449.
182 Gregory of Nyssa, De panperibus amandis I, 8.23-9.4; cited and translated by Daley in “Building a New City,”
451. Susan Holman offers an alternate translation of this first sermon “On the Love of the Poor,” entitled “On
Good Works,” in Appendix C of The Hungry are Dying: Beggars and Bishops in Roman Cappadocia (Oxford: Oxford
University Press, 2001), 193-199. In her translation, the passage reads, “Do not despise those who are stretched
out on the ground as if they merit no respect. Consider who they are and you will discover their worth. They
bear the countenance of our Savior. The Lord in His goodness has given them His own countenance in order
that it might cause the hard-hearted, those who hate the poor, to blush with shame” (195). Daley’s translation is
Here, Gregory of Nyssa asserts that Christ has given the sick poor his own figure; his person is present with and revealed through them. Gregory of Nyssa then goes on to invoke Matthew 25 and the last judgment, in which all will be held accountable for what they have done for the sick poor as the least of these. Therefore, the Christological logic encoded in the Rule of St. Benedict and so within Western monasticism was also present at the start of the Christian hospital. The message, repeated over and over, is that in the sick and the poor, we encounter Christ; act accordingly.

If the sick reveal Christ, then for healthcare practitioners to act accordingly involves another Christological element, which we see by returning to Gregory of Nazianzus's funeral oration for Basil. After making reference to the Basileias as that “new city” founded on the outskirts of Caesarea, Gregory of Nazianzus turns to the example of Basil’s own care for the sick. Basil received a basic medical education as part of his education in Athens, and he evidently put it to use in Caesarea through a radical embrace of the marginalized sick. As Gregory of Nazianzus describes it,

Therefore, [Basil] did not disdain to honor disease with his lips, that noble man of noble family and dazzling renown, but he greeted the sick like brothers, but not, as one might think, from vainglory. For who was farther removed from that sentiment? But he set us an example by his own Christian spirit of approaching them and caring for their bodies; a mute but eloquent exhortation….Others had their cooks and rich tables and enchanting refinements of cuisine, and elegant marriages, and soft flowing garments. Basil had his sick, and the dressing of their wounds, and the imitation of Christ, cleansing leprosy not by word but in deed.  

given in the text because it draws out the rich theological and philosophical valences of πρόσωπον and φιλανθρωπία.

183 Because πρόσωπον is such a theologically rich word, the translator’s rendering of it as “figure” could be replaced by the even stronger “person.”  

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By embracing the sick with a kiss and in dressing their wounds, Basil displays what is entailed by the proper imitation of Christ. And even if Gregory of Nazianzus’s funeral oration was in many ways a work of hagiography, in its effort to highlight hospitality and care for marginalized sick people it sets these as standards of excellence for Christian faithfulness moving forward. Given the intense focus on healing throughout Jesus’ ministry, hospitable bodily care itself reveals something of the presence of Christ and places demands on others to follow his example and take up the practice.

In the theological discourse surrounding Basil’s founding of the hospital and care for the sick, then, we can discern a Christian framework for hospitably navigating guest/host relations in this new institution. From Matthew 25 forward, the fundamental refrain is that the presence of Christ is particularly pronounced in those who are sick and poor, and any encounter with them should reflect this theological claim. In this light, when a medical practitioner enters a patient’s room, he or she enters a room in which Jesus is present in their patient. Because of this, hosting patients in a hospital is a theological activity of the highest calling, for it is actually an opportunity to host Christ. In fact, so great is the honor accorded to Christ, and so to the patient, that she becomes host in the room. To say, “Make yourself at home,” to the Lord should not be an empty gesture of hospitality; instead, it should transform the host, in some meaningful sense, into the guest.

At the same time, there are power differentials in the hospital between practitioners and patients that cannot be set aside. There is a real difference between the practitioner entering the patient’s actual home, as in the cases presumed by the Hippocratic Oath, and the patient being housed within a hospital fully embodying its commitments to hospitality. In this light, then, caring for the sick as an imitation of Christ is morally instructive. When
engaging with vulnerable guests in what can be an overwhelming institution, medical practitioners are exhorted to care for them as Christ would. Therefore, even though inpatient care in the hospital reverses the guest/host dynamics presumed by the Hippocratic Oath, the theological foundations of the institution frame the guest/host encounter. In the patient, the hospital and its practitioners encounter Christ, and so they seek to host such a guest appropriately even while recognizing that they are ultimately guests in Christ’s—and so the patient’s—vulnerable presence. Simultaneously, the practitioner’s bodily care of the patient is to be an imitation of Christ, and so the host’s role is normatively guided by the witness of Jesus. In this complex Christological interplay between guest and host, then, we find guidance for how to approach many of the moral questions raised by care in the hospital.

In his book *Hospitality as Holiness*, Luke Bretherton narrates the Christian practice of hospitality in ways that flow forward from the witness of Matthew 25 and the Cappadocians. Hospitality “takes many forms in the Christian tradition,” including “care for the sick and the poor” and “hospitality to strangers.”\(^\text{185}\) In all these practices, Christians welcome “the vulnerable stranger as representing Christ.”\(^\text{186}\) Hospitality is modeled after Christ’s “life and ministry, whereby he was the *journeying guest/host*.”\(^\text{187}\) Hospitality is structured as a practice existing in between the ascension of Christ as Lord and his return, when all things will be made right. In between these events, in what Augustine deemed the *saeculum*, Christians live by the power of the Spirit as poured out at Pentecost. “As an eschatological social practice, Christian hospitality is inspired and empowered by the Holy Spirit,” and it “bears witness to


\(^{186}\) Ibid., 149.

\(^{187}\) Ibid., 135.
the eschaton and corresponds to the tension at the heart of the eschaton, whereby it is established by not yet fully manifest.”188 For Bretherton, this practice is at the heart of Christian witness today, and it enables the church “to both be a guest and host of the life of its neighbors.”189

As such a central practice, Bretherton argues that hospitality is fundamental for how Christians are to navigate relations with their neighbor. For Bretherton, practices of hospitality form the precondition for the church establishing “patterns of sociality which bear witness to how a particular moral issue is transfigured by God.”190 As a case study in how hospitality transfigures moral issues, Bretherton concludes his book by considering the question of euthanasia and care for the dying. He describes the goodness of finite life in ways similar to our argument in chapter two, and he concludes that Christians are to oppose euthanasia but not seek to fight death at all costs. Instead, “Christians should recognize the suffering-dying as vulnerable strangers under threat of being neglected, oppressed, or killed off, and thus in need of a ‘place’ within the church so that they might be welcomed and cared for.”191 Bretherton goes on to describe the innovative modern practice of hospice care, as begun by Dame Cicely Saunders, as “an embodied and institutionalized form of hospitality.”192 Bretherton connects this practice with the hospitality engrained in the hospital as founded by Christian in the fourth century.193

188 Ibid., 143.
189 Ibid., 146.
190 Ibid., 150.
191 Ibid., 178.
192 Ibid., 183. Bretherton recognizes that hospice care is in danger of becoming a “technical manipulation” instead of a hospitable practice. Jeffrey Bishop investigates this concern at length near the end of The Anticipatory Corpse in the chapter entitled “The Palliating Gaze,” 253-278. In light of Bishop’s critique, perhaps Bretherton’s description of the hospice movement as a “faithful, albeit fragile, form of Christian hospitality” should be amended to say that hospice care is a practice inspired by Christian hospitality and one in which such Christian hospitality is still possible 189.
193 Ibid., 185.
Bretherton’s argument about hospitality can be extended to the moral issue at the heart of this project. Throughout this work and especially in this chapter on labor and delivery we have considered this question: in the modern hospital, what are the most fitting and faithful modes of imagining and encountering the body disrupted and made strange? We have traced a medical imaginary that considers body as enemy through the ways that surgery and the military hospital have become a cornerstone of the modern hospital, as revealed in the surgical ward as a paradigmatic medical site. In response, a just-war inspired bioethics seeks to discipline and mitigate hostile encounters. We have also traced a medical imaginary that considers the body to be an object through the ways that the birth of the clinic and scientific medicine following the French Revolution have deeply shaped the modern hospital, as seen in the ICU as a paradigmatic medical site.

In this chapter we have considered how both of these medical imaginaries are present in the modern labor and delivery ward as a third paradigmatic medical site. Crucially, however, we have discerned within the practices of labor and delivery a third medical imaginary focused on befriending estranged flesh. Through the maternity hospital in particular and charity hospitals more generally, we can trace this commitment back to the birth of the hospital as a Christian institution focused on hospitable practices of bodily care. The theological roots of this vision of the hospital and the practices of healthcare seek to respond fittingly and faithfully to the patient as someone who brings with them the presence of Jesus and, in so doing, imitate Christ in practices of bodily care. In these practices of hospitality and bodily care, we see the church offering a theological response to the problem of estranged flesh. In this way, it represents a faithful instantiation of the vision Bretherton describes at the close of his book:
Empowered by the Spirit, the only response the church can make to moral problems is to bear witness to their resolution in and through Jesus Christ. The church, following after Jesus, is both the guest and host of its neighbours and in being a good guest and a faithful host the holiness of the church is shown forth.\footnote{Ibid., 198.}

Because this response has taken on institutional form in the charity hospital, and because the charity hospital has been formational for the modern hospital, it is possible for medical practitioners to participate in this work of “being a good guest and a faithful host” to patients. Christians can understand this institutional transformation as part of the Spirit’s material work through time, and Christians can also understand the Spirit as empowering practices of hospitality and bodily care to be ways of participating in the person of Jesus Christ, who is both encountered and imitated in the hospital.

Here we return to the central role played by the hospital as an institution in the formation of the moral agency of medical practitioners. Recall from chapter one that we drew from the work of Mary Douglas, Michel Foucault, and Alasdair MacIntyre to describe the ways in which institutions make possible and form particular modes of moral agency. In Byron Good’s \textit{Medicine, Rationality, and Experience} we saw just how powerful these forces of formation are for medical residents being trained in the hospital. We then turned to more recent work by Bretherton to describe the hospital as an anchor institution committed to shaping moral agents while pursuing the goods of healthcare in a particular place.\footnote{Bretherton, \textit{Resurrecting Democracy}, 294.} As an anchor institution, the hospital is a large structure containing diverse sectors with their own individual interests, values, and visions of the good. We have explored these different visions of the good through three paradigmatic medical imaginaries and medical sites. In
Bretherton’s terms, these are three “exemplary case studies” in the formation of phronesis within the hospital as an anchor institution. Recall that for Bretherton,

Analysis of exemplary case studies enables a movement beyond subjectivity into the arena of publicly adducible reasons or grounds. The intellectual task is to give an account of the conditions and possibilities for judgment, the process of developing grounds for judgment, and the practices said to embody or enact those judgments.\(^{196}\)

Given our exploration of the “conditions and possibilities for judgment” in the surgical ward and the ICU, it is now time for us to turn to our final exploration of fitting modes of moral response. In other words, what moral prescriptions follow from how we have described the labor and delivery ward? Given that we have examined the presence of three distinct medical imaginaries within labor and delivery, we will find three different kinds of moral responses. The first two have already been covered in detail in chapters two and three, so we will only engage them briefly. The bulk of our reflection will be on what moral response is entailed by imagining and engaging the body as friend. As we shall see, this moral response can be rendered theologically, following our exploration of the Christian commitments to hospitality and bodily care that have shaped the history of the hospital as an institution.

