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The illusion of trust: A phenomenological and theological investigation of the medical profession's fiduciary commitment

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Rice University, 1990

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THE ILLUSION OF TRUST:
A PHENOMENOLOGICAL AND THEOLOGICAL INVESTIGATION
OF THE MEDICAL PROFESSION'S FIDUCIARY COMMITMENT

by

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The Illusion of Trust:
A Phenomenological and Theological Investigation
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Abstract

The professional work of physicians always has entailed the application of specialized knowledge in the interest of patients. The control of medical knowledge provides the medical profession with great authority in society. This control also shapes the phenomenological horizon of meaning for the profession’s members. However, as the physician’s technical knowledge and expertise has increased in recent years, the trust marking the fiduciary side of the relationship with patients has eroded. In an effort to assert social control over physicians, society has resorted to mistrusting the profession. An atmosphere or climate of mistrust is pervading the relationship between physician and patient.

This climate affects the fiduciary component of physicians’ professional identity. Consequently, there is a predisposition for physicians to use their fiduciary reputation to shape their relations with patients. The profession’s traditional commitment to trustworthiness becomes a form of social control assumed by physicians in a potentially adversarial relationship with clients.

With physicians’ employment of trust as a form of social control, trust becomes a commodity to be brokered between self-interested parties. The sense of trust reflected by the profession’s accent of meaning becomes a "confidence" based on competent performance, no longer a "trust" grounded
in the risk and dependency that accompanies interaction with others. As a result, the profession’s declaration of fiducial commitment to the patient’s interest becomes illusory, and an economy of domination occurs in which the physician secures his or her own autonomy at the expense of the patient.

The theological discussion begins with the declaration that separation from God creates the basic human condition of dependency from which an awareness of incompleteness flows. The movement in medicine towards trust-as-control represents the attempt to eliminate dependency and ensure professional autonomy. Trust-as-faith, as a response to others and a reliance on others, requires relationships of mutual dependency. If God is envisioned as a presence whose divine life is enriched by relationship with humans, interdependence becomes the basis for relationship. Thus, a theological analysis of an “illusion of trust” argues for an understanding and appreciation of interdependence in the medical relationship.
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Chapter One

Introduction: The Illusion of Trust

The Problem and the Purpose

The aim of this dissertation is to explore the connections between a Christian theological ethics and the field of bioethics. I have construed the project as a descriptive one. That is, I indicate some basic structures of Christian theology and some ways in which the values it emphasizes bear on the medical profession's ethics (professional ethics, broadly conceived, is certainly a concern of bioethics). To press the question of possible contributions of theology to this aspect of bioethics, I focus on the particular implications of a theological understanding of "trust-as-control" and "trust-as-faith" for the physician's understanding of the meaning of fiduciary commitment to his or her patients. The value of physicians' fiduciary commitment is becoming an illusion.¹

The purpose of the dissertation is two-fold: first, to examine the concepts of trust-as-control and trust-as-faith as these apply to the physician's understanding of the world "present-at-hand" in their practice; and second, to see how these concepts contribute to a medical theological

¹I am not claiming that a fiduciary commitment does not exist, nor am I saying that such a commitment has no reality, no place or meaning in medical work. As Freud pointed out in a different context, an illusion masks an underlying, more authentic explanation for the manifestation of a wish; see Sigmund Freud, The Future of an Illusion, trans. James Strachey (New York: W. W. Norton and Co., 1961), pp. 30-31. In this case, the fiduciary commitment of medicine represents a wish for control in the face of the disruption, risk, and uncertainty caused by illness. If physician's trade on that commitment to control their work, the trustworthiness which they represent will become illusory.
ethics. There is an erosion of trust which is affecting relations between physicians and patients. Since the one who gives and the one who receives trust in the medical relationship are linked and mutually dependent, the recovery of a theological view of trust-as-faith represents an appreciation of interdependence in medical matters.

The project is constructed around two concerns. Each has a pertinence to the meaning and character of theology applied to bioethics. The first concern is theoretical; the second concern is immediate and practical. On a more general theoretical level, the question of the relationship between theology and bioethics is by no means clear. While, as a matter of fact, religious ethicists have contributed to the emergence of bioethics as a discipline in the last two decades, the question persists: just what, if anything, does theological ethics have to offer to bioethics and to the practice of health care? Every moral decision as well as every act of knowing depends upon some center of value, some power or worth, some object of devotion whose goodness and truth we cannot prove. 2 It is critical to bioethics to assess the way in which such "faith" shapes the biomedical enterprise. However, both theology and philosophy concern themselves with this assessment. Each discipline consists of knowledge systems and structures of meaning, with a complex history internally composed of a variety of details in need of clarification, and externally already related historically in a problematical way. The relation between them requires

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At the heart of the Christian theological perspective on ethics is the conviction that there is a God who has offered humans the gift of an ultimate structure of meaning, which they must acknowledge as they shape the patterns of their lives. For many Christians, this gift elicits a faith-response that is foundational to an adequate understanding of morality and its practical application in the world of everyday reality. However, to apply theological structures to a problem in the everyday world of reality is to adopt a perspective whose plausibility is not immediately obvious to all contemporary moral philosophers and ethicists.

For instance, Englehardt claims that the importance of religious moral commitments to individual and social life has been negated by post-Enlightenment attention to general rational considerations. For theological ethics to be persuasive outside of the boundaries of religious communities, in secular society, religious claims require support by secular arguments. He finds this support to be lacking. MacIntyre argues contemporary secular moral thinking treats the Kantian distinction between autonomy and heteronomy as key to the character of morality. Only the autonomous agent

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4Although he is not "anti-religious," Englehardt feels that theological bioethics cannot provide "a particular account of the meaning of life and the world that can be justified in terms of general rational considerations." Theology can conserve the theologies of particular faith communities; H. Tristram Engelhardt, Jr., "Looking for God and Finding the Abyss: Bioethics and Natural Theology," in Shelp, pp. 79-91; The Foundations of Bioethics (New York: Oxford University Press, 1986), pp. 11-14. For a critique of Engelhardt, see Stanley Hauerwas, Suffering Presence: Theological Reflections on Medicine, the Mentally Ill, and the Church (Notre Dame: University of Notre Dame Press, 1986), pp. 1-16.
can be said truly to be acting rationally and morally; "the heteronomous agent has surrendered his or her moral will to some determinant other than his own rational will." The application of this distinction by many post-Kantian moralists yields a powerful argument against theistic morality.\textsuperscript{5} Thus, in the eyes of contemporary secular moral philosophers, theological ethics cannot impose its preconceptions and conclusions on medical matters. Moreover, theological ethics is irrelevant to ethical issues in medicine.

However, I agree with Jeffrey Stout that contemporary philosophical ethics has failed to establish one way of defining what is right or wrong that any rational person ought to accept. It is now apparent that all ethical arguments, philosophical or theological, grow out of particular traditions, and no universal moral argument can be abstracted from them.\textsuperscript{6} In the growing awareness of cultural pluralism, a climate of moral relativism becomes problematical in applying ethical reasoning to medical matters. No one argument appears persuasive for all cases. The result is a crisis of moral authority in bioethical decision-making.

\textsuperscript{5}If I follow a given rule commanded by God, either I am following it because as a rational agent I have judged it worthy of being followed, whether God commands it or not, or I am following it precisely because God has commanded it. If the former is the case, the fact that God commands it is irrelevant to its moral authority; if the latter, I am not acting morally; Alasdair MacIntyre, "Theology, Ethics and the Ethics of Medicine and Health Care," The Journal of Medicine and Philosophy 4 (1979), pp. 435-436.

\textsuperscript{6}"You cannot somehow leap out of culture and history altogether and gaze directly into the moral law... any more than you can gaze directly into the mind of God"; Jeffrey Stout, Ethics After Babel: The Language of Morals and Their Discontents (New York: Beacon, 1988).
The contemporary preoccupation with pluralism need not necessarily end with a radical moral relativism. The appreciation that culture is comprised of multiple, often competing, traditions, each with its own moral horizons, must be taken seriously. People do not make ethical judgments simply concerning those who share their own values. From within their tradition's boundaries, people do extend their moral beliefs to the behavior of others not of their own tradition. Each argument necessarily draws upon a particular legacy which may distinguish it from others, yet the possibility for some shared resolution is not impossible. The existence of moral diversity does not necessarily mean that all traditions are incommensurate. However, each party must clarify his or her particular moral language if understanding is to be achieved, and even then, efforts to formulate some common ground must remain tentative.

Although I appreciate the dilemma, I cannot resolve it in the bounds of this project. However, in reply to this broad theoretical problem, there are at least three attempts to relate theology and the philosophical enterprise. First, perhaps theology can be accommodated to philosophical structures. One can search for a method which would prove that there is an underlying rationality, a set "of recurring operations" which underlies all disciplines, including philosophy and theology, such that there cannot be in principle any opposition between them. Vocabularies may differ, but a reconciliation is possible by a return to the invariant foundation of all. In this way theology and philosophy can converse through common vocabulary of knowledge and in differing but not incompatible structures of concepts.7 However, this effort

7George P. Schner, "Theology and Science: Their Difference as a Source of Interaction in Ethics," in Shelp, pp. 17-25.
explains away the radical distinctiveness of Christianity which its theology seeks to enunciate. It certainly accepts the view that no aspect of Christianity stands outside of the nexus of causal relations which together constitute culture.