4.6 Description, Prescription, and Multiple Pathways of Perception

As we turn from how bodily disruption and encounters are described in labor and delivery to what moral actions are prescribed in response, we begin by acknowledging that this chapter’s attention to the perception of the pregnant body is indebted to the work of James Mumford and in particular his book *Ethics at the Beginning of Life: A Phenomenological Critique*. In it, Mumford draws from the work of Iris Marion Young and several firsthand

\(^{196}\) Bretherton, “Coming to Judgment,” 181.
accounts of pregnancy and birth in order to describe the “phenomenon of human emergence” as something markedly different than what is tacitly assumed by diverse normative approaches to reproduction. According to Mumford, “theories of recognition” relevant to human emergence are “predicted on things being otherwise than they are,” and this problem ranges across the spectrum of normative theories.\textsuperscript{197} Like this project, then, Mumford’s work is deeply committed to examining the relationship between moral description and prescription. As Mumford says,

\begin{quote}
The pivotal presupposition which justifies this application of phenomenology to ethics is that ethics has a stake in description. Some of the most pivotal moral decisions we face, even decisions taken at moments of crisis, hinge upon competing descriptions. How we describe something—some phenomenon in the world, some situation in which we find ourselves involved—makes all the difference as to how we decide we are permitted to act.\textsuperscript{198}
\end{quote}

Following his phenomenological work in chapter one, Mumford offers an insightful analysis of how the theories of recognition undergirding various debates at the beginning of life are not fitting for the phenomenon of human emergence itself. This disconnect is true for Buber and Barth’s I-Thou relations, Lockean contract models of encounter, and Judith Jarvis Thomson’s famous analogy of someone involuntarily connected to a comatose violinist.

There is much to learn from Mumford’s insightful and wide-ranging analysis.

A key difference, however, between Mumford’s use of phenomenology and the approach of this chapter becomes clear in Mumford’s commitment to the classic phenomenological position on the givenness of things in themselves. Mumford argues that even though it may take some time for a thing to disclose itself, as in a pregnancy first

\begin{flushright}
\textsuperscript{197} Mumford, xi.
\textsuperscript{198} Ibid.
\end{flushright}
Crucially, Mumford gives no clear indication of how to delimit that range of time. Moreover, Mumford does not acknowledge, as we did above, that his primary phenomenological source, Iris Marion Young, limits her analysis to “those pregnant women who have been able to take up their situation as their own.” Mumford takes Young’s phenomenology of pregnancy and birth as a universal given when she explicitly names it as a particular kind of phenomenological account, implying that it is one among several pathways of perception.

In contrast, this project has argued that in moments of bodily disruption, our conversions to new modes of bodily perception are largely—though not entirely—dependent upon the institutional contexts within which they occur. This chapter in particular has argued that pregnancy is a phenomenon that can lead to differing interpretations and conversions, each potentially coherent depending upon the contingencies of a particular pregnancy and birth, the contexts of the pregnant woman, and the histories and background assumptions that shape a woman’s perception of pregnancy. In other words, the phenomenon of pregnancy acutely highlights the ways in which bodily disruptions are epistemically underdetermined. This culminates in the ways in which all three of the medical imaginaries examined in this project can be found within the modern labor and delivery ward, where the pregnant body can be perceived as enemy, object, or friend.

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199 Mumford accounts for this by arguing that “the new one...veils as it unveils—a woman's unborn offspring, coming to herself from herself, remains concealed” 24. This “state of hiddenness” means that we must “wait for the entity to unfold itself” 29. To make this claim, Mumford draws from Heidegger’s argument that “Being itself is thus made visible in its temporal character” and ‘cannot be grasped except by taking time into consideration.’” In other words, Mumford’s argument that patience is required of the pregnant subject in order for her to perceive correctly. An undetermined amount of time is necessary. Heidegger, *Being and Time*, trans. John Macquarrie and Edward Robinson (Oxford: Blackwell, 1962), §5, 40; quoted in Mumford, 29.

200 Young, 47.
As we turn from description to prescription, recognizing these multiple pathways of perception is absolutely crucial. We can see that this is the case by briefly engaging one of the fundamental moral debates of our time: abortion. If pregnancy is an epistemically underdetermined phenomenon, then debates over abortion are not easily resolved by asserting the givenness of an event unfolding over time. For if valid pathways exist for perceiving the body as enemy, object, or friend over time, then people perceiving the body in those ways (or are attempting to advocate for those who will have such perceptions) have legitimate reasons to both operate from and insist upon moral frameworks befitting these descriptions of reality. So, those perceiving pregnancy as an assault upon the woman, whether because it was conceived as a result of rape or because it is a threat to her life and projects, have good reason to demand the availability of force to counter that threat. Various kinds of just-war inspired bioethics will attempt to govern when abortion as controlled violence is a fitting response to pregnancy as an assault. Likewise, those perceiving pregnancy as simply the development of a biomedical object within the woman’s body as object will insist upon their own property rights over their body. Various contractual arrangements will be created to govern abortion as an intervention that the pregnant subject has willfully requested and permitted to occur upon their body. Finally, those perceiving pregnancy as the process of befriending a stranger will press the question of how to welcome life. Such a commitment to hospitality is not epistemically required. But for those who perceive pregnancy as welcoming this strange new life, a new set of moral questions arise. Rather than devoting bioethical debate to when violence is justified or whose bodily property rights are to be privileged, the fitting moral endeavor becomes one of seeking to
foster the conditions and possibilities of hospitality and care both for the pregnant subject and the emerging life within her.

In this chapter, however, our primary focus is not on the moral questions surrounding abortion. Instead, we are concerned with the fitting moral responses to the three ideal types of bodily disruptions experienced by the laboring subject in the labor and delivery ward, as described above. As with the abortion example, these moral responses are threefold. We begin with moral responses that center on bodily threat and the laboring subject, drawing from our work in chapter two on James Childress’s just-war inspired bioethics. We then turn to moral responses to perceiving the laboring body as an object, drawing from our work in chapter three on Tristram Engelhardt’s concepts of permission and separatism. The bulk of our attention, however, will be devoted to the moral response that seeks to promote the conditions and possibilities of bodily care that befit the work of labor and delivery as befriending estranged flesh. In order to nurture hospitable bodily care within the modern hospital, it turns out that we will need the presence of diverse moral communities willing to join in this shared work as it is understood from the perspective of their own commitments. By engaging all three medical imaginaries and their fitting moral responses, what follows also serves as a summary of the project as a whole.

4.6.1 Bodily Threat and Just-War Inspired Bioethics in the Labor and Delivery Ward

Recall from chapter two that we traced the ways in which James Childress incorporated his early work on just-war theory into his work on bioethics, culminating in the establishment of criteria for balancing the four bioethical principles of respect for autonomy, beneficence, nonmalefice, and justice. There, we argued that Childress’s just-war inspired bioethics is a fitting moral response to the discourses, practices, and practitioners found
within the surgical ward. The history of surgery’s incorporation into the practice of medicine and the institution of the modern hospital tells the story of a craft that learned to discipline and control its interventions. This process of disciplining and controlling the practice of surgery can be described according to the just-war criteria that Childress listed: “legitimate or competent authority, just cause, right intention, announcement of intention, last resort, reasonable hope of success, proportionality, and just conduct.” We also explored several ways in which this moral schema offers a fitting moral response to the patterns of practice we found within the surgical ward.

In a similar way, these criteria for just-war can be seen as fitting constraints on the practices found within the labor and delivery ward. For nearly three decades, an important strand of thinking within the ethics of pregnancy and labor and delivery has presumed conflict to be at the heart of the labor and delivery ward, both in what is known as “maternal-fetal conflict” and in presumed conflict between the laboring subject and the medical practitioner. In such conflicts, of course, the question of who is the “legitimate or competent authority” is central, and physicians have sometimes appealed to courts to override the laboring subject’s authority in order to protect the interests of the fetus. In response, there have been significant efforts to mitigate this conflict through practices of dialogue, negotiation, and persuasion, thus illustrating the need to buttress classical just-war theory with efforts to prevent conflict from ever developing. Yet, such efforts still seem to

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201 Childress, Moral Responsibility in Conflicts, 64-65.
203 See, for example, Frank A. Chervenak and Laurence B. McCullough, “Clinical Guides to Preventing Ethical Conflicts between Pregnant Women and Their Physicians,” American Journal of Obstetrics & Gynecology 162, no. 2 (1990): 303-307. Chervenak and McCullough have published several articles on this topic.
presume the framework of conflict as fundamental; little attention is given to the practices of peaceableness that should be at the heard of any effort to prevent conflict from erupting.

In our discussion above, we saw that the language of risk dominates many of the encounters between healthcare practitioners and pregnant subjects. Anne Lyerly has argued, with others, that such discourses produce outcomes that disproportionately harm the pregnant subject:

> When treating pregnant women’s non obstetrical medical needs, it turns out, there is a tendency to notice the risks of intervening without adequately noting the risks of failing to intervene. In contrast, when we turn from the management of pregnancy to management of birth, we note a tendency to intervene without due regard for the burdens to both fetus and woman that such interventions might bring.\(^\text{204}\)

Lyerly gives the example of a woman’s appendix rupturing and having a miscarriage because she did not receive a CT scan due to the perceived potential threat to her fetus, even though the risks of a single scan for fetuses are negligible. In contrast, women in labor are subject to an array of interventions meant to ‘keep the baby safe.’ According to Lyerly, the discourse of risk may overprivilege the threat of harm to the fetus without considering the threats of harm to the woman, resulting in undertreatment that threatens the pregnant subject’s wellbeing and overtreatment that threatens the laboring subject’s wellbeing. Here, questions of right intention, proportionality, and just conduct come to the fore when we consider how to weigh bodily threat and act appropriately. Even as Lyerly seeks to balance the scales of risk according to more just criteria, she presumes some measure of conflict as fundamental. In her later work, *A Good Birth*, which we examined above, Lyerly is much more focused on promoting the conditions of flourishing for both the laboring subject and the life emerging from within her.

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\(^{204}\) Lyerly et al., “Risk and the Pregnant Body,” 35.
A key test of the success of the application of just-war constraints is the high rate of cesarean sections, which indicates a failure to follow the criterion of surgery as a last resort. As we saw above, many obstetricians are quick to recommend this surgical procedure because of its proven safety. But in doing so, they violate the criteria of last resort for such an intervention. Moreover, as Claire Wendland notes, many refusals of last resort criteria are bound up with skewed judgments about the proportionality of injury caused by the cesarean section. In her review of “three particularly influential studies” of the impact of cesarean sections, Wendland found that “none of these authors considers the cesarean itself as injurious.”