Second, the two could claim different spheres of influence within culture. Philosophy could concern itself with the truths that can be known through reason alone, while theology would work to clarify the intelligibility and truthfulness of Christian convictions for the faith-community. In the most radical formulation of this approach, one could take the attitude that philosophy and theology have nothing to do with each other, and allow adherents to while away their time happily pursuing their respective interests. Any relation with "culture" becomes prophetic and instructive, as the Christian is one who lives in the world but is not of it. However, the issue remains unresolved since this approach requires each discipline to establish the limitations of the other.

A third approach seeks a way to bring the two together by accepting the autonomy of each, yet establishing their relationship as well. Claiming that philosophy and theology are not separated, and yet not identical, Tillich's concept of correlation has been described as the attempt to show the

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8Barth, for instance, protested that accommodation with philosophy threatens the reality of the divine-human relationship by making God dependent upon human structures of meaning. His theological reaction was one of a "positivism of revelation"; see Karl Barth, Church Dogmatics (Edinburgh, 1957), Vol 2, p. 174. The description of Barth's "positivism" is from Schner, p. 22. A less severe position is taken by Hauerwas who places Christianity over and against culture, stressing the role of theology in delineating the character and narrative of the Christian faith community; see Stanley Hauerwas, A Community of Character (Notre Dame: University of Notre Dame Press, 1981).
correspondence between the "questions" asked by philosophy with the "answers" that only theology can provide. To him, philosophy was the expression of the self-understanding of an age or a people. It then deals with the questions of meaning and understanding which develop in any age. Philosophy gives expression to the "forms" of culture from which this self-understanding develops. However, since the object of theology is what concerns us ultimately, "only those statements are theological which deal with their object in so far as it can become a matter of ultimate concern for us."9 Thus, Tillich argued that it was the role of theology to mediate the necessarily reciprocal and interdependent relationship between historical Christianity and contemporary culture.

One criticism of Tillich's ideas is that he inappropriately linked his specifically theological use of "correlation" to the ordinary use of the word in the sense of a logical interdependence of concepts -- he suggested that God and world, for instance, mutually imply one another.10 However, God and world are not related in a reversible fashion. "For it belongs to the concept of God that God cannot be related to the world in just the same way that the world is related to God."11 In other words, this relationship is asymmetrical. However, Tillich's work is still valuable for this project if his concept of

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10Ibid., p. 61.

correlation is understood to show the interdependence of two independent factors. In this sense, correlation functions as a metaphor.

Therefore, finally, philosophy and theology can be related in a metaphorical way. Metaphors contain indeterminate, ever unfolding dimensions of meaning and convey a sense of the unity of experience while dramatizing its multi-faceted character. They bring into play a set of meanings which are interrelated, even conflictual, and not reducible one to the other. They conceal even as they disclose meaning and associations.

Following Tillich, theology is the discipline which articulates the drive of humans towards the transcendent (ground of being). However, it does so within the tradition of a particular community. It cannot adopt philosophy's definition of truth as clarity and certainty. This is not to say that theology cannot be clear in what it says, that its arguments are not logically rigorous, persuasive, or "truthful." It cannot hold, however, that reality is ultimately perspicuous.

My concern in the dissertation is not to validate theological presuppositions, whatever form such validation would entail, nor to propose their acceptance by theology's critics. I intend to show the indissoluble connections of theology and phenomenology without collapsing their discrete


\textsuperscript{14} Gadamer claims that there is an infinity of the unsaid which always accompanies the finitude of the said; quoted in Schner, p. 2.

\textsuperscript{15} Schner, p. 23.
meanings. The presence of moral dilemmas in medical practice will not be
eliminated by utilizing theological ethics, nor are they resolved by rejecting
it. My intention is to apply this ethics to a particular problem within the
context of medical ethics, and take up the problem in a new way. 16 In this
sense, the project is an interpretive one. The intention is to accomplish what
Paul Ricoeur calls a "de-centering of perspective." 17 My hope is to break the
preoccupation of ethical theory (philosophical or theological) with taken-for-
granted perceptions arising from an a person's own vantage point within the
world. "This emphasis is a corrective to the Western tendency to begin and
end ethical analysis with a self--either logical or actual--who reads the
experiences of others in terms of his or her own experiences, and who
assimilates the moral import of the other into his or her own self-
actualization." 18 Inasmuch as theology is concerned with delineating the
meaning structures which are given in the life-world, this becomes an
exercise in theological ethics.

I am claiming that, if secular discourse is also just one tradition among
others, a critical use of theological ethics can be instructive in bioethics
within carefully defined or expressed limits. The search for
presuppositionless knowledge, for knowledge based on pure reason, is
bankrupt. Boldly stated, philosophy, like science and theology, has its own

16Douglas Sturm, "Contextuality and Covenant: The Pertinence of Social

17Paul Ricoeur, Freedom and Nature, trans. Erazin Kohak (Evanston:

18Thomas Ogletree, Hospitality to the Stranger (Philadelphia: Fortress Press,
position of faith to which it appeals. Thus, Englehardt's claim is misdirected; morality need not be played out only on the fields of secular moral philosophy. This counter-claim needs to be demonstrated in examining the erosion of trust confronting the medical profession. More specifically, while taking seriously the "fact" of moral pluralism (that pluralism cannot be simply dismissed by adherents of a particular tradition), my interest is phenomenologically to explore pluralism in light of the fiduciary dimension of medicine's professional ethics. Secondly, my interest is to explore ways in which theology can inform an understanding of that dimension. Inasmuch as it is concerned with the "limits" of human life, theology is engaged in the quest for truth in human life. To claim that the theological world-view has nothing to do with bioethics is "either to separate faith from one's view of the world (which is to trivialize faith by reducing it dualistically to an utterly other-worldly thing) or to separate one's view of the world from bioethics (which is to trivialize bioethics by isolating it from the very persons it purports to serve)."19 The dissertation is an attempt to deal with the trivialization of theology with regard to ethical dilemmas in the medical context.

I return to the question of the appropriate role, if any, of theology in issues of bioethics. Given the theoretical dilemma for moral philosophers, what is the distinctive voice which theology offers to the ethical dimensions of biomedicine? If theology cannot impose its presuppositions on medical work, what part can theological ethics play in a discussion of the erosion of public trust in the profession's fiduciary commitment? The fact that medical

work involves individual and social dimensions raises a sociological focus. Theology, in and through its many forms, is concerned with the nature and destiny of human life. This concern raises the issue of the relation between God and the world, for God represents the objective ground of confidence in the ultimate significance of the world and, in particular, of human activity. According to Douglas Sturm, this is the elemental issue that resides at the foundation of all human life, including the practice of medicine.20 The social issue of trust, or distrust, in the medical profession's fiduciary commitment raises a theological focus and brings us to the practical concern.

The practical problem is the erosion of public trust in the medical profession. Because of their role within the social order, physicians have claimed and been granted autonomy, authority, and special status. In return, the profession has pledged to serve the well-being and interests of humankind. This fiduciary commitment becomes a taken-for-granted aspect of the physician’s identity, both for the physician for whom this dedication is definitional and for the public which expects trustworthy service from this person. With recent social changes affecting the medical profession, however, suspicions have been roused regarding the depth of the fiduciary commitment. Although this suspicion is manifest in a variety of forms, in its most common (and, therefore) disturbing expression, it disrupts the trusting relationship between physician and patient on which much of the meaning of "health care" depends. Efforts to counter suspicion and distrust, I will argue, tend to exacerbate the problem. Since trust is the concept representing the

20In Max Horkheimer’s phrase, "behind all authentic human activity stands theology." By theology, Horkheimer means the realization that the world as it exists is not the last word; quoted in Sturm, p. 138.
conditions of confidence and expectation on which human life depends, individually and socially, consideration of this practical problem involves attention to social theory. Health and well-being, illness and disease are experienced by individuals, but they are, also, expressive of the social context of human life. Inasmuch as physicians are members of the profession which is charged with responsibility in these areas, and inasmuch as the profession is a social institution, this issue of trust is of crucial importance to the question of what it means to be a "physician" and to the meaning of medical "practice."

I will argue that there is no essence of the medical profession and no essence of Christianity which can be established with any finality. The meaning of each must be reinterpreted in every age. The dissertation is an attempt at this reinterpretation. In the particular "situation" with which I am concerned, because of an erosion of the fiduciary relationship between the physician and patient, there is a danger of a preoccupation with trust-as-control in medical matters. Acknowledging theology's presuppositions, I claim that theology offers a corrective to this development. After Babel, pluralism is a given in social reality. Human intersubjectivity is the ground on which all knowledge and commitments are based. In theological language, this ground is "under God." Therefore, beginning with the Christian premise that there is "something more" to religion which is irreducible to philosophical or scientific categories, I focus on the divine-human correlation expressed through the human responsiveness of fiducia or trust-as-faith.
A Map of the Method

If one is to know where one is going, one must know where the journey begins. The "map" of methodology is crucial to the purpose and direction of the dissertation. This discussion begins with the methodological problems inherent in the study of religion.

Broadly put, there are two basic methodologies in the study of religion: the reductionistic and non-reductionistic approaches. First, the reductionistic approach assumes that religion fully can be explained in terms of social, economic, psychological, and other factors. In the process, religion is "explained away," and there is nothing unique left in the end. Second, the non-reductionistic approach to the study of religion argues that the social, economic, psychological and other dimensions of religion cannot be denied, but what is denied is the claim that religion can be reduced to these.21 Religion is something more. Religion perhaps cannot exist without being implicated in social, cultural, historical matrices, but that it cannot exist without them does not mean that it necessarily can be reduced to them -- it retains a uniqueness, an essence, a non-reducible element, all its own.

If its uniqueness is admitted, in the academic study of religion (or any other phenomenon), how does one gain an understanding of this non-reducible dimension? In the confessional study of religion, a religion is studied because it is believed to be true. In the phenomenology of religion, however, a religion is studied as true because it is believed, because it exists

as a phenomenon in the world.\textsuperscript{22} The belief does not have to be true for the person studying the religion; it only has to be accepted as true by the believer being studied. What is more, in the phenomenology of religion, the question of the belief's validity beyond that context is "bracketed" or suspended in the course of the study. In the effort to be descriptive, any statement about the essential validity of religious faith must be tentative.

As a phenomenon of social reality, religion can be analyzed in terms of the critical philosophical discipline of phenomenology. However, phenomenology has various meanings and applications. It is necessary briefly to make a distinction between phenomenology in its philosophical form and the particular school of thought known as the phenomenology of religion.

Phenomenology is a creature of ambivalence. Like the serpent who lives in both water and land, phenomenology crosses boundaries. In the phenomenological attitude, the interpreter is enabled to leave his or her own familiar world for a moment, cross into the unfamiliar world of the "other," and return with a knowledge made possible by the crossing. Often, he or she appears to be in two worlds at once. Thus, his or her interpretations may seem vague from the vantage point of his or her colleagues. For a study of symbolism, which itself crosses boundaries, this attitude is appropriate for the task.\textsuperscript{23}

\textsuperscript{22}Ibid., p. 32.

The philosophical approach to phenomenology, particularly that of Edmund Husserl, parallels the intentionality of the phenomenologist of religion. Through the science of interpretation, both expressions of phenomenology intend to uncover the essence of a particular phenomenon. The range of Husserl's work extends beyond the scope of this project. It is important to note that Husserl's phenomenology was a method and an attitude, a way of critically approaching the world in an effort to gain insight into it. Husserl's method of investigation made possible the reconstitution of the appearance of the world in terms of its transcendental structure or essence. From the perspective of the person's ordinary or typical attitude, this essential dimension is hidden. In the phenomenological attitude, in eidetic analysis, attention is shifted away from the object perceived (its


facticity or *noesis* to the perceiving itself (the essence, or *noema*).\(^{26}\) In this reduction or epoché, Husserl believed that it was possible to bracket those views relating to the the historical stance of the natural attitude which cause one to base his or her conclusions on historical facts and preconceived values concerning those facts.\(^{27}\) Freed from these "blinding" preconceptions and typicalities, phenomenology enables one to re-view experience in the world.

Many of the insights of phenomenology have been adopted to the work of other disciplines. In the sociology of knowledge, phenomenological categories and method are utilized to pierce the veil of appearances and

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\(^{26}\) "Eidetic analysis aims at seeing through the particulars (concrete or existential) to discover that which is essential (ideal or typical). The essential structure of the phenomenon under study, whether it be social organization, social relationship, or belief system, refers to those elements which make up the phenomenon and without which it either ceases to be what it is or changes considerably. In an eidetic analysis we analyze the phenomenon, that is, our consciousness of the object, in order to discover its constitutive elements; then conceptualizations can be developed which assist us in discerning and understanding the empirical representations of the ideal-type"; George Psathas, *Phenomenological Sociology* (New York: John Wiley & Sons, 1973), p. 10.

\(^{27}\) The terms "epoché" and "natural attitude" are used in phenomenological discourse. The natural attitude is the term used to encapsulate the essential presuppositions, structure, and significations of the world of everyday life. It is the standpoint which reflects an individual's ordinary, unquestioning outlook on daily life in which the person assumes that reality corresponds to his or her understanding of it. In phenomenological theory, one can become deliberately, systematically disengaged from the natural attitude through the method of the epoché or "suspension of judgement." The epoché "brackets" or suspends the taken-for-granted understanding of reality. Husserl gives the terms their classical formulation; see Maurice Natanson, *Literature, Philosophy, and the Social Sciences* (The Hague: Martinus Nijhoff, 1962), pp. 34-44. By freeing one from a fixed subject-object dichotomy, this form of radical criticism presents a more complete understanding of social action and meaning.
uncover the basic meaning structures within which individuals make sense of their social world. When applied to the study of the medical profession or a religion, for instance, the phenomenological attitude and method enables the investigator to suspend the conceptualizations he or she brings to the phenomenon, and opens the way to "see" its noema. Given these presuppositions, it is possible to present a phenomenological and sociological examination of the way in which the natural attitude structures and is supported by the system of relevances by which a person make sense of the world. Thus, the purpose of phenomenological sociology is not to philosophize about the nature of existence or to refine a metaphysics of being, but to interpret these systems of relevances on their own terms.

Phenomenological and sociological categories also can be applied to the study of religion. More particularly, sociological factors do shape religious institutions and theological conceptions of ethics. From a sociological point of view, the priorities given to particular ethical notions are different from age to age and from one culture to another. A perspective based on the sociology of knowledge suggests that these changes can be analyzed in terms of changing social contexts. Ethics, as with any other cognitive enterprise or human activity, can be analyzed in terms of the social factors that have shaped it. In like fashion, ethical notions can be analyzed in terms of their possible influence upon particular societies. Ethics can be described as a "social reality," as a phenomenon shaped by social determination or itself as

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shaping other social realities. These ideas apply to ethics in general, to religious ethics, or to Christian theological ethics.

Religious institutions and conceptions also provide an accent, a distinctive emphasis, which shapes the believer's view of "reality." Similarly, the medical profession and the tradition of medicine provide an accent which shapes the physician's view of reality. In applying theological analysis to issues of trust in medicine, a correlation must be drawn between these views. However, this correlation represents a departure from a strictly defined Husserlian phenomenology. Theology provides a particular critique of social relations and institutions. Therefore, it represents an interpretation of the meaning of human existence and social activity. Just as every assessment is also a criticism, so every descriptive analysis also implies a normative statement. A phenomenological and theological account of the medical profession's fiduciary commitment carries particular implications for a medical theological ethics.

This methodological map points a way to answer the theoretical and practical questions raised in the dissertation. What is the distinctive voice of theology in ethical matters? Can one take detached position vis a vis a religious tradition, yet understand something of its theology? Through the phenomenological method, one can suspend preconceptions and uncover the

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30 Schutz borrows the term "accent of meaning" from William James; see Ogletree, Ch. 1.
intentionality of an(other) position. In this context, intentionality refers to the orientation of consciousness to those meanings which make up its contents. If the task of phenomenology is to describe the constitutive features of the life-world in terms of the intentional structure of consciousness, an investigation of "faith" certainly becomes appropriate. This study is not empirical in nature; it does not suspend the peculiar acts of consciousness which figure in observation in order to give privileged status to sense data. Rather, it seeks an account of the elemental structures (the "limiting" structures) which are the preconditions of all experience whatsoever. In this sense, the study is theological.

The project also will examine the way in which sociality constitutes trust and trustworthiness, and shapes the physician's identity in relation to others. (This comment is not intended to suggest that what it means to be a physician can be reduced to sociological categories. The physician is "something more" than such an analysis implies.) If Tillich is correct that theology gives answers to questions posed in a cultural situation, again, the study presents a theological focus. Tillich does state that the "content" of theological answers cannot be derived from experience. This content is "spoken" to human existence from beyond the limits of human existence. To establish the "situation" from which questions arise, however, social theory and the social sciences can be employed (human existence in its "situation" has a psychological, historical, and social "reality"). Therefore, the study of sociality also illustrates way in which a person understands "trust-

31Ibid., p. 15.

32Tillich, Systematic Theology, Vol. 1, pp. 8, 64.
as-faith," and the way in which it shapes a person's identity and relations with others. (This statement is not intended to suggest that faith be reduced to sociological categories. There is "something more" to religious faith.)

In setting out the "map" of the dissertation, the direction which will not be taken is as important as the path which will be followed. Before beginning a fuller discussion of the problems and purpose which the dissertation will address, several cautionary points must be made. I want to identify claims about the possible relation between theology and bioethics which I am not trying to make. First, slightly amending Margaret Farley's argument, I do not expect theology to articulate for bioethics moral principles or fundamental values which are unique only to a theological perspective. It is not only a particular theology that can ground, for instance, a requirement to respect persons, nor can Christian theology claim to represent the only means of viewing human persons as fundamentally interpersonal and social. However, theologies do yield ethical perspectives that are "unique in some respects, moral positions that can claim hermeneutically privileged insights, even particular moral action-guides" for decision-making.33 The critical function of theology may offer new perspectives on issues in bioethics.