According to Wendland,

Unintended wounds—cervical lacerations, vaginal hematoma, or fracture of a newborn’s clavicle—count as major morbidity, but the intentional wound is exempted by fiat: Only unintended complications of the cesarean are weighed in the balance. This choice in fact reflects an up-front assumption that cesarean and vaginal delivery are equal alternatives, and that vaginal delivery must be justified as a delivery method as much as cesarean is, or more.

Analogically, then, the presumption for non-violence that Childress deemed essential for the just-war tradition has been discarded in these studies of the morbidity rates following vaginal deliveries and cesarean sections. When surgical interventions are no longer seen as a last resort and their seriousness for the laboring subject is not given due weight in considerations of proportionality, then the criteria of a just-war inspired bioethics need to be applied more rigorously in this setting. Thankfully, cesarean sections seem to be increasingly disciplined by something like the logic of just-war bioethics in recent years; after rising for quite some time, the rates of cesarean sections seem to have leveled off recently.

205 Wendland, 220, 223.
206 Ibid., 223.
207 For example, in the series of three nationwide Listening to Mothers surveys, rates of cesarean sections increased from 24% in 2002 to 32% in 2006, but actually declined slightly to 31% in 2013. Eugene R. Declercq,
Further work would need to be done in order to discern other fitting moral responses to practices in the labor and delivery ward that flow from a just-war inspired bioethics. For example, the widespread practice of episiotomies in vaginal deliveries could be more stringently evaluated by the criteria of just cause and proportionality. In the words of one woman, “Having the episiotomy [was the worst thing about my birth experience]. It really made healing a lot more difficult.”208 Such concern for long-lasting outcomes for laboring subjects will raise the standards of justification for this surgical incision. Also, a just-war inspired bioethics would facilitate one kind of response to what we described above as a fundamental lack of credibility given to the first-person accounts of pain by women of color. If practitioners in labor and delivery were committed to the patient being the “legitimate authority” in all medical decisions, then the pain experienced by Ingmarie Stith-Rouse, Serena Williams, and countless other women of color would be taken much more seriously.

If the labor and delivery ward is a site of bodily threat, then there is much work to be done by a just-war inspired bioethics in disciplining bodily interventions and mitigating these hostilities. Like Childress’s just-war inspired bioethics, however, the labor and delivery ward, when construed as a site of bodily threat, is in need of a more thoroughgoing commitment to fostering the conditions and possibilities for peace, to which we will turn at the close of this chapter. First, however, we will connect our work from chapter three on fitting moral responses to imagining the body as object with the context of the labor and delivery ward.

4.6.2 The Body as Object, Permission, and Separatism in the Labor and Delivery Ward


208 Ibid., 46.
In chapter three, we examined how the body becomes objectified in the processes of medicalization, as seen through the work of Kay Toombs, Sharon Kaufman, Michel Foucault, Jeffrey Bishop, and others. Following Kaufman and Bishop, we took the ICU to be a paradigmatic medical site revealing a constellation of discourses, practices, and practitioners creating the conditions and possibilities for the patient’s body to be imagined and encountered as an object. In response, we turned to the bioethical theory of Tristram Engelhardt, whose libertarian response to the moral confusion of modernity centers on the concept of permission. Since shared commitments cannot be presumed, Engelhardt argues that each moral agent must be ensured of her absolute property rights over her own body. In light of this conception of the body as property, the moral agent has the power to grant or deny permission to medical interventions. Such a moral response, we argued, might be fitting for the body as object if it were not for the formative power of the discourses, practices, and practitioners we discerned in the ICU. In light of the seemingly all-consuming nature of medicalization, the most fitting moral response might be to separate from the modern hospital and instead found alternate institutions with their own constellations of discourses, practices, and practitioners. Such a separatist response is found in the closing chapter of Jeffrey Bishop’s book, *The Anticipatory Corpse*.

Just as we discerned two potential moral responses to imagining the patient’s body as an object in the ICU, so too there have been two similar responses to the objectification experienced by laboring subjects in the labor and delivery ward. Roxana Behruzi and others argue that these two responses can be traced to how the first and second waves of feminist activists understood and organized around childbirth. They describe the first wave’s efforts in labor and delivery, saying,
During the nineteenth and early twentieth centuries the first wave of feminist activists argued persistently for women’s rights to relieve their own suffering, and hence to gain control over the birthing process, the right of extended choices during childbirth, and full control over their body, as well as their reproductive life.209

Earlier, we saw Wertz and Wertz make a similar argument about women’s activism for “Twilight Sleep” as a form of pain relief that best reflected their desires and control over their own bodies. Behruzí et al. claim that the first wave of feminist activists gained access to pain relief but “lost control over the process of childbirth,”210 through processes like sedation and shackling.211 In other words, as we saw in chapter three, the sense of control over one’s body entailed by something like Engelhardt’s concept of permission paled in the face of the formative power of medicalization found within the modern hospital.

If choice ultimately did not offer enough control, then perhaps a more radical solution was required. Behruzí et al. find just such a response in the work of the second wave of feminist activists during the late 1960’s and early 1970’s. Their moral response to the medicalization of childbirth was separatism; they “began to take an active interest in the “alternative birth” or “natural birth” movement, and once more advocated home birthing as well as midwifery services.”212 Anne Lyerly argues that such an approach is represented by sociologist Barbara Katz Rothman’s book, In Labor: Women and Power in the Birthplace, which:

[P]rovided a systematic analysis of modern maternity care and childbirth, and ultimately argued for the exodus of women from hospitals and obstetrical care into


211 Rich, 176.

the home-birth setting as a means to ensure their experience of childbirth will be good. At the crux of her argument is the claim that women’s loss of control and dissatisfaction with the birthing experience has resulted from the introduction of technology into obstetrical practice. “Technological society,” she claims, “dehumanizes people by encouraging a mechanical self-image—people viewing themselves as machines.”\(^{213}\)

Similar moral responses are found within the works by Adrienne Rich and Robbie Davis-Floyd we examined above. They are represented paradigmatically in the work of midwife Ina May Gaskin, who started the separatist commune, The Farm, in 1971 as the culmination of a counter-cultural caravan departing from San Francisco. Located in Summertown, TN, the Farm exists alongside a nearby Amish community, which provided both a steady stream of patients for the midwives and something of a conceptual paradigm for separatist movements in America.\(^{214}\) The separatism counseled by this second wave of feminist activists seeks either a “natural” home birth or the founding of standalone birthing centers as alternate institutions.\(^{215}\)

4.6.3 The Body as Friend and Care in the Labor and Delivery Ward

The above moral responses have in common the project of controlling the bodily disruptions experienced by the laboring subject, whether through surgery, technology, or separatist spaces. In contrast, the moral response that befits befriending estranged flesh starts from recognition of the loss of control that comes during pregnancy and childbirth. Susan Maushart refers to this as “the central paradox of childbirth: that the only way to gain...


\(^{215}\) It is important to note that midwifery’s association with separatist movements may be a contingent feature of the American healthcare system, as midwifery is much more integrated in the healthcare systems of the United Kingdom and much of Europe. For an example of this, see the report on midwifery issued by *The Lancet*, Britain’s premier medical journal, summarized in Mary J. Renfrew, Caroline S. E. Homer, Soo Downe, Alison McFadden, Natalie Muir, Thomson Prentice, and Petra ten Hoope-Bender, “Midwifery: An Executive Summary for *The Lancet’s* Series,” *The Lancet* 384, no. 1 (2014): 1-8. It is hard to imagine such a report being issued by a top American medical journal.

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control is to lose it.”\textsuperscript{216} Anne Lyerly opens her discussion of control with this quotation from Maushart, and she proceeds to argue that, according to the women she interviewed, “ambivalence (or rejection) of control was in the service of the good birth, that letting go can be \textit{what makes it good}.”\textsuperscript{217} Losing control in this way means eschewing the first wave of feminism’s desire to control through medical technology the pain and suffering experienced, and it also means avoiding the control implicit within the second wave of feminism’s desire to create a pure, separate space of childbirth, either in the home or a birthing center. It means losing the sense of control found in the mapping and manipulating of the body as object in the ICU, and it also means losing the sense of control found in a pure, separate institution. And finally, it means losing the sense of control found within those who hold up cesarean sections as a more safe and reliable method of delivery than vaginal birth.

Such a loss of control does not mean a mere passivity, nor does it necessarily mean avoiding utilizing various modern technologies. We can see this in those Behruzi et al. refer to as “the contemporary feminists or ‘third wave’ of feminist activists.”\textsuperscript{218} In this approach to childbirth, there is a discerning moral agency that seeks to avoid the Scylla of uncritical acceptance of the labor and delivery ward and the Charybdis of unflinching rejection and separation. Instead, this moral response attends to the perceived bodily disruption and prudentially judges which practices of bodily care best enable the bearing with and eventual befriending of estranged flesh. Anne Lyerly and the women she interviewed represent this approach; for them, a good birth is not identical with particular “modes of delivery.” Instead, recall that “what makes it good will relate in a substantial way to the person or

\textsuperscript{216} Susan Maushart, 96; quoted in Lyerly, \textit{A Good Birth}, 25.
\textsuperscript{217} Lyerly, \textit{A Good Birth}, 32.
\textsuperscript{218} Behruzi et al., 207.
people who have experienced it. A good birth has very much to do with the lives that precede it and the lives that follow.”

Earlier, we noted that this means the good birth has a narrative character. Given that a good birth is marked by the loss of a certain kind of control, we must be quick to say that the laboring subject is not the sole author of her narrative. Instead, as Alasdair MacIntyre says, “the agent who enacts” this narrative “is at once subject and author, or rather coauthor.” As the “subject” of a narrative, the agent is subject to a variety of events beyond her control. In response, however, one can seek to “coauthor” a fitting story along with the others whose lives are constitutive of one’s own story. Margaret Mohrmann describes this phenomenon within the context of healthcare, saying, “The process of composing jointly the next chapter of the patient’s life is perhaps the central ritual around which the healing community gathers.”