Second, there is no one definitive form of Christian theology which can represent all of its possible implications for bioethics. Theology in general is a pluralistic enterprise. There are multiple religious traditions which contain multiple theologies. Within Christianity, the various theologies themselves are pluralistic in nature. The existence of diverse perspectives, then, must be kept in mind while exploring the possible role in bioethical matters of a Christian theological view of faith. It may be that there is no "essence" of Christianity, nor of Christian theological ethics when applied to ethical issues in the medical context.34

34This issue of the "essence" of Christianity will be addressed in the dissertation. For a discussion of the difficulty in determining a fundamental, unique, or single understanding of the Christian kerygma or ethical position, see Clayton, pp. 34, 244; and Hauerwas, Suffering Presence, pp. 71-75. As I am using the term, an "essence" is defined by those features of a thing or event, without which the thing or event could not exist or would be other than it is; see Marvin Farber, "Values and Scope of Scientific Thought," in Maurice Natanson, ed., Phenomenology and Social Reality: Essays in Memory of Alfred Schutz (The Hague: Martinus Nijhoff, 1970), pp. 1-16. An essence has several descriptive and normative features. It may be the most important feature of a thing or event, around which all other aspects are ranked. It may be the most basic or elementary feature, less than which we can not do without or upon which all else builds. The essence of a thing or event can be its "unique" feature, that which makes it different from all else. An essence could be characterized as its inward feature, its constant feature, the outward manifestation of which varies over time. Finally, an essence is the indispensable feature, that which makes something what it is, rather than something else. Within the broad scope of the Western philosophical tradition, if we can determine the essence of something, we will approach a normative understanding of it. I will argue that there is no essence of Christianity, no essential (universally present and universally true) profession, professional ethics, or solution to an ethical dilemma waiting to be discovered. Following Tillich's argument on the purpose of theology, formulations of these concerns are "re-created" in every age; see Tillich, Systematic Theology, Vol. 1, pp. 18-28.
Third, while it is possible to identify some parameters of an ethics which derives from and is reinforced by particular Christian theological analysis, a systematic development of a Christian theological ethics applied to very specific bioethical issues is beyond the scope of this project. Therefore, in applying theological depictions of the nature of the divine-human relationship to an understanding of the fiduciary commitment which physicians bring to their "work," there will be no attempt to develop this discussion beyond a focus on this particular issue. Discussions of theological themes such as faith, incarnation, or community will be directed to this problem.

Finally, although the dissertation concentrates closely on the development of a hermeneutical method for examining the context and meaning for a theological understanding of the fiduciary element in social relationships as these occur in the medical encounter, I am cautious of a preoccupation with technique. Preoccupation with method is symptomatic of
the postmodern age. The self-critical, reflexive awareness which characterizes this postmodernism has an effect on theological work. If only we develop the correct techniques, so the argument goes, the necessary understanding can be achieved, and truth will be disclosed. However, that upon which the method is applied should remain the focus of any study. Although I agree with Tillich that the task of theology is to articulate the theological "answer" to the cultural "situation," I do not claim to have uncovered the essence of Christianity as it applies to this particular problem. Rather, if there is to be any interaction between theology and the social or biomedical sciences, it is in the reshaping of the imaginative constructions

35 The term postmodern requires explanation. Premodernity presupposed an axis mundi between hidden and manifest forces which was accessible through myth and ritual. Modernity raised the question of how one knows what is given and thereby undermined the unquestioned authority of the premodern consensus. Postmodernity recognizes the dependence of all truth claims on the vested interest of the claimant, thus undermining the premodern consensus even further. In a more positive sense, it also recognizes that the reality of diversity allows for a "back and forth movement between participation in meaning and objectifying critique." This movement permits dialogue; see David Klemm, ed., Hermeneutical Inquiry: The Interpretation of Texts (Atlanta: Scholars Press, 1986), p. 23. In the dissertation, a "postmodern" world is one characterized by a secular, scientific, and technological world-view; an age in which pluralism and relativism are taken for granted; in which consciousness of alternative views is pervasive; and in which distrust of authority is commonplace. Hans Kung argues that in postmodernity the absolutized forces of the modern period (e.g., science and technology) will be relativized for the sake of human welfare; Christianity and the World Religions (New York: Doubleday & Co., 1986), pp. 55–57.

36 Theologians are often more interested in other theologians than they are in God; see MacIntyre, p. 440.
which constitute the felt and reflected world of our age.37 The method becomes a tool; the purpose is the engagement which reconstructs meaning in the world. Such a theological engagement should retain a focus on the centrality of God for human affairs. In this dissertation, that focus provides the background.

A Theological Positioning

Theology starts when faith begins reflecting upon itself.38 Sittler notes that the theme of biblical narrative is God’s "going out from Himself in creative and redemptive action towards men."39 The response of the believer to this “self-giving” God is the total commitment of the person known as faith.40 This religious faith is not the mere affirmation of propositions, nor can it be reduced to cognitive or dispositional commitment. For the Christian theologian, the world of God is uncompromised and heeds no other voice of

37See Schner, p. 22.

38As McCormick argues, there are two things to note: First, there are different faiths (e.g., Christian, Jewish, Muslim); and second, the communities in which these faiths originate exist in history and, therefore, must continually reappropriate their inheritance in changing times and circumstances; p. 5. Thus, it is clear that there are radically different theologies, and there are many theologies within any one faith community. Of course, how theology relates to medicine and bioethical issues can vary from community to community, and within the same community.

39Joseph Sittler, quoted in McCormick, p. 5.

rationality. It has its own intelligibility as demanded by faith itself.\textsuperscript{41} Mouw points out that to the Jew or Christian, MacIntyre’s argument against theistic morality is irrelevant, since he or she is committed to rejecting the premise on which it is based.\textsuperscript{42}

For the Christian believer, God’s self-disclosure in Jesus is at once the self-disclosure of himself and his world.\textsuperscript{43} The response to this gift is not psychological, emotional, cognitive, or social (although it may affect and be manifest in these modes). It is an empowering faith-response and is transforming. In Paul’s words, in faith the person is a “new creature.” In theological language, faith, then, is the total commitment of the whole person which is required by the character of the revelation. It is a gift freely given and freely received which transforms the receiver and, I will argue, has a concurrent affect upon the giver. Unfortunately, it is easy to reduce theology to categories and formulas, for faith is a response to a transcendent God and finally exceeds the reach of human language. Historical communities that provide the context of the faith-response have symbol systems on which ethical codes may be based. The temptation exists to confuse belief in these systems with faith properly directed to God. In this fashion, faith becomes

\textsuperscript{41}Schner, p. 17.

\textsuperscript{42}Mouw, p. 371.

\textsuperscript{43}McCormick, p. 5.
bound to particular cultural representations.\footnote{See H. Richard Niebuhr, Christ and Culture (New York: Harper Torchbooks, 1951).} This confusion can lead to idolatry and alienation.\footnote{Idolatry is the replacement of a focus on God's centrality in human life with something finite. In theological language, alienation is the condition of being separated from relationship with God. It can be argued that faith in a political candidate or a sports team can unite and orient people. Certainly, the terms alienation and reconciliation can have secularized psychological, social, and political meanings. However, theologically, these meanings are placed in different perspective, transformed by the totality that God represents.}

A discussion of theological ethics is an appropriate way to address this issue. "For theological ethics... the first task in order of importance is to establish the convictions about God and God's relation to the world. To make a case for how things really and ultimately are..."\footnote{James M. Gustafson, Ethics From a Theocentric Perspective, Vol. Two: Ethics and Theology (Chicago: University of Chicago Press, 1984), p. 98.} A theistic ethics is rooted itself in a transcendent and immanent God. Its primary referents will be God's relation to humans and their relation to God. The prime analogate of the term "morality" will be this relationship.\footnote{McCormick, p. 6.} A Christian theological ethics derives from the fact that something has been done to and for people in the person of Jesus. This gift engenders faith and provides the entire grounding and meaning of the Christian ethics. Faith transforms the person, and reveals
a new basis for understanding the world and one's actions in it. Outside of relationship with God, human efforts to know the self and others are doomed to failure. Therefore, in faith, the believer is dependent upon God, not independent, called upon to give in return for the total self-gift by which God is in relation to him or her.

However, Christian theological ethics exists in the postmodern world with contrasting, competing explanations for meaning in human existence. Theology is one among many systems which offer relative explanations, each claiming authority. Also, under the pervasive climate of suspicion that characterizes the postmodern world, the conception of God as transcendent and immanent is subject to renewed debate. In the postmodern world, for many people, this tension is showing signs of fracture, leading to a loss of trust in the first conceptualization of God and a quest to secure the latter. This movement pushes for control and domination which obscures an appreciation of God as "other," and relativizes or trivializes God as immanent. The relevance of theology for medical work (and bioethics) is unclear, and efforts are made to secure a fully plausible, rational grounds for moral authority in medical decision-making.

Such criticism of a theological basis for ethics has created a search for final, universal moral precepts and principles to which all rational agents can pledge allegiance. With the seemingly insurmountable problems of subjectivism and relativism, it appears that this search has negated itself in
Western, postmodern world. Moreover, this critique overlooks the possibility that faith can inform reason, not in the sense of claiming that only the person who has been transformed by faith will "see" rightly, but that theological discourse can broaden understanding of the medical dimension. Therefore, the dissertation explores the possibility of a medical theological ethics which derives from issues arising from a sociological and phenomenological examination of the fiduciary commitment of physicians to their patients.

The Practical Problem of Trust and Control

It commonly is assumed that people trust physicians; it is taken for granted that physicians see themselves as trustworthy. However, there are recent signs that serve to call the first assumption into question. I am not interested in the reasons why public confidence in physicians has been eroding. I am interested in the effect that this erosion has on the physician's perception of himself or herself as a physician whose identity is tied to a declaration of fiduciary commitment to his or her patients. In reaction to an erosion of confidence in its image, the profession appeals to the physician's dedication to superior knowledge balanced by a fiduciary commitment to

service as virtues characterizing the "good" physician.\textsuperscript{49} However, as the physician's medical expertise and knowledge have grown, the understanding of trust as a virtue in relations between patient and physician has undergone a shift. The protestation of trust, the declaration of trustworthiness, by the profession becomes an illusion masking the growing uneasiness felt by the profession's members in their relations with others.

According to sociological theory, human society is a complex matrix of associations and relations which results from the social negotiations among individuals and institutions. Ordinarily, we assume that others present themselves to us in a trustworthy fashion, and that negotiations are based upon the desire to achieve relations of mutual benefit. When the balance of power among individuals and social groups is upset, the parties seek to restore an acceptable balance of power. During these periods, each party becomes defensive and self-protective in its relations with the other, each striving to preserve its power and autonomy in what has become an

\textsuperscript{49}A wide list of virtues necessary to medicine has been proposed through the centuries. For several excellent discussions of the meaning of virtue in relation to medicine, see Earl E. Shelp, ed., \textit{Virtue and Bioethics} (Dordrecht: D. Reidel, 1985). I realize that there are various understandings of virtue in different contexts within a moral pluralism. For instance, virtue has distinct meaning within Christian thought. The "theological virtues" transform human character and give rise to others; see Darel W. Amundsen and Gary B. Ferngren, "Virtue and Medicine From Early Christianity Through the Sixteenth Century," \textit{ibid.}, pp. 23-61. I adopt Edmund Erde's definition that virtues are a socially produced means for a person to be a good and reliable member of his or her society. In terms of medicine as a social subgroup, Erde argues that medical virtues share three meanings: a) the orientation of character which the institution of medicine demands of its practitioners; b) the advantages which organized medicine offers to a society; and c) the orientation of character which constitutes being a physician; "The Virtues of Medicine: Meaning and Import," \textit{ibid.}, pp. 201-222.
adversarial relationship. In such a relationship, trust can be used as a manipulative tool to enhance the power and control of one party in the social matrix. The fiduciary element in the relationship becomes a shell, outwardly polished but inwardly hollow. This condition is the result of a serious misunderstanding of the distinctions between confidence, trust, and faith.

Often these terms are used interchangeably. I can have confidence in the physician's skills and knowledge, but I may not trust him with my welfare. The application of the phenomenological method to the profession's fiduciary focus uncovers two dimensions to trust. The first dimension allows me to take for granted that the physician possesses the requisite knowledge and skills, and to posit confidence in the assertion that he or she is dedicated to my interests. This first instance of trust is equivalent to the phenomenological epoche of the "natural attitude" in which a person assumes reality is as it is represented. In a climate of eroding public confidence in the profession's fiduciary commitment, this attitude is "shocked" into the realization that what we once believed to be "real," or "true," can be otherwise. The profession is attempting to maintain or reestablish such an epoche so that the patient will accept its power and authority. The shock to the taken-for-granted trust in physicians is reconciled or explained away, and the epoche is restored. In this condition, trust is used to reinforce a fixed means-ends orientation which obscures the value-judgments held to be

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meaningful by the medical profession's members. "It allows reality to be disclosed only in accordance within certain predetermined possibilities, yet it represses the fact that things have been interpreted in this manner."\textsuperscript{51} This order of trust is termed "trust-as-control."\textsuperscript{52}

The second dimension of trust is a deeper, more complete condition which has similarities to an act of freely given and received faith which transforms the person's relationships with others. It rests on an opinion or decision based on past experience, demonstrated skill, and evidence of benevolence. This trust involves a calculated risk based on evidence that is still not conclusive enough to compel assent or guarantee success -- a trust "in spite of" the uncertainty and incompleteness of human finitude. The second instance of trust results from the reintegration of a more comprehensive understanding of trust, and makes possible an authentic, mutual decision to be trustfully responsive and present to each other in relationship. Attention to the virtue of "trust-as-faith" suggests a way to reinterpret the fiduciary component of medical "practice."\textsuperscript{53}


\textsuperscript{52}Certainly the focus of medical practice, the alleviation of suffering, raises issues of control. "Disease, which is the occasion of the social interactions of medicine, imposes peculiar restrictions and reveals unique needs for trust and keeping trust"; H. Tristram Engelhardt, Jr., "Rights and Responsibilities of Patients and Physicians," in Tom L. Beauchamp and LeRoy Walters, eds., Contemporary Issues in Bioethics (Belmont, CA.: Wadsworth, 1982), pp. 133.

\textsuperscript{53}For a discussion of "practice" that is relevant to the social construction of medicine, see Alasdair MacIntyre, After Virtue (Notre Dame: University of Notre Dame Press, 1981).
Phenomenological sociologists would argue that what it means to be a physician is constituted by the definitional boundaries of the social institution of which he or she is a member. These boundaries are determined internally by a coherent and complex system of knowledge, skills, standards, values, and organization. They also are determined externally by the profession's complex matrix of relations with other individuals and institutions in the world of working. If the public's trust in the profession, and by extension, in its members, is eroding, there will be a concomitant effect on the way in which the profession and its members construe the meaning of trust -- in themselves, in their work, and in their patients.

The present relationship between physicians and the public indicates that physicians' thought and practice, on the one hand, and the beliefs and expectations of their fellow citizens, on the other, are uncoordinated and disharmonious. Therefore, a phenomenological "reduction" of the medical accent of meaning invites a re-interpretation of trust's importance in shaping the boundaries of professional identity. This interpretation reveals the roots of the uneasiness and resentment which complicates relations between physicians and patients, and suggests possible directions for a recovery of mutual trust.

If theological ethics is to be taken seriously by physicians, the contribution of a theological morality to medicine must be demonstrated.

54Stephen Toulmin, "On the Nature of the Physician's Understanding," The Journal of Medicine and Philosophy 1 (1976), 32-50. Toulmin believes that the disharmony in public attitudes toward the medical profession joins with a confusion of aims within the profession itself. As a result there is a shared uncertainty about the roles doctors are to play in our lives, the knowledge and understanding demanded of medical practitioners, and hence the quality of concerns that a medical "agent" should display toward any patient (p. 32).
However, in a postmodern world, plural moral positions compete with religious orientations. For instance, with the biomedical model the physician works within an "accent" or "habit of mind" which primarily is based in a "finite province of meaning" for which religious values are not definitive.55 In a secular view, for example, the virtues constituting the trustworthy physician are not necessarily those shared by Christian conceptions of faithfulness. Talk of trust becomes meaningful only in situations of uncertainty and risk, yet trust does not eliminate the risk -- it becomes meaningful in the face of risk. Although medical work and physicians need not be religious to be efficacious, theology can contribute to an understanding of these situations in which risk and uncertainty are

55Alfred Schutz argues that a person structures experience and organizes his or her "world" in terms of sub-universes of reality" or "finite provinces of meaning"; see Alfred Schutz, "On Multiple Realities," Collected Papers I, ed. by M. Natanson (The Hague: Martinus Nijhoff, 1962), pp. 226-259. A finite province of meaning is defined as a certain set of experiences, all of which show a specific cognitive style -- its "accent of meaning" (p. 230). The "habit of mind" is an approach to the world, the backgrounds and horizons of meaning against which and through which the particular province takes shape; see Victor Kestenbaum, "Introduction," in V. Kestenbaum, ed., The Humanity of the Ill (Knoxville: The University of Tennessee Press, 1982), pp. 6-7. These provinces represent different worlds consistent within themselves but distinct from each other. All of the provinces are contained within the social matrix that Schutz calls the "world of daily life" or the "everyday world of working" (Schutz, pp. 208, 222). I am arguing that the medical profession is one of these "sub-universes" within the world of daily life. Christianity and other religious traditions represent various other sub-universes within the world of daily life.
present. The theological themes of alienation and reconciliation suggest loss and recovery in such boundary, definitional, or limiting situations. Trust represents a "leap" of faith which occurs in those situations and moments of uncertainty and risk in which assumptions regarding meaningfulness of life are challenged. Religious faith provides a confidence and trust in the face of these "limiting" moments. In faith, the self is transformed and meaning is (re)established. Again, the elements of risk and uncertainty are not

56I characterize these situations as "boundary situations." By boundary situation, I mean the point at which the horizon of known experience encounters the unknown; these are moments of uncertainty and risk. For instance, in medicine, no matter how knowledgeable or well practiced the physician, no matter how many tests have been run, there is the moment when the body is "uncovered" and the incision (or decision) is made. This moment of "crossing" represents a boundary situation; also see Brenneman, et al., pp. 31-53.