For the laboring subject and her healthcare practitioners, the narrative of a good birth is not predetermined, nor is it controllable. Rather, it is marked by a variety of contingent events and failures through which the good birth is realized—or not. Alasdair MacIntyre argues that it is in the response to contingent events and failures that the good life is discerned and achieved. As he says,

A life in which an agent moves toward the achievement of her or his specific goods and good will characteristically be a life in which it is through constructive responses to failure that agents comes to understand what that good in fact is, an understanding commonly expressed at the level of everyday practices in particular

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220 MacIntyre, *Ethics in the Conflict of Modernity*, 231. Saba Mahmood makes the point about the lack of control even more strongly when she investigates what it means to consider humans as “only partially responsible for their own actions, versus an imaginary in which humans are regarded as the sole authors of their actions.” Saba Mahmood, *Politics of Piety: The Islamic Revival and the Feminist Subject* (Princeton: Princeton University Press, 2005, 2012), 168.
judgments, in the directness of desires, in intellectual and moral dispositions, and in actions.\textsuperscript{222}

If the good birth is to occur, then, it is realized through the ways in which the laboring subject and her healthcare team continually respond to the changing but ever present bodily disruptions and failures that are found throughout labor and delivery. Such work requires what Lyerly describes as truthfully facing the “glaring facts of vulnerability” present in childbirth. By recognizing reality truthfully, it is possible to “renegotiate” within the revealed contours of the situation and so act in a responsible and fitting manner.\textsuperscript{223} In the actions of responding to the estrangement of the body, the laboring subject and her healthcare team can discern and achieve a good birth befitting their particularities. Here, in the space of “slippery uncertainty,” the laboring subject must both “mourn life’s edges” and also “celebrate what’s in between.”\textsuperscript{224} By recognizing finitude and failure and responding in fitting ways, women who experience birth in this way “end up embracing deeper notions of the ‘good’ that emerge time and again, whatever the birth mode or its distance from what they had imagined, before birth, as ideal.”\textsuperscript{225}

In a context set by a commitment to hospitality, the agency achieved through losing control is made possible by a broader community’s attentive practices of bodily care. These active and prudential responses to vulnerable bodies subject to failure and contingency reveal a moral response to bodily disruption in labor and delivery that resonate with a contemporary stream of moral reasoning focused on practices of care. Inspired in large part by the work of Carol Gilligan, who questioned Lawrence Kohlberg’s stages of moral

\textsuperscript{222} MacIntyre, \textit{Ethics in the Conflict of Modernity}, 40. He goes on to say that such good is understood “sometimes, although much less often, as well-articulated theory.”
\textsuperscript{223} Lyerly, \textit{A Good Birth}, 231.
\textsuperscript{224} Ibid., 231.
\textsuperscript{225} Ibid., 187.
development as implicitly masculine, this wide-ranging literature seeks to elevate practices of care as fundamental for any moral vision. Lyerly herself says that she was inspired by Gilligan’s work to interview women directly to understand how they “spoke about and valued birth.” This project follows Bernice Fisher and Joan Tronto in defining care as “a species activity that includes everything that we do to maintain, continue, and repair our world so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web.” This definition encapsulates the work of both the laboring subject and her team of healthcare practitioners as care. By focusing on care as an activity, the practice is made available to all.

In order to consider the practice of care within labor and delivery, we will consider the work of philosopher Annemarie Mol, whose book The Logic of Care seeks to trace out the work of care within the world of healthcare. While Mol’s focus on the care comes in part through her ethnographic work in a diabetes clinic, her argument matters for the work of

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228 Fisher and Tronto, 40.

229 Gilligan’s work and those who follow it has been criticized as implicitly essentializing gender. Maurice Hamington recognizes this and argues: In fact, a careful review of the literature reveals that, although the language of essentialism sometimes slips into their arguments or a superficial reading of their work may give the impression that essentialism is being advocated, few feminist ethicists strongly support the idea of care as an exclusively feminine value….The far too common interpretation of Gilligan as an essentialist is not fair to the full corpus of writing and research she has offered since the publication of *In a Different Voice*.

Hamington, *Embodied Care*, 17.
care in labor and delivery. By examining it, we will see on display a fitting moral response to bodily disruption in labor and delivery, one that aligns with the commitment to hospitality that we explored above. However, because Mol does not consider the conditions and possibilities of such care either philosophically and institutionally, we will return to our work on the theological origins of the charity hospital to enrich her argument.

Mol’s account of the logic of care shares deep similarities with Anne Lyerly’s arguments for what constitutes a good birth. Mol states clearly that “caring is not a matter of control let alone oppression,” therefore resisting the modes of control that come with imagining the body as an enemy or as an object. \(^{230}\) Instead, “the art of care is to act without seeking to control. To persist while letting go.”\(^{231}\) Such vulnerable persistence is an action; losing control in this way does not imply passivity. Rather, losing control in a good birth requires the work of what Mol describes as “attending to the balances inside, and the flows between, a fragile body and its intricate surroundings.”\(^{232}\) In this way, Mol’s account of care resonates with what Young described as attending to bodily “sensations and limitations for their own sake” and so experiencing them “as a fullness rather than as a lack.”\(^{233}\)

For both Young and Mol, such attention is part of an effort to enable subjects “to find a way of nursing, fostering and enjoying” their body so that they are able “to lead a good life.” This vision of care does not provide a procedure by which bodily disruption can be handled. Instead, according to Mol, “all kinds of question follow” from this effort to befriend the body. “What to go for, what to let go; which results are worth what kind of effort? And, most of all, what can be realized in practice?” These questions are part of the

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\(^{231}\) Ibid., 32.  
\(^{232}\) Ibid., 39.  
\(^{233}\) Young, 51.
work of care in “exploring ways of shaping a good life.” But such explorations are constitutive of the pursuit of a good life that is subject to a variety of contingencies. Mol agrees with MacIntyre’s account of how the good life is developed in response to contingent events and failures when she says, “And then something changes and you have to start all over again. Exploring how a good life may be lived is...chronic.”234

In the work of care, Mol describes a continual process of attunement. “Nothing is taken to be entirely fixed or entirely fluid. Technologies, habits, hopes, everything in a patient’s life may have to be adjusted.” This is a process of careful experimentation: “Try, be attentive to what happens, adapt this, that or the other, and try again.”235 Such attunement marks the work of the laboring subject as she moves between practices of bearing with her body. From the birthing ball to a bath, from breathing exercises to an epidural, the laboring subject seeks ways of attuning herself with her estranged flesh. Crucially, she does not do this alone, as medical practitioners have years of training in “craving more bearable ways of living with, or in, reality.”236 The wisdom they have accumulated is in recognizing which responses to bodily disruptions may be most fitting in particular situations. This wisdom is not a mode of control: they are “trained to respond actively to their patients’ suffering, while at the same time accepting quietly that their efforts may fail.”237 It is an embodiment of care’s commitment to “maintain, continue, and repair our world.”238 Following this wisdom may mean that practitioners encourage the laboring subject to work through their pain, or it

234 Mol, *The Logic of Care*, 47.
236 Mol, *The Logic of Care*, 53.
237 Ibid., 95.
238 Fisher and Tronto, 40.
may mean that practitioners discern that only an emergency cesarean section can make
possible maintaining, continuing, and repairing the patient’s embodied world.

This vision of care involves ordering a variety of practices towards the goal of
befriending estranged flesh. Because of this, it recalls our arguments from chapter one about
the ways in which standpoint theory offers a mode of ordering the medical imaginaries
found within the modern hospital. The vision of bodily care involved in the work of
befriending estranged flesh is a marginalized standpoint in the modern hospital, as it is often
practiced best by those perceived to have less power, such as nurses, nursing assistants,
therapists, nurse-midwives, and midwives. Their practices of bodily care, however, provide
the basis for evaluating and ordering the modern hospital’s dominant standpoints.

As a marginalized standpoint, care that seeks to befriend estranged flesh enables
patients and practitioners to recognize the contingency of modes of construing the body as
enemy and as object. In other words, the work of care can provide the means of discerning
when and how the body may need to be imagined and encountered as an enemy or as an
object, always in states of limited exception, towards the goal of befriending estranged flesh.
Emergency cesarean sections or immobilizing epidurals may be momentarily necessary to
make possible bearing with the body. But they are done towards the goal of befriending
estranged flesh. So the work of care can “experiment, experience and tinker” with practices
in light of a fundamental commitment to bodily peace.239

Mol recognizes that this account of care is difficult to articulate. She asks, “But in
what language to speak of care and its specificities? The ideal of good care is silently
incorporated in practices and does not speak for itself. Given that it is under threat, it is time

239 Mol, 65. Sara Ruddick offers a connection between standpoint theory and the work of care in her chapter
“Maternal Thinking as a Feminist Standpoint,” Maternal Thinking, 127-139.
to put it into words.” By emphasizing the need to make articulate the care carried within the healthcare practices she observed, Mol partially echoes Charles Taylor’s concerns for articulacy that we noted in chapter one. Recall that in *Sources of the Self*, Taylor seeks to make articulate “the full range of goods we live by,” and such articulacy “will open us to our moral sources, to release their force in our lives.” Mol’s description of care is an effort to make articulate the kind of care present in practices of befriending estranged flesh discerned within the labor and delivery ward.

In her account, however, Mol does not fully explain what Taylor calls “moral sources.” The closest she comes to defining these is at the end of the book where she seeks to describe how the logic of care could operate in fields outside of healthcare. She recognizes that difficulties will face such work, and only here does she admit that “one may wonder what kinds of institutional conditions are needed for care to flourish.” One of the central concerns of this chapter, of course, has been to provide an account of just that. In Taylor’s language, we are exploring the “moral sources” needed to sustain the care that Mol describes. We find one account of these sources in the work of Stanley Hauerwas, who offers a theological account of this moral response to bodily disruption that largely comports with Mol’s depiction while also articulating how the befriending of estranged flesh is a part of the Christian life.

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240 Annemarie Mol, 2. Throughout the book, Mol contrasts the “logic of choice” with the “logic of care.” Mol’s conception of choice shares deep similarities some of the moral responses we discerned in Childress and Engelhardt, though Mol is more concerned with consumeristic choice, which is fitting given her focus on an outpatient clinic.
242 Mol, 92.
4.7 “Something Very Much Like a Church Is Needed”: Hauerwas and Healthcare

For over forty years, Stanley Hauerwas’s work has been influential in Christian bioethics. By examining a few key elements of his thought, we can see how Hauerwas’s work offers a theological account of the practices of bodily care that constitute the work of befriending estranged flesh. In doing so, we will see how Hauerwas’s work resonates with the account of bodily care provided above. Additionally, by placing his theological account of peaceably welcoming the stranger in conversation with his work in *Suffering Presence*, we will see that his moral vision for healthcare is dependent upon the historical roots of hospitality that are built into the hospital as a Christian institution. In other words, in Hauerwas’s work we will see one particular set of moral sources capable of sustaining the kind of care that Mol described. And in response to Hauerwas’s claim that “something very much like a church is needed” to sustain hospitable practices of bodily care, we can draw from the work of Luke Bretherton for a better understanding of how to nurture the conditions and possibilities of befriending estranged flesh in the modern hospital. Faithful Christian moral agency in the modern hospital may depend upon the robust presence of diverse moral communities working together to support a medical imaginary that construes the body as friend within an institution that often seems dominated by medical imaginaries that consider it as either enemy or object.

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244 Hauerwas, *Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped, and the Church* (Notre Dame, IN: University of Notre Dame Press, 1986), 65.
We begin with two theses from Hauerwas’s *A Community of Character* that are particularly relevant for our concerns. The first is: “Communities formed by a truthful narrative must provide the skills to transform fate into destiny so that the unexpected, especially as it comes in the form of strangers, can be welcomed as gift.” In this sentence we can find several of the concerns of this chapter linked. First, we see echoes of the Christian commitment to hospitality that we explored above in the work of Bretherton and the witness of the Cappadocians and St. Benedict. But by phrasing this as welcoming the “unexpected” as gift, Hauerwas also accounts for the experiences of bodily disruption that we have attended to throughout this project. When the body is made strange, how are we to receive it? We are to receive it as gift, Hauerwas says, and that means that we must practice the skills that enable the transformation of this stranger into a friend. Such skills are part of the work of transforming fate into destiny, which involves the recognition that that which happens to us is part of our own project of who we are becoming. Here we see what MacIntyre referred to as being both the “subject” and the “coauthor” of one’s story.

Hauerwas adds further specification on what it means to befriend the stranger in a second thesis: “Christian social ethics can only be done from the perspective of those who do not seek to control national or world history but who are content to live “out of

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245 Stanley Hauerwas, *A Community of Character: Toward a Constructive Christian Social Ethic* (Notre Dame, IN: University of Notre Dame Press, 1981), 10. The two theses we are examining are part of a broader set of ten theses for “Reforming Christian Social Ethics.”

control.” Given his focus on the control of “national or world history,” it perhaps should come as no surprise that Hauerwas’s work on living “out of control” has been interpreted through the lens of political theology. But I suggest that Hauerwas’s thesis can be illuminated through the work of bodily care that we named above. Recall that both Lyerly and Mol named certain forms of being “out of control” as essential for a good birth and care, respectively. If hospitable care is a marginalized standpoint within the modern hospital, then the medical practitioners who best exemplify it—nurses, nursing assistants, and therapists—must be taken seriously as sources of moral wisdom. These practitioners find themselves flourishing in positions that have no pretense of control, and they help their patients to flourish as well when illusions of bodily control are shattered. Because of this, when we turn to Hauerwas’s work on healthcare, we should also imagine practitioners like nurses, nursing assistants, and therapists whenever he refers to “physicians.”

This shattering of the illusion of control is what we fear as our bodies become strange. In *The Peaceable Kingdom*, Hauerwas argues that we “fear the stranger” who comes into our lives and questions the fragile orders we have constructed. The stranger calls into question the control that we have over our lives, and, as we have seen throughout this project, such threat is felt most intimately when our bodies become strangers to us. In the labor and delivery ward and the hospital more generally we see medical imaginaries that engage the estranged body as enemy or as object as modes of seeking to reassert control in this way. But in responses of bodily care that seek to befriend estranged flesh, we see what it means to live out of control.

248 Hauerwas, *The Peaceable Kingdom*, 143.
In theological terms, Hauerwas offers an account of how such lives lived out of control are possible because of how Jesus Christ has entered the world as a stranger. Through his life, death, and resurrection, Jesus makes possible a community of friendship and peace. By faithfully suffering the world’s violent efforts at control unto death on a cross, Jesus shows us a way of life that refuses violent control. As God the Father, through the power of the Spirit, raises Jesus from the dead, Jesus’s resurrected body is open to all as the site in which we join in the befriending of all of creation. “Now,” according to Hauerwas, “it is possible for us to live at peace, to be God’s agent of reconciliation, in a violent world. We are able so to live not because we have answers to all the world’s troubles, but because God has given us a way to live without answers.”

Hauerwas emphasizes the church as that community of “those whose lives have been opened by God, often an opening that has extracted a great cost, and so are capable of being open to others without fear and resentment. Hospitality is part of their holiness, as they have learned to welcome the stranger as the very presence of God.” Here Hauerwas has offered a Christological and ecclesiological account of hospitality to the stranger, one that resonates with the work of the Cappadocians that we examined above. Hauerwas’s account conveys their central insight, flowing from Matthew 25, that helps us understand the work of patients and practitioners to befriend estranged flesh as the work of befriending Christ. Recalling our arguments from chapters two and three, Hauerwas also offers a robust account of peace that we found lacking in the work of Childress and Engelhardt.

249 Stanley Hauerwas, Cross-Shattered Christ: Meditations on the Seven Last Words (Grand Rapids, MI: Brazos Press, 2004), 88.
250 Hauerwas, The Peaceable Kingdom, 146.
So far, we have shown how Hauerwas’s work on welcoming the stranger is made intelligible by his theological commitments, and traced several points of connection with this account that resonates with our work above on practices of care that seek to befriend estranged flesh. But we have not yet discussed Hauerwas’s most influential book on healthcare, *Suffering Presence*. In it, we find on display what it means for such hospitality to the stranger to provide a fundamental orientation for practices of bodily care. At a key point in the book, however, Hauerwas does not specify the theological convictions necessary to sustain these practices. In order to develop this further, we return to the historical roots of the hospital and draw from the work of Luke Bretherton to offer an account of how Christians can witness in a postsecular context to the truthfulness of hospitable practices of bodily care.

Hauerwas begins his most famous essay from *Suffering Presence*, “Salvation and Health: Why Medicine Needs the Church,” with a story from his youth. For two years, Hauerwas and his friend Bob were “inseparable” companions until Bob’s mother committed suicide. Hauerwas tried to be a good friend to Bob in his grief, as he describes in the following reflections, worth quoting at length:

> As often as I have reflected on what happened in that short space of time I have also remembered how inept I was in helping Bob. I did not know what should or could be said. I did not know how to help him start sorting out such a horrible event so that he could go on. All I could do was be present. But time has helped me realize that this is all he wanted—namely, my presence. For as inept as I was, my willingness to be present was a sign that this was not an event so horrible that it drew us away from all other human contact....Yet the story cannot end here. For while it is true that Bob and I did go on being friends, nothing was the same....Neither of us wished to recapture that time, nor did we know how to make that night and day part of our ongoing story together. So we went our separate ways.  

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This story is at the heart of Hauerwas’s understanding of healthcare. With it in mind he argues, “Our pains isolate us from one another as they create worlds that cut us off from one another.”252 In an analogue of Scarry’s arguments about pain’s dissolution of the language and world of the self, Hauerwas goes on to claim, “Pain not only isolates us from one another, but even from ourselves.”253 Given the bodily estrangement experienced by those in pain, what modes of response are offered by healthcare?

Within *Suffering Presence*, Hauerwas mentions modes of response that align with what we have described as medical imaginaries that construe the body as enemy or as object. Hauerwas does something like the latter when he chronicles an effort to make our pain and suffering “subject to therapeutic intervention.” In such a response, “medicine can be interpreted as the attempt to have us view our suffering as pointless” and instead have us think of it “in terms of a mechanical model.”254 This kind of response correlates with imagining and encountering the body as object, stripped, as Bishop argues, of any formal and final causality. Something more like imagining the body as enemy is present in his description of a surgical response to pain and suffering: “Think how quickly people with a terribly diseased limb or organ are anxious for surgery in the hope that if it is just cut off or cut out they will not be burdened by the pain that makes them not know themselves. This gangrenous leg is not mine. I would prefer to lose the leg than face the reality of its connection to me.”255 Hauerwas suggests that there is another mode of response available,

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252 Ibid., 76.
253 Ibid., 77. Throughout the essay, Hauerwas offers an understanding of pain remarkably similar to the account developed by Elaine Scarry, which we explored earlier in this project. Scarry’s *The Body in Pain* came out in 1985 and Hauerwas’s *Suffering Presence* was published in 1986. No reference to Scarry appears in Hauerwas’s text, and so we can safely assume that Hauerwas had not yet read Scarry when he wrote his book.
254 Ibid., 33. It is important to note that even though pain and suffering may not be the same thing, they cannot be easily distinguished, as both depend upon first person reports. Ibid., 27
255 Ibid., 77.
one that is perhaps more fundamental for the practice of healthcare, especially in light of his story about his friend Bob.

Hauerwas describes healthcare’s commitment to be present to the sick in ways that resonate with what we have described as a medical imaginary committed to befriending estranged flesh. Hauerwas asserts that the activity of “physicians is characterized by the fundamental commitment to be, like Job’s comforters, in the presence of those in pain.” He sees such presence as “fundamentally an educational process for both doctor and patient, in which each is both teacher and learner. It is from patients that physicians learn the wisdom of the body. Both physicians and patients must learn that each of them is subject to a prior authority—the authority of the body.” Here I take Hauerwas to mean that both patients and practitioners must attend and respond to the finite, contingent, and changing needs, demands, and rhythms that constitute the patient’s body, much in the way that Annemarie Mol described the nature of care above. Medicine is therefore a “practice of learning to live with finitude,” and as it has developed over time, medicine has become “a tradition of inherited wisdom and practices through which physicians acquire the responsibility to remember, learn, and pass on the skills of learning to live with a body”—skills that they have learned from exemplary patients and practitioners.

By “learning to live with the body,” practitioners have learned to make prudential judgments for what is fitting in seeking to care for their patient; that is, they “maintain, continue, and repair” their patient’s embodied world. As we saw above, this work of care requires attention to the patient’s narrative context and the ability to evaluate and order

\[\text{256} \text{ Ibid., 78.}\]
\[\text{257} \text{ Ibid., 48.}\]
\[\text{258} \text{ Ibid.}\]
\[\text{259} \text{ Fisher and Tronto, 40.}\]

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medical practices towards their flourishing. At times, this means that practitioners help the patient bear with their estranged flesh, knowing that the possibility remains for a life to go on. Hauerwas observes that in certain moments “it may be the function of medicine…to relieve painful suffering which makes it impossible for us to claim suffering as our own. And the only one who can tell us when we are suffering that kind of pain is the agent.”

Hauerwas implies that medical practitioners must “tinker” with their practices, to use the language of Mol, in order to fittingly care for their particular patient. Within labor and delivery, this means that an emergency cesarean section or an epidural may indeed be fitting and necessary in order to enable a particular patient to emerge from birth with the chance to make the experience their own. But in order for the prudence of such practices to emerge, the faithful presence of the practitioner attending to the patient over time is required. If the same practices are hastily imposed upon the patient’s body as techniques of control and mastery, then they likely will no longer befit healthcare’s commitment to caring presence.

“But,” Hauerwas asks, “how can we account for such a commitment—the commitment to be present to those in pain?” Here he goes beyond the account of care offered by Mol to investigate the moral sources that might make possible a commitment to hospitable bodily care. The most immediate answer, according to Hauerwas, is that “we need examples—that is, a people who have so learned to embody such a presence in their lives that it has become the marrow of their habits.” Here, Hauerwas makes his theological turn: “Put briefly...if medicine can be rightly understood as an activity that trains some to know how to be present to those in pain, then something very much like a church is needed

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261 Ibid., 80.
262 Ibid.
to sustain that presence day in and day out.” We will spend the remainder of this chapter considering the implications of Hauerwas’s ambiguous phrase, “something very much like a church is needed,” as it both reveals the history of Christianity’s influence on the hospital and healthcare while also pointing the way toward a postsecular theological bioethics.