57Focusing on the boundaries or limits of provinces places us "betwixt and between" taken-for-granted meanings, and exposes the risk or uncertainty which constitute these moments of interaction. These situations expose hidden, yet present, meaning structures. See Mark Taylor, Erring: A Post-Modern A/theology (Chicago: The University of Chicago Press, 1984), p. 5. Stephen Toulmin argues that moral reasoning can give answers as to why an act is right or wrong. However, there remain the "limiting question" which may be asked — e.g., why should I be moral at all? In Toulmin's view, religious assertions have to do with these limiting questions (which can be asked when all moral answers and explanations have been given). Religion speaks to the condition of those who in actual living are afflicted by the sense of uncertainty: An Examination of the Place of Reason in Ethics (Cambridge: Cambridge University Press, 1960).

eliminated; the possibility of meaningless remains. However, a transformation of faith can provide meaning in human life and restore a more integrated "natural attitude" to one's experience of the everyday world.

An erosion of trust exists which is affecting the medical profession's sense of its traditional fiducial commitment to its clients. The alliance of medicine with science, coupled with social changes, has made the profession and public more self-conscious of the asymmetrical nature of their relationship. With the perception of cultural pluralism and the loss of an "assumed" moral consensus, participants in the medical relationship are becoming uneasily aware of the constituted nature of trust. A more controlled and self-possessive approach to medical encounters is developing on the part of patients towards physicians, but also on the part of physicians towards patients. Under this condition, the fiduciary dimension of medicine takes on an illusory quality.

**Trust and the Medical Profession**

The questions which emerge when one considers the relation of trust and the medical profession dictate my approach to this subject. Since it is usually assumed that the profession is primarily a fiduciary one, why should there be need of comment at all? Have the two become so separated that their relation is no longer obvious? Have the terms "trust" and "physician" become so ambiguous that their meanings are no longer clear, and the attempt to address their relation is actually a commentary on our uncertainty as to their purpose and function? Is it necessary to re-interpret to physicians the meaning of the medical profession's fiduciary commitment?
One thing is clear: When people are asked to say which professions command the most respect, they usually place physicians at the top of the list. Adjectives used to describe physicians include honest, reliable, and trustworthy. Doctors are seen as competent professionals, people of good character, whose priority is the good of the patient. Never in modern history has the medical profession been stronger. However, at the same time, the profession's image seems to be "sinking."

Polls taken in the last few years show that the public is changing its perception of the medical profession. A recently published study of opinion polls demonstrated a substantial decline in public confidence in the medical profession. There is much public questioning of professional trustworthiness. Childress mentions a Harris poll in 1973 which discovered

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59George Lundberg claims that modern doctors are better trained and more competent to deal with practically every kind of treatment problem and prevention strategy -- and wonders why the profession is undergoing reappraisal; "Medicine -- A Profession in Trouble?" The Journal of the American Medical Association 253 (May 17, 1985), 2879-2880; David Mechanic sees the growth of public disillusionment accompanying magnificent medical advances; "Public Perceptions of Medicine," New England Journal of Medicine 312 (Jan. 17, 1985), 181-183.

60"The Changing Image of Doctors," editorial, The British Medical Journal 289 (December 22-29, 1984), 1713-1714. Irwin C. Lieb has commented that "many of us have lost confidence in the ways such supposedly well-trained professionals as physicians... among others, serve the public," in Kestenbaum, p. 4.

61Since the 1960s, public confidence in physicians has dropped from 73 to 33 per cent; Robert J. Blendon, "The Public's View of the Future of Health Care," The Journal of the American Medical Association 259 (1988), 3587-3593.

62Barber, p. 131.
that 57% of people surveyed trusted the medical profession while 52% had
confidence in local trash collectors. While seventy-three percent of
Americans surveyed in 1983 saw physicians as up to date on the latest
knowledge and technology, 64% of people felt that people are losing faith in
doctors. "[Over] two-thirds of the American public now believe that people
are beginning to lose faith in doctors."65

These figures require interpretation, for when people are questioned
about their experiences with their personal physician, they indicate
confidence in his or her technical competence while expressing concern with
quantity of contact time and increasing medical costs. Admittedly, it is
difficult to measure patient "trust" in physicians. Polls generally elicit
responses to categorical questions concerning physician competence,
humaneness or personal qualities, efficacy of care, and availability.66 A
response to these categories can vary with the wording of the questions.

There is no doubt that physicians possess special privilege in the
public's eyes. However, there is a growing public concern that physicians are
trading on their fiduciary reputation. An increasing number of people are

63James Childress, Priorities in Biomedical Ethics (Philadelphia: The

64Adele Lash, "Public Attitudes Towards Physicians," Indiana Medical Journal
79 (February, 1986), 184-186.

65Mechanic, p. 181.

66See B. S. Hulka, et al., "Correlates of Satisfaction and Dissatisfaction with
Medical Care: A Common Perspective," Medical Care 13 (1975), 648-658. The
difficulty of measuring patient satisfaction was confirmed in R. D. Hays and J.
E. Ware, "My Medical Care is Better Than Yours," Medical Care 24 (1986),
519-524.
disenchanted, finding that physicians are more interested in money or
prestige and less concerned with their patients.\textsuperscript{67} In 1982, forty-two percent
of the public queried expressed the opinion that physicians' fees are usually
reasonable. This figure declined to 27\% by 1984. During the same period,
there was an increase of from 60\% to 67\% of those people who thought that
doctors were too interested in money. To a great extent, physicians are
coming to be seen as highly successful businessmen who are functioning
"with the business ethic rather than the professional ethic."\textsuperscript{68} Since one of
the basic features believed to distinguish professionals from occupational
workers is the separation of client interest from personal and financial
interest, public concerns with physicians' trustworthiness indicate a sense of
distrust and uneasiness with the sincerity of physicians' "professional"
dedication.

More directly, fear of the commercialization of physicians' knowledge,
expertise, and power is shown by the issue of doctor referrals to laboratories
or clinics owned by the physician or in which he or she has a financial
interest. Common services in which doctors are shareholders include

\textsuperscript{67} A 1984 survey by the American Medical Association indicated a growing
public perception that physicians were becoming too interested in money,
spending less time with their patients, and expressing little interest in them;
see Larry Freshnock, \textit{Physicians and Public Attitudes on Health Care Issues}
(Chicago: The American Medical Association, 1984); William L. Stewart, "The
335-336.

\textsuperscript{68} Lundberg, p. 2879. Businessmen might express dismay at Lundberg's
disassociation of business and professional ethics. Also, for a comment on the
business aspects of medicine, see Eugene M. Bricker, "Industrial Marketing
and Medical Ethics," \textit{New England Journal of Medicine} 320 (June 22, 1989),
1680-1692.
radiology centers providing X-ray and other diagnostic imaging tests, diagnostic laboratories, physical rehabilitation centers, cardiac rehabilitation centers, medical equipment leasing and sales companies, radiation therapy centers, hospital services such as operating rooms and laboratories, and same-day surgery centers.\textsuperscript{70} Given the vulnerable position of patients vis-a-vis the physician's knowledge, a suspicion that doctor's referrals rebound to the physician's fiscal benefit fuels the public's concern with physicians' patient-centered interest.

Because physicians are the holders and wielders of powerful knowledge, the issue of their trustworthiness is a social problem. An erosion of trust affects physicians' perceptions of themselves and their work. The more the public expresses concern, anxiety, and resentment, the more doctors are concerned and uncertain. There have been several reactions to this public questioning of their professional commitments. Many physicians and others hold that the idea of medicine as a business is disturbing, if not

immoral. There have been appeals to physicians to consider customer satisfaction and public relations to restore the profession's fiducial image. Others address public concerns with health care costs by concentrating on physician accountability and cost-effectiveness.

Some people argue that these concerns represent an implicit threat to medicine's professional mandate or an attack on the position of doctors as free agents. Medical practitioners assert that they cannot function satisfactorily when public distrust results in litigation and excessive regulation. They also object to "outside interference" in what they perceive to be the special prerogatives of their work, claiming that their professional codes already establish sufficient moral and ethical guidelines for their


72 See R. G. Lacsamana, "Cracks in the Mirror or What Patients Think of Us," Journal of the Florida Medical Association 72 (August, 1985), 573-575; James R. Webster, Jr., "The Physician's Image and Options," The American Journal of Medicine 83 (June, 1987), 123-126. These authors advocate a concentration on "customer relations" and "public relations" as the means to recover a positive image in the public's eye. Also, see the AMA Judicial Council, "Conflicts of Interest -- Guidelines," Adopted at the Interim AMA Meeting (December, 1984).


74 Barber, p. 131.
practice. For example, many physicians look upon philosophical and theological analysis of their work as meddlesome and potentially debilitating to their care for their patients. Self-control of the limits of their work is viewed by physicians as necessary to their professional practice. Consequently, even when stress is placed on the moral distinctiveness of the medical profession's ethics, for many doctors this position represents a call


for the restoration of physicians to their central and elitist position of control in health care.  

The meaning of "central position" is subject to discussion. Social and economic changes over the last fifty years have served to question the physician's autocratic image as "captain of the ship." Previously, doctors enjoyed some latitude in shaping the content of health care decisions by gathering, defining, and dispensing information. The infusion of public monies into health care, the development of biomedical technology and therapeutic techniques, and the media's increased attention to these matters have made medical issues into public issues. More attention is given to the interests of various parties concerned in medical matters and to their respective beliefs and ways of reaching decisions. As a result, the doctor's authority competes with the increasing emphasis on the patient's autonomy (and claims to professional power by other "supporting" health care occupations). Since some form of power and control is necessary in social relationships to set goals, direct work and establish order, the competition between physician authority and patient autonomy raises the issue of trust in health care.  