Hauerwas argues that the church is “a resource of the habits and practices necessary to sustain the care of those in pain over the long haul.” In language that recalls his theses in *A Community of Character*, he writes that in the church we may be “saved from our fevered and hopeless attempt to control others’ and our own existence.” While Hauerwas does not offer a detailed Christological and ecclesiological account of what makes that possible here, he does imply the need for such when he says that it “entails a belief in a presence in and beyond this world.” Then, at the conclusion of his essay, Hauerwas offers a summary of what “something very much like a church” can make possible in healthcare:

> Only a community that is pledged to not fear the stranger—and illness always makes us a stranger to ourselves and others—can welcome the continued presence of the ill in our midst. The hospital is, after all, first and foremost a house of hospitality along the way of our journey with finitude. It is our sign that we will not abandon those who have become ill simply because they currently are suffering the sign of that finitude. If the hospital, as too often is the case today, becomes but a means of isolating the ill from the rest of us, then we have betrayed its central purposes and distorted our community and ourselves.

This passage sits at the heart of this entire project. The hospital is an institution where strangers whose bodies have been made strange to them are welcomed and cared for.

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263 Ibid., 65.
264 By using the term “postsecular” I follow Luke Bretherton’s description of our contemporary context as “a period in which, for the first time, multiple modernities, each with their respective relationship to religious belief and practice, are overlapping and interacting within the same shared, predominantly urban spaces.” Bretherton, *Christianity and Contemporary Politics*, 15.
266 Ibid.
267 Ibid.
268 Ibid., 81-82.
through bodily practices that seek to make possible the befriending of their estranged flesh. On this account, the hospital is a place of hospitable care that promotes peace with the body, not hostility or objectification. Insofar it becomes a place where the body fundamentally is imagined and encountered as an enemy or as an object, then “we have betrayed its central purposes and distorted our community and ourselves.” Such a betrayal marks the histories in healthcare that have given rise to considering the body as fundamentally an enemy or an object.

Yet, Hauerwas does not historicize his account of the hospital and healthcare; he simply presents it as a given institution and set of practices, with the sense that it could be lost but with no account of how it was gained. In other words, he does not make clear that the vision of the hospital and healthcare that he puts forward is itself a historical achievement, one made possible by the institutional and ideological transformations that crystallized in fourth century Cappadocia. Instead, Hauerwas simply wonders “if medicine as an activity of presence is possible in a world without God.” In a sense, Hauerwas has proposed the church as a solution to a problem that the church herself created in committing the hospital and healthcare to welcoming and caring unconditionally for those experiencing bodily estrangement. Therefore, at least at this juncture, Hauerwas has not fully wrestled with the contingent but real gifts that Christendom has given.

Hauerwas comes much closer to recognizing this in his essay, “Suffering Presence: Twenty-Five Years Later,” where he engages Jeffrey Bishop’s arguments in The Anticipatory Corpse, admitting they reveal that modern biomedicine may offer a “healing” that is

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269 Ibid., 81.
“determined by an understanding of the body that is in tension with the lived body of the patient.”

Therefore,” Hauerwas argues,

I think it important to say explicitly what I only hinted at in Suffering Presence. If the Christian body is first and foremost a body meant to glorify God, then Christians must begin to contemplate that the kind of medicine that should characterize the Christian body may be quite different from the kind of medicine that does not share the practices of the church. In short, I think Christians may well find that they will need to develop a medicine that reflects the Christian difference. For the body the church presents to be cared for is not the isolated body of strangers but the baptized body of the people of God.

In this reflection on Suffering Presence, Hauerwas displays the same separatist tendencies we discerned within Bishop's work. Both fail to reckon with how Christians have already developed “a medicine that reflects the Christian difference.” The hospital, as a hospitable institution committed to welcoming and caring for those experiencing the estrangement of their flesh, can be a visible and formative sign of that Christian difference. In the words of Oliver O'Donovan,

While our immediate reflection on the disappearance of the church from its institutions may be that the salt which has lost its savor is fit for nothing but to be thrown out and trampled underfoot, that may not be God's own last word. A rediscovery of their original dedication to Christian understanding and practice can—if only for one person or a few, who come to appreciate their significance—be an occasion for a renewal of meaning. It is an argument not to dismiss too quickly the scattered institutional relics of Christendom that remain in our time.

O'Donovan's account reminds Christians that new possibilities for moral life can be found within institutional relics like the hospital.

If “something very much like a church is needed” to sustain this presence of hospitable care, we can find the possibility of a postsecular approach to theological bioethics

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271 Ibid.

272 Oliver O'Donovan, Entering into Rest: Ethics as Theology 3 (Grand Rapids, MI: William B. Eerdmans Pub., 2017), 198-199. I am grateful to Emily Dubie for bringing this passage to my attention.
in the first part of that phrase: “something very much like,” which indicates that many types of robust moral communities can provide the practices necessary to sustain the commitments to be present to those suffering. Hauerwas offers one particular set of “moral sources” that can undergird something like Mol’s vision of care, but his account is not the only one capable of doing so. Warren Kinghorn, Matthew McEvoy, Andrew Michel, and Michael Balboni develop this insight further in an essay advocating what they call “open pluralism” as the response to efforts to instill “professionalism” in medical students.

Kinghorn et al. argue that “If the professional virtues are to survive, they must be grounded in moral narratives and cultivated in moral communities that exist outside medicine as it is currently practiced.” To do this, they advocate for an “open pluralism: a commitment to explore, understand, and hear the voices of the particular moral communities that constitute our culture.” Such an “open pluralism,” however, can easily devolve into a shallow form of exposure and appropriation that does not fully consider what it means to be thoroughly formed from within a particular community. While it points the way forward from Hauerwas’s “something very much like a church,” for a full realization of this claim we turn again to the work of Luke Bretherton.

Following Hospitality as Holiness, Bretherton turns to consider how the work of broad-based community organizing enables faithful Christian engagement in public life. In such work, a variety of moral communities come together to discern and seek particular goods

274 Ibid., 43.
275 Kinghorn et al. contrast their proposal for “open pluralism” with both a “melting-pot pluralism” that seeks a “least-common-denominator consensus ethic” and a “detached, objective pluralism” that serves to provide practitioners with data about moral communities without making any truth claims upon them. Without a richer understanding of the ways in which the lives and work of practitioners can be grounded within particular moral communities, something like this latter option is likely to develop, perhaps as a shallow syncretism of various moral communities that is not able ultimately to sustain practitioners.
held in common, with each community approaching the work in the terms given by their traditions in all their robust particularities. According to Bretherton, broad-based community organizing “allows for multiple traditions of belief and practice to identify and pursue goods in common while recognizing these common objects of love are provisional and penultimate: that is, of the world but not necessarily worldly.”276 Using Bretherton’s arguments, we can recognize that a variety of traditions may be capable of sustaining practices of hospitable bodily care. We can see this on display in the histories of the Abrahamic religious traditions of Judaism, Christianity, and Islam, particularly in the ways each has sustained and transformed the moral commitments of healthcare and the hospital.277 These religious traditions are all capable of providing “something very much like a church” to foster and sustain practitioners’ commitment to caring presence. Each is committed to health, though each recognizes that the kind of health provided within the modern hospital is not a final good but instead must be set within a particular theological narrative of human flourishing.

Bretherton recognizes that navigating such work will be complex; it will require sustained attention to both “interfaith and intra-faith” relations, as these religious traditions will need to understand how the work of caring presences matters both in relation to each other and within themselves. Bretherton names a further complexity that emerges

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276 Bretherton, Resurrecting Democracy, 109.
“dialectically in relation to state policies and market policies.”

Recall, however, that such complexity was not a barrier to Basil, who negotiated with the emperor Valens a shared understanding of the importance of philanthropy for Basil’s new hospital. While state and market certainly matter for contemporary healthcare, an interesting analogy to Bretherton’s concern can be found within this project’s focus on moral formation and agency in the modern hospital. Seen this way, traditioned commitment to hospitable bodily care within the hospital must be navigated dialectically in relation to medical imaginaries that construe the body as enemy and as object. Can a medical imaginary that construes the body as friend be sustained by any particular religious tradition in light of the powerful institutional forces at play in the other two medical imaginaries?

Bretherton takes up this question in an analogous way when he considers the practice of listening as “a constitutive dimension to hospitality” that “trusts and gives space and time to those who are excluded from the determination of space and time by the existing hegemony.”

Can such a practice—either listening or caring presence—be sustained when a “single voice” of a dominant social imaginary “drowns out all other voices or predetermines how they may speak and what they will say”? Here we realize that multiple answers to what constitutes “something very much like a church” may work to assist any particular religious tradition. For, as Bretherton argues, “the formation of complex space and an institutional plurality is thus part of what it means to listen in practice as it creates a place in which different voices may be heard, each in their own way.”

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278 Bretherton, Resurrecting Democracy, 99.
279 Bretherton, Christianity and Contemporary Politics, 215. According to Bretherton, “for the church listening is the constitutive political act.” His argument for listening role in faithful politics is similar to Hauerwas’s argument to presence in faithful healthcare.
280 Ibid.
281 Ibid.
Christians will be aided in their work to offer practices of hospitable care insofar as Jews, Muslims, and other robust moral communities are doing the same thing according to their own traditions.

Here we can add a significant addendum to our reference to standpoint theory above and in chapter one. Not only is it difficult for a single individual to sustain the adoption of a marginalized standpoint, thereby reordering her or his practices and discourses towards a new end; it is also difficult for a single religious tradition to sustain such a marginalized standpoint within the institution of the hospital. Bretherton’s argument for a plurality of “somethings very much like a church” points a way forward for sustaining a medical imaginary in which estranged flesh is hospitably encountered in hopes of befriending the body.

In summary then, Stanley Hauerwas offers a theological account that serves as a fitting moral response to the concerns that accompany the work of living out of control that we discerned within the labor and delivery ward. For Hauerwas, as for Bretherton, hospitality to the stranger is fundamental to the Christian life. Through befriending the stranger we become friends of God, and so peace with estranged flesh, with strangers, and with God are all related. Within that overarching theological vision we can understand Hauerwas’s account of healthcare as described in *Suffering Presence*. Through being present to the patient, practitioners discern how practices of hospitable bodily care can enable patients to bear with bodily disruption in ways that are recognizably their own. By being trained in the “wisdom of the body”—learned from patients and passed down among medical practitioners—practitioners are capable of making prudential judgments about what practices may be necessary for the patient’s embodied life to go on meaningfully. Hauerwas argues that
“something very much like a church is needed” to sustain such practitioners, but this need itself is the result of how a basic posture of hospitable care was engrained in the Christian institution of the hospital as it was founded in fourth century Cappadocia. From Bretherton, we see more clearly that a variety of moral communities may be able to sustain such commitments. Following his arguments, Christians in healthcare have a vested interested in nurturing the robust presence of these other communities. Their combined commitments to hospitable bodily care foster and nourish the conditions and possibilities for such a medical imaginary to order work within the modern hospital.

4.8 Conclusion: “Not Because It Is Effective, But Simply Because It Is True”

A final word of caution is necessary. In this chapter, we have argued that pregnancy and childbirth are epistemically underdetermined events, and the labor and delivery ward is a site in which the laboring body can be construed as an enemy, object, or friend. Given this plurality of medical imaginaries and the contingencies that accompany all bodily disruptions, there is no way to guarantee that the labor and delivery ward in particular or the hospital more generally will be a site of befriending estranged flesh. Instead, what we have described, both in our phenomenological, ethnographic and historical investigations, and in the moral vision of bodily care offered by Mol and Hauerwas, are the conditions and possibilities for the befriending of a body made strange. Some bodily estrangements must be borne over a lifetime in an often unfilled hope for the befriending of the body. Others threaten bodily dissolution so acutely that they must be dealt with in states of exception, as seen in the surgical ward and the ICU. Such states of exception should be disciplined and ordered
within an overarching commitment to befriending the body, but, again, there is no guarantee of success here. So while these conditions and possibilities for the befriending of estranged flesh in the modern hospital ought to give us hope for faithful moral agency, a commitment to such a moral vision must occur, in the words of Hauerwas, “not because it is effective, but simply because it is true.”\footnote{Hauerwas, Peaceable Kingdom, 151.} This project in Christian bioethics seeks to make articulate this medical imaginary because its presence makes possible a substantive argument about the goods of healthcare and the agency of medical practitioners shaped within the modern hospital.\footnote{This kind of argument follows Hauerwas when he says, “Calling attention to the necessity of witnesses suggests to many people, particularly those of the philosophical bent, the end of argument. For Christians, however, “witness” names the condition necessary to begin argument...To speak of witnesses, then, is not the end of argument; however, what Christians believe about God and God’s relation to the world requires that the form and manner of our arguments have a particular shape.” Stanley Hauerwas, With the Grain of the Universe: The Church’s Witness and Natural Theology (Grand Rapids, MI: Brazos Press, 2001), 207.} We now conclude with the witness of a constructive theological account of the practice of healthcare.
Conclusion

5.1 Opening Questions Revisited

In the last chapter, we argued that the labor and delivery ward contains three distinct medical imaginaries, in which the body was imagined and engaged as enemy, object, and friend. After summarizing fitting moral responses to encountering the body as enemy and as object, we detailed a third moral response, that of hospitable bodily care. This overarching normative vision was traced back to the historical and theological roots of the hospital as an institution welcoming and caring for patients as if each was Christ himself. Such a moral and theological framework provides a way of ordering healthcare’s discourses, practices, and practitioners toward the goal of assisting patients in befriending their estranged bodies. In this way, the project offers a new way of doing bioethics, one attentive to the moral and theological formations occurring within the modern hospital while arguing for an overarching normative vision for the work of healthcare.

Recall that this project originates in a set of conversations with a physical therapist seeking to make sense of her work within the world of the NICU. What might we have to say to her now, here at this project’s conclusion? In order to give an account of the moral sources and conflicts in the NICU, three medical imaginaries that operate within the NICU can be articulated, as in the labor and delivery ward. First, as an ICU, the NICU maps and

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1 For an overview of the history of the NICU and how it has been considered in the field of bioethics, see John D. Lantos and William L. Meadow, Neonatal Bioethics: The Moral Challenges of Medical Innovation (Baltimore, The Johns Hopkins University Press, 2006). For a recent evaluation of the site by a Christian ethicist, see Charles Camosy, Too Expensive to Treat?: Finitude, Tragedy, and the Neonatal ICU (Grand Rapids, MI: William B. Eerdmans Pub., 2010). For an ethnographic account of the NICU that provides an overview of work in that field, see Wendy Cadge and Elizabeth A. Catlin, "Making Sense of Suffering and Death: How Health Care Providers’ Construct Meanings in a Neonatal Intensive Care Unit," Journal of Religion and Health 45, no. 2 (2006): 248-263. Cadge and Catlin’s account informs my own, as have numerous conversations with my wife, Dana McCarty, whose work as a pediatric physical therapist with years in the NICU sits at the origins of this project.
manipulates the infant’s body as matter in motion. What might a fitting moral response be to a site that contains babies within incubators, connected to various technological apparatuses? We may be tempted to counsel separation, arguing that patients, their families, and practitioners cannot experience anything like the moral practice of medicine within the NICU. But such a response does not fully address the moral ambivalence that many parents and practitioners feel about the NICU, as real good is done in the space, good that cannot be accounted for within the framework of a medical imaginary that considers the infant’s body to be an object. This brings us to the second medical imaginary within the NICU, one that frames work within the site as a series of controlled interventions that seek to stave off the threat of debility and death in order to create the conditions in which the infant can thrive. These interventions cause distress for patients as well as their parents and healthcare practitioners, who together lament the necessity of these procedures. Something like a just-war inspired bioethics can provide the criterion to judge when they may be appropriate—and when they should be foregone. Wise medical practitioners can make these discernments and assist others in doing the same, but they may find such an account unable to articulate the deepest goods of their work.

This brings us to the final medical imaginary present within the NICU, that of hospitable bodily care. Nurses, therapists, neonatologists, and family members all work together to welcome and care for the infant’s life. As we saw with this kind of care in chapter four, this requires attention and attunement to contingent and changing embodied realities. But it also provides a way of ordering the discourses, practices, and practitioners of the NICU that foreground hospitality to the infant. Exemplary practitioners in the NICU take seriously the creation of an environment attuned to the flourishing of each child, and they
seek to order their work, from basic acts of bodily care to medicalizing technologies and surgical interventions, toward the good of the particular life before them. Here, as in labor and delivery, there is recognition of working out of control, as practitioners recognize that some infants thrive and others do not in ways that they often do not understand and certainly cannot control. Furthermore, as we saw in chapter four, patients, their families, and practitioners all need communities of support that extend beyond the hospital’s walls.

In response, this project, as a work in postsecular bioethics, has argued that healthcare in the modern hospital requires robust moral communities capable of sustaining an overarching normative vision committed to hospitable bodily care. As we noted in chapter four, these communities can be found within the Abrahamic traditions of Islam, Judaism, and Christianity. Wherever they are found, their presence within the modern hospital should be fostered and sustained in order to support those seeking to instantiate a medical imaginary devoted to befriending the body. Given that this project’s work in postsecular bioethics is also a work in Christian ethics, what theological account should be given from within Christianity to frame and nurture this commitment to care hospitably for embodied life? While we answered this question in part through the vision of hospitality found in fourth century Cappadocia and developed through the work of Hauerwas and Bretherton, we now turn to offer a more foundational theological account of healthcare, one in which practices of hospitable bodily care are understood through the person of Jesus Christ and the Holy Spirit’s work of incorporating material life into the Triune Lord through the body of Christ.
5.2 Enemy, Object, or Friend?: A Christological Grammar

Recall from chapter one that this project follows the theological anthropology of David Kelsey, who emphasizes the embodied public agency of human beings. Through our responsive interactions with material, relational, and social environments, the God who created us in and through those realities is “as it were, talking living human bodies into being personal.”² Throughout this project, we have examined a variety of ways in which people are formed to speak, perceive, and act within the modern hospital. How might we describe the work of God shaping human existence within this institution? To offer an answer to that question, we first detail a Christological grammar of human existence, drawing from scriptural accounts of the life of Christ and the work of Kelsey. We then draw from Gene Rogers to offer a theological account of healthcare as part of the Spirit’s work of befriending bodies.

At the conclusion of Kelsey’s theological anthropology, he argues that God is at work creating, reconciling, and drawing to eschatological consummation human beings who are given their definitive identity in Jesus Christ as the “grammatically paradigmatic human being.”³ Human beings are called to image Jesus Christ, who is the image of God. This involves incorporation into the life of Christ, in whom we participate in the Triune Lord. Because of this, the scriptural accounts of Jesus Christ “work like buoys that mark out the channels in which theological discourse about human beings flows.”⁴ In order to understand how human existence is given in Christ, especially as it relates to this project, we examine

² Kelsey, Eccentric Existence, 293.
³ Ibid., 1008.
⁴ Ibid.
scenes from the beginning and end of the life of Christ. In particular, we can interpret the formations that occur within the modern hospital within the scriptural narrative of Jesus, whose body was imagined and engaged as enemy, object, and friend at the opening and close of his life. This requires what may seem like a bit of a scriptural detour, but doing so provides the theological framework for the overarching constructive normative vision of this project.

We begin at the beginning of Jesus’s life, the one whom the Magi sought out as “the child who has born king of the Jews” (Matt. 2:2). From the first moment that Herod heard of him, the body of Jesus was marked as an enemy. Herod sought “to destroy him” (Matt. 2:13), and in response, Jesus, Mary, and Joseph fled to Egypt to escape this hostility. Also, from the start of his life the body of Jesus was marked as an object by the state; he was born in a manger because Rome demanded a count of his life and the lives of his parents as part of the census. When “a decree went out from Emperor Augustus that all the world should be registered” (Luke 2:1), we see the power of empire mapping its domain in order to manipulate the bodies under its purview. Jesus’s body, along with the bodies of Mary and Joseph, were marked as objects under control. At the beginning of Jesus’s life, then, the governing authorities imagined and engaged Jesus’s body as enemy and object.

Within this narrative, however, a different imaginary is at work, one that delights in the body of Jesus. When Mary visits Elizabeth, John the Baptist leaps in the womb in her presence and Elizabeth proclaims, “Blessed are you among women, and blessed is the fruit of your womb” (Luke 2:42). In her Magnificat, Mary rejoices that the Lord’s covenant with Israel is fulfilled in her life and in the life she carries “according to the promise he made to our ancestors” (Luke 2:55). Following his birth, Jesus’s body is storied into the people of
God, as we see when he is marked in circumcision, and when he comes to the temple as a child. Here, in the heart of Israel, Jesus is recognized as the “redemption of Jerusalem” and “salvation…prepared in the presence of all peoples” by Anna and Simeon (Luke 2:38, 30-31). Israel carries through time the promise that the Lord has and will befriend a chosen people, and in Jesus that promise is realized and extended to all of creation. In scripture, we see that Jesus’s body is befriended by the people of God, and through his body Israel and the entire world are befriended by God.

We see Jesus’s body marked as enemy, object, and friend again at the end of his life. Jesus is crucified, declared by the cross to be an enemy of Rome. All are invited to gaze upon the power of empire over its enemies; above his body hangs the sign, “This is the King of the Jews” (Luke 23:38). Dying, Jesus asks why God has forsaken him, and in death his body becomes a lifeless object under Pilate’s control (Matt. 27:46, 58). But, again, the body of Jesus is not ultimately defined by the governing authorities imagining and engaging it as enemy and object. His body is befriended by Joseph of Arimathea, who buries Jesus, and by Mary, Mary Magdalene, and the other women who beheld the crucifixion and “prepared spices and ointments” (Luke 23:56) to mark his dead body as still beloved by the Lord. Their practices of bodily care frame the moment of the resurrection, when the Father through the power of the Holy Spirit befriends the dead body of Jesus, resurrecting him to new life. In this moment, the Lord’s work to befriend Israel and all of creation through Jesus triumphs over all powers and principalities seeking to swallow up Jesus’s body as an enemy to the state and an object in the grave. In Jesus and through the Spirit, the Father draws material reality into the life of God, and the Lord’s befriending of flesh is more fundamental to reality than
any other claim. Given that Jesus is “the grammatically paradigmatic human being,”\textsuperscript{5} then this account is determinative for our bodies today, which are often marked as enemy and object by the ruling principalities and powers, but are ultimately claimed and befriended by God.