Sociologically, trust is necessary to social relationship since it is the basic ingredient without which the relationship would falter. However, trust is not an absolute feature of relationship -- trust depends on a situation of  

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risk in which the other person or thing is not under one's control. It is commonly believed that doctors know what is best for their patients, and that, therefore, patients should trust them to act in the person's best interest. In reality, the relations between physician and patient are a mixture of cooperation and self-interest, and trust must be created and maintained in an on-going relationship. Ideally, this relationship is one in which trust is given and received freely. However, when uncertainty and suspicion are present, relationship becomes marked by self-concern and self-protection.

This issue is not of only speculative or abstract interest. Practical problems arise in particular social and intellectual contexts within the world of working. Medical theory and practice are guided by multiple values and paradigms that sometimes conflict — both within medicine and with values of the multiple groups outside the boundaries of the professional view — and shape the expectations which physicians and patients have of each other. Of immediate importance, the uneasiness caused by such conflicts disrupts the social interaction which forms the basis for the medical relationship.

As the public image of physicians has suffered in recent years, the medical profession's understandable reaction is to examine ways to restore its image and prestige. While the profession has begun to appreciate certain criticisms of the biomedical model of illness, has begun to appreciate the calls for patient autonomy and rights, and has revised its codes to reflect

80 After all, the manner in which the doctor conceives, thinks, and views "his own knowledge and understanding directly shapes the manner in which he perceives, thinks about, and treats the patients who are the objects of that knowledge." The reverse is equally true. If physician and patient have contrary ideas about the character and claims of medical knowledge, they are likely to end up also with conflicting notions about the nature, terms, and mutual obligations of the professional relationship; Toulmin, p. 33.
these concerns, the depths of the issue remain unexamined. These efforts serve to maintain the authority of the profession. The "shock" caused by public distrust is ameliorated by incorporating the conflicting concerns into the physician's accent of reality, thereby restoring his or her sense of control, power, and authority.

**Theological Concerns Raised by the Use of Trust-as-Control**

A Return to the Problem

The reinterpretation of trust-as-control and its effect on the fiducial component of professional identity has implications for a medically informed theological ethics. Social interaction necessarily involves relationships of power. Biblically, the poor, the sick, and the vulnerable are to be protected from exploitation. Their presence represents a call to communality and solidarity, a limitation to self-interest. The relationship between the medical profession and the public, particularly the specific dimension of the physician-patient encounter, is suited to theological investigation because of the issues of the dependency and vulnerability caused by illness and the possibility for human exploitation.

A theologically descriptive task which begins with a phenomenological bracketing of the natural attitude of everyday life (even the natural attitude of groups within the Christian community) reveals the roots of the fragmentation of moral experience. The natural attitude generally takes for

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granted particular assumptions and expectations of perceived reality. In a pluralistic culture, people become aware of "otherness" (that things could be other than they are believed to be), yet struggle to maintain their assumed view of reality against its encroachment. Engelhardt's libertarian morality is a reaction to this perception of otherness. As a means to retain trust and social interaction, such a morality becomes grounded in an appeal to rights language which at best insures a condition of mutual non-harm.82 However, I would argue that attempts to maximize individual autonomy are more indicative of an erosion of trust among members of the social matrix. As agents become self-oriented and possessive of their assumed autonomy, they become caught in an illusion of trust. The roots of trust-as-control lie in a basic condition of dependency and neediness that motivates, even as it alienates, the members of a social relationship such as the one between physician and patient.

A phenomenological and theological investigation of the medical profession's fiduciary focus suggests a manner by which trust's meaning in medical matters can be reinterpreted.83 When trust is used as a device for establishing or maintaining social control, it becomes merely a means for furthering self-interest at the expense of others expressed through an

82The interest in autonomy reflects this concern. Autonomy requires an exercise of self-respect, self-concern, and self-control. Ideally, autonomy leads to relationships of mutual respect, benefit, and trust. However, realistically, autonomy fosters an ethic of mutual non-harm; see Erich Lowry's critique of Engelhardt in "Beneficence in Trust," Hastings Center Report 19 (January/February, 1989), 42-43.

83The expression "hermeneutical phenomenology" represents a particular form of phenomenological interpretation as it applies to the study of religious material; see Brenneman, et al., p. ix.
economy of domination. Distrust among people is "real." It does occur and has consequences in their self-understanding and relations with others. According to theological ethics, human dependency cannot be eliminated, but it can be taken up into a certain relationship that offers the hope for a restoration of a sense of trust in the meaning of everyday life. Humanistic psychology offers hope for a restoration of meaning and trust in life. However, from a theistic horizon of meaning, the estranged relationship caused by distrust is an illusion grounded in an alienated relationship with God.

**Review of Literature**

To sharpen the issues and to show the background of the argument, a review of literature is required. It is necessary to establish a definition and sociological understanding of the "medical profession"; to establish the meaning of "trust" as the term will be used; to outline the phenomenological dimensions of trust and medicine; and to set out the theological parameters of the discussion.

To describe the erosion of trust's effect on the medical institution, I first will develop a sociological analysis of the profession to establish the features of the medical profession which mark it as a particular institution within society. There is no essential ingredient characterizing the medical profession. The boundaries of meaning defining the profession are not eternally the same, discoverable in a pristine state within the conditions of temporality. These boundaries are fluid, changing according to the expectations of the participants in the social relationship.
Few scholars agree on the characteristics which determine professional status. In a broad sense, a profession is an occupation for which one is paid. However, all occupations do not qualify as professions. In a narrower sense, a professional is one paid for skill and expertise in an area of specialized work.\(^{84}\) In the last century a range of activities and occupations have claimed professional status. Plumbers, dry-cleaners, and baseball players are among the many groups which describe themselves as professionals. Yet while baseball players and dry cleaners are paid for their skill, few would grant them the same respect as physicians.\(^{85}\) If we distinguish between status professions and occupational professions, occupational professions are those groups whose members use their

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\(^{84}\)Freidson describes medicine as one of the "learned" professions which, traditionally, are the occupations of the educated and high born; Eliot Freidson, Professional Powers: A Study of the Institutionalization of Formal Knowledge (Chicago: University of Chicago Press, 1986), pp. 20-35. In modern usage the word "profession" is often defined in terms of technical expertise sold for a fee, but the more traditional meaning describes a group that professes a vow to an ideal of service; see Allen Dyer, "Virtue and Medicine: A Physician’s Analysis," in Shelp, Virtue and Medicine, pp. 223-235. The word profession comes from the Latin "profiteri" which means "to declare aloud," and a professional may be defined as one who "professes, who takes an oath, a scared vow"; B. Dan, "Patients Without Physicians: The New Risk of AIDS," The Journal of the American Medical Association 258 (1987), 1940, quoted in Sanford C. Sharp, "The Physician’s Obligation to Treat AIDS Patients," Southern Medical Journal 81 (October, 1988), 1282-1285. For further discussion of the "professional" nature of medicine, see Vern Bullough, "A Brief History of Medical Practice," in E. Freidson and J. Lorber, Medical Men and Their Work (Chicago: Aldine-Atherton, 1972), pp. 86-102.

knowledge and skill primarily to make a living.\textsuperscript{86} A status profession is one which is given qualitatively higher status because it is assumed that financial reward is a secondary concern to its members.\textsuperscript{87} If people regard a particular occupation as a status profession, scholars have assumed that there must be a fundamental quality of that group which sets it apart from occupational professions. Often it is argued that this quality is a dedication to service or a fiduciary commitment to the client. In examining this issue, it is necessary to review attempts to define the meaning of "profession," particularly in relation to the medical profession. This review will define the way in which the term is used. It also will establish that a theological analysis of trust-as-control and trust-as-faith in the medical context must take into consideration the social and historical structure of the medical profession.

\textbf{A Sociological Understanding of the Medical Profession}

\textbf{Medicine as a Status Profession}

Three theories specify the medical profession as a status profession: the traits theory, the function theory, and the institutional structure theory. The first theory takes as its premise the assumption that those who are

\textsuperscript{86}Peter Elliot, \textit{The Sociology of the Professions} (London: Macmillan, 1972), pp. 14, 32.

\textsuperscript{87}According to Barber, the occupational professional's ordinary desire for reward is replaced by a "status" system of rewards that is primarily a set of symbols of work achievement. To a professional, these symbols are ends in themselves, not the means to some end of individual self interest; Bernard Barber, "Some Problems in the Sociology of Professions," \textit{Daedalus} 92 (Fall, 1963), p. 671.
members of the medical profession reflect a set of common attributes which distinguish them from other professionals or from non-professionals. The trait theory claims that there are identifiable attributes which form the representative core of a professional occupation. Therefore, this approach conceptualizes a status profession as an inherently distinct occupation, distinguished by essential qualities which can be found in other status professions, although these qualities may vary in importance among them.

The trait approach is an inadequate theory because it implicitly accepts the premise that there are "true" professions which exhibit all of the essential elements. The problem with this approach is that "essential" is defined by abstracting from the known characteristics of existing

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professions. Because there is no commonly accepted definition of an ideal profession, the theory does not explain why trust is necessary in medical work.