5.3 Healthcare and The Spirit’s Befriending of Bodies

In order to understand how this might be true in the modern hospital today, we must give a theological account of the work of healthcare following this Christological grammar of human existence. We do this by drawing from the work of Eugene Rogers in order to understand how hospitable practices of bodily care participate in the Spirit’s work of befriending bodies. Rogers’s constructive pneumatology gives us the resources to reimagine healthcare.

At the heart of Gene Rogers’s pneumatology, After the Spirit, is the claim, “The Spirit characteristically befriends the body.”\textsuperscript{6} This claim is also at the heart of this project’s constructive normative vision. This “befriending of material bodies” is the Spirit’s “continual elaboration and crowning and consummation of the Incarnation.”\textsuperscript{7} The Spirit’s work befriending the body of Jesus is extended to other bodies, as they are befriended and brought into Christ’s body. According to Rogers,

Resting upon the corporeal body of the Son is not the end of the Spirit’s distribution of gifts, but she rests there that she might rest also on the body of the Son in the Church, and on the body of the Son in the baptized, and on the body of the Son in the bread and the wine, and on the body of the Son in whatever other place she

\textsuperscript{5} Ibid.
\textsuperscript{6} Rogers, 60.
\textsuperscript{7} Ibid., 62.
conceives it.\textsuperscript{8}

This pneumatological account of the befriending of bodies provides a Trinitarian understanding of the ways in which our embodied lives are transformed into the image of Jesus Christ. In the birth, life, death, and resurrection of Jesus, the Triune Lord overcame efforts to mark the body of Jesus—and all of material reality—under the sign of enemy or object. Instead, as displayed in his resurrected body, the befriending of flesh is the final word of God over all of creation. As we are incorporated by the Spirit into the body of Jesus and so into the life of the Triune Lord, we participate in this overcoming of all efforts to mark our bodies as anything other than befriended by God. This work unfolds throughout our lives, and even as it awaits its ultimate culmination in our resurrected flesh, we can discern its presence within the rhythms of ordinary life. As we care and are cared for, our bodies are marked as beloved by God.

In light of this reality, we return to the work of healthcare, for in practices of hospitable bodily care the Spirit is at work befriending our bodies. When finite and fragile bodies are made strange through bodily disruption, patients and practitioners are called to do the hard and good work of attending hospitably to estranged flesh and discerning how it might be befriended. This is work done primarily by the patient, who is assisted by practitioners trained in the wisdom of the body. Within this overarching vision of hospitable bodily care, they seek to discipline and order efforts that, left to their own devices, might mark the body as enemy or as object. Through the joint efforts of patient and practitioner, the Spirit is also at work, bringing peace to the body as a gift from God. This gift is ultimately given in the eschatological body, but in the current age we are to seek out signs of

\textsuperscript{8} Ibid.
its presence even as we bear with the hostile and objectifying forces of death within healthcare systems shaped in part by them. In this way, we participate in the birth pangs of an inbreaking new creation (Rom. 8:22-23).

The Spirit’s work befriending bodies has also unfolded throughout history. Through the church as Christ’s body, God has made possible the befriending of all flesh as creation is drawn into the divine life. As we saw in chapter four, this work through time has had real institutional implications, as the modern hospital carries within it the theological commitment to hospitable bodily care. At the same time, however, the church has enabled distorted visions of God’s work in the world to take root in society at large and in the hospital in particular; as we saw in chapters two and three, construals of the body as enemy and as object have their own theological, historical, and institutional lineages. In Augustinian terms, the church exists in this current age, the saeculum, as a mixed body within an earthly city that has itself been shaped for good and ill by theological commitments. This is also true of the hospital, as it has been bequeathed in part by the church and marked by competing theological visions contained within its medical imaginaries.

Within this current age in general and the hospital in particular, Christians seek the peace of their earthly city, while also anticipating and participating in the city of God, which, as Augustine says, “has been coming down out of heaven since its beginning” through the power of the Spirit. It is only in the final judgment of the Lord that “the glory of that city will by God’s gift appear with a clarity so great and so new that no trace of what is old shall

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9 As Jeremiah wrote to those carried off to exile in Babylon, “But seek the welfare of the city where I have sent you into exile, and pray to the LORD on its behalf, for in its welfare you will find your welfare” (Jeremiah 29:7).
remain.” On this side of that last judgment, Christians work in the hope that the heavenly city is indeed descending but without the presumption that they can clearly delineate its bounds. Because the Spirit rests “on the body of the Son in whatever other place she conceives it,” Christians engaged in healthcare welcome any allies as they seek to befriend the body through the work of hospitable bodily care. For this project in Christian ethics, therefore, this work among and across robust communities of moral support is what it means to engage in a post-secular approach to bioethics.

5.4 Touching and Awaiting Christ

How might the ordinary practices of daily life within the hospital be reimagined in light of this theological account of healthcare? We conclude by answering this question through examining two scenes of healing in the Gospel of Mark, which we then set in conversation with the theological account of care described in Matthew 25 and understood through the work of the Spirit in conceiving the image of Christ in the befriending of flesh. In doing so, we return to the phenomenon of “double sensation,” which we have attended to throughout this project. In chapter one we considered the intersubjective implications of the ways in which the act of touching involves the sensation of being touched, particularly in light of theological claims about belonging to the body of Christ. Given this phenomenon and these theological commitments, what might it mean to touch and be touched in the context of healthcare? We turn to two scenes of healing from the life of Jesus.

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11 Ibid.
12 Rogers, 62.
In the Gospel of Mark, surrounded by a crowd of people, Jesus is approached by Jairus, a leader of the local synagogue whose daughter is near death. Jairus asks Jesus to heal his daughter, and he does so by focusing in on the power of Jesus’s touch: “Come and lay your hands on her, so that she may be made well, and live” (Mark 5:23). Jesus proceeds to Jairus’s house, and there the motionless child’s body is surrounded by cries of grief and lament. Jesus takes the girl “by the hand” (v. 41) and tells her to get up. Immediately, she is healed.

This story is clearly about the healing power of Jesus’s touch. Taken by itself, it provides a clear, simple analogy for the work of contemporary healthcare practitioners as imitating the work of Christ. A helpless, sick person is touched by Jesus, and she is healed; so too healthcare practitioners heal their passive patients. In between Jairus’s request and Jesus’s healing of the child, however, another scene of healing is given, one that deeply enriches our theological account of bodily care.

On his way to Jairus’s house, Jesus is pressed on all sides by a large crowd. Within the crowd is a woman who has been “suffering from hemorrhages for twelve years” (v. 25). During this chronic experience of bodily disruption, she had sought out healing, but her healthcare practitioners were of little help. Under their care, she “endured much” and “spent all that she had.” At the end of all her medical care, “she was no better, but rather grew worse” (v. 26). Desperate for care, she reaches out to Jesus and touches the edge of his cloak. In response, her bleeding “immediately” stops, and the woman “fe[els] in her body that she was healed of his disease” (v. 29).

Here we have a story of a woman who suffered both from her body’s bleeding and also from her healthcare practitioners. She is no passive recipient of healing, but instead
reaches out and touches Jesus. For his part, Jesus recognizes that in this moment of healing he has been touched; he is “immediately aware that power had gone forth from him” (v. 30). Jesus searches for the woman, and she comes to him “and tells him the whole truth” (v. 33). Following her active touching of Jesus, then, this woman tells him her entire story. He listens and tells her to “go in peace, and be healed of your disease” (v. 34).

Taken together, what moral vision might these two stories give for practices of touching and being touched in the practice of healthcare? For healthcare practitioners whose daily work is experienced as a perpetual rushing around, pressed on all sides by crowds of people as they seek to provide care, this story reminds them to attend to the ways in which they are touched by their patients. They are challenged to stop and seek out the stories of their patients, for in doing this they may both “go in peace.” For patients who may feel like Jairus’s daughter, helpless and waiting on the arrival of medical practitioners who seem to be perpetually delayed, or like the woman who had been bleeding for twelve years, suffering much through their medical care, these stories encourage them to reach out as agents. In the midst of contexts where they may be marginalized or passed by, this active work of caring for their estranged flesh may make possible their own bodily peace.

We can also articulate the theological underpinnings of the moral vision of these practices, for as we saw in chapter four, these intersubjective encounters between patients and practitioners are Christologically charged. For if healthcare practitioners imitate Christ and participate in his healing work through their own practice, patients also bring with them the presence of Christ. Given the pneumatological account offered above, we can say that in the practices of bodily care that bring together patients and practitioners, the Spirit is at work
befriending bodies. Through the mutual exchange of touching and being touched in the hospital room, the Spirit is forming both patient and practitioner into the image of Christ.

In this life, however, we often acutely feel the incompleteness of the Spirit’s work of befriending flesh, which is only fulfilled in the resurrection. Our bodies may not feel very much like they are being formed into the image of Christ as we experience bodily disruption, and healthcare practitioners may struggle to see the presence of Christ in the agony of their patients. Likewise, patients may struggle to discern the form of Christ in inattentive medical practitioners, and medical practitioners may discern little of the presence of Christ in their own daily failures to heal. What closing word do we have for the work of hospitable bodily care in an age which may often still seem to be defined by death’s victory?

To answer this question, we return to Matthew 25 and its scriptural context. Before Jesus proclaimed that care for the sick is care for himself in Matthew 25, he gave a series of parables emphasizing the importance of watchfulness. These parables focus on the posture of expectancy that should mark the disciples as they wait for the return of their Lord. “Keep awake therefore, for you do not know on what day your Lord is coming” (Matt. 24:42). These parables focus on the parousia, the second coming of Christ, and it is in this eschatological fulfillment that our hope ultimately lies. It is important, however, to note how they culminate: in the judgment of the nations, where Jesus proclaims that he has already come to them in the presence of the “least of these” (Matt. 25:40).

What might this mean for how bodily disruption is imagined and engaged in the hospital? First, in the face of the power that death still wields, it is right that we yearn for Christ to return and set all things right. In the midst of such eschatological expectation, however, we are called to the daily work of watchful waiting in which we seek to care for the
sick. As patients and practitioners attend to the body made strange, they do so in
expectations that such a body may indeed be carrying the presence of Christ. This posture of
expectant hospitality frames the practice of bodily care as seeking to welcome Jesus.
Through such hospitable bodily care, Christian patients and practitioners participate in the
Spirit’s work of befriending flesh.
Bibliography


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