The second approach identifies particular patterns of social behavior which distinguish physicians from other members of society. Those who favor function theory argue that the physician is characterized by the role he or she plays in society, and that this role is consistent over time and in various situations. According to this theory, occupations become status professions when they function as controllers of and gatekeepers to specialized knowledge and skills. Because of the gap in competence and knowledge between professional and client, to fulfill its role the profession must be dedicated to acting in a disinterested way for the benefit of its clients. This commitment to knowledge and objectivity serves to elicit the


92 In reviewing Talcott Parsons' work on the physician-patient relation, Renee Fox discusses the importance of the "competence gap" that exists between physician and patient which binds the two parties together in a semicollegial relationship; Renee Fox, Essays in Medical Sociology (New York: John Riley and Sons, 1979) p. 500.
trust of the public in the profession. It also serves to maintain social equilibrium by controlling access to and removal from the "sick role."\textsuperscript{93}

As a member of the medical community, it is argued, physicians possess the theoretical and technical knowledge necessary to fulfill their functional role. However, their knowledge is not unlimited or absolute. To pursue its social function, the profession must dedicate itself to the continual pursuit of knowledge and expertise. Thus, another functional component of the profession becomes the application of scientific knowledge to clinical practice.\textsuperscript{94} Also, to fulfill their role physicians must cultivate objectivity as a

\textsuperscript{93}Talcott Parsons sees illness not merely as a biophysical condition. It is an integral part of a social process that is governed by the institutionalized roles of the medical profession, which has as its particular function the "management" of disease and illness. His analysis of medical practice also recognizes the physician's semicollegial relationship with the patient whose "sick role" is complementary to that of the physician. See Talcott Parsons, "The Sick Role and the Role of the Physician Reconsidered," Milbank Memorial Fund Quarterly (Summer, 1975), pp. 257-278; "Social Structure and Dynamic Process: The Case of Modern Medical Practice," in T. Parsons, The Social System (Glencoe, Ill.: The Free Press, 1951), pp. 428-479; also see Fox, ibid., p. 500.

\textsuperscript{94}Parsons, The Social System, pp. 431-432. Parsons stresses the innate relationship of medicine with science. The use of science to bolster knowledge, and in turn better enable doctors to perform their function, increases the impact of the argument that scientific medicine and technology improve the doctor's ability to act for the patient's own good. Parsons sees the medical profession as the embodiment of the "primacy of cognitive rationality"; see "Professions," in D. Sills, ed., The International Encyclopedia of the Social Sciences (New York: Macmillan and Free Press, 1968), Vol. 12, pp. 536-547.
guard against any emotional involvement that might cloud their professional judgment.95

Functional theory offers some advantages over the trait theory of professions. Traits ascribed to an "ideal" profession become secondary to the social function played by the professional. According to the functionalist perspective, a dedication to beneficence is attributed to physicians because it enables the doctor to gain the patient's trust, thereby better enabling the doctor to restore the social equilibrium by removing the patient from the sick role. Therefore, the ranking of traits, or the inclusion of some and the exclusion of others, may vary over time, depending on how efficacious they are in supporting or structuring this function.

Just as trait theory attempts to characterize normative qualities of professions, however, functionalist thinking treats the medical profession as a generic concept rather than as a changing historic concept with particular

95For a description of the particular institutional conditions which lead to the development of objectivity as a characteristic attitude, see Robert K. Merton, et al., The Student-Physician: Introductory Studies in the Sociology of Medical Education (Cambridge, MA.: Harvard University Press, 1957), and Howard Becker, et al., Boys in White: Student Culture in Medical School (Chicago: University of Chicago Press, 1961). In order to function effectively, the doctor must establish his or her authority through technical expertise and affective neutrality. The primacy of cognitive rationality in medicine allows for functional specificity and affective neutrality. Parsons argues that an emphasis on technical roles in therapeutic relations serves to exclude considerations which would undermine the efficacy of physician's function and impede performance. The alliance of science with medicine fosters this combination of technical skill and affective neutrality, thus actually reinforcing trust in the therapeutic relationship; see Terence J. Johnson, Professions and Power (New York: Macmillan, 1972), pp. 35-36.
roots in industrial nations influenced by Anglo-American institutions.96 The assumption that all status professions at any time and in any culture have similar roles suggests that a common function, with common norms, can be abstracted or distilled.97 However, if no normative function can be elucidated, functional theory is explanatory, not descriptive, of the medical profession. Such a view undermines the assumption that physicians are a homogeneous group sharing a unique, univocal character.

Consequently, recent work in the sociology of professions argues that professions are social organizations whose structure and relations with other social groups vary over time. In this view, professions are distinguished by certain social dynamics of interaction that give them access to power, an institutional structure which evolves to sustain that position, and activities by which they exercise that power.98 Traits, then, are reflections of ideals which underscore the profession's power. Their variability is not as important as the way in which they are used to realize professional power and authority. Power enables and authorizes physicians to play a social role around which certain traits accrue. These traits enable physicians to control their work in society. The way in which a social institution controls its work, therefore, influences conceptions of its function. The third theory states that

96Johnson claims that the functionalist emphasizes the gatekeeper role as ahistorical and homogeneous among (status) professionals; pp. 36–37. Also, Berlant critiques Parsons' functionalist theory of the medical profession by noting that Parsons claims to present a descriptive argument. Minimally, however, it contains an implicit explanatory theory for the institutionalization of the profession's normative structure; Berlant, p. 12.

97Freidson, Professional Powers, p. 31.

98Ibid., p. 16.
the medical profession is a social institution which is able to control its
relations with others in the society (both those within and outside of health
care).99

If we assume that medicine is a social institution essentially similar to
other social institutions, it develops, changes, and adapts historically, and in
response to social, economic, and political changes.100 According to this focus,
medicine is an occupation which has most effectively gained and works to
maintain a monopoly in its market. Berlant argues that medicine developed
as a commercial organization working to achieve control of its "market
situation."101 To gain power and control of its art, the medical profession
developed an organized structure, developed an institutional ideology,
limited access to its ranks, and claimed "status" as a profession acting in the
best interests of its clients.102 This process results in professional solidarity,

99 Johnson and Freidson argue that the functionalist perspective is too
unilinear in concept. Instead they favor a social analysis of professions as
social institutions. Professions are those collegial occupational groups which
exercise control over their work; see Johnson, Professions and Power; Eliot
Freidson, Professional Dominance: The Social Structure of Medical Care (New
York: Aldine-Atherton Press, 1970); Doctoring Together: A Study of

100 See Michael Foucault, The Birth of the Clinic: An Archeology of Medical
Perception (London: Tavistock, 1973); N. D. Jewson, "The Disappearance of
the Sick Man From the Medical Cosmology," Sociology 8 (1974), 369-385; and
P. Wright and A. Treacher, eds., The Problem of Medical Knowledge:
Examining the Social Construction of Medicine (Edinburgh: Edinburgh
University Press, 1982).

101Berlant, pp. 51-58.

102 See Paul Starr, The Social Transformation of American Medicine (New
protects the profession from competition, and fosters a high degree of autonomy against lay control.

The drive for institutionalization creates a condition of uncertainty and distance between the expert and the layperson which reinforces the demand for professional autonomy. First, an expert's high degree of competence and knowledge means that lay people cannot judge the quality of professional performance. Accordingly, a patient must trust the doctor's knowledge and skill, and subordinate his or her own autonomy to the doctor's authority. Second, medicine claims that its professional organization and structure efficiently work for the client's benefit. As the sole legitimate arbiter of proper performance, the profession argues that this autonomy enables it to serve its clients most effectively, efficiently, and safely. Thus, self-regulation through codes of ethics and informal mechanisms of control through education, training, referrals, and peer review play a major role in

103 Johnson, pp. 42-44.
the medical profession's claim to autonomy. The medical profession sees itself, and works to be perceived by the public, as a service occupation dedicated to the society's central values. Thus, the profession's "profession" of service rests on a claim to power and control over work, and preserves physicians' autonomy and authority.

Trait and function theories represent a static view of the medical profession, the first by seeking qualities possessed by the "ideal" physician, the second in describing a gatekeeper or mediator role played by physicians. The third alternative description of the profession as an institution of power dismisses the discoverability of essentials, and suggests that a profession creates its identity and purpose in an ongoing struggle of social dimensions. However, such a description still suffers from the deficiency of the earlier sociological theories. Although it emphasizes the process by which occupations become institutionalized or professionalized, it still presupposes

104 Arlene Kaplan Daniels, "How Free Should Professions Be?" in The Professions and Their Prospects, pp. 39-57. She notes that, for the profession, the autonomy of the physician is not desired out of self-interest, but is a requirement for offering the best possible service in the public interest (p. 39). Such an argument, echoing Parsons, is used as an apologia for public trust. However, "it may be that the characteristic claim of service to mankind which professions make is as much an unquestioned assertion that everything and anything a professional does is by definition service to humanity as it is an assertion that professionals are obliged to determine what it is that does serve humanity and how they might better strive to do so"; Freidson, The Professions and Their Prospects, p. 13. Therefore, codes function as a device to retain or advance monopolistic control of work, as a means for receiving government sanction of an exclusionary shelter in the marketplace. Knowledge, skill, and service orientations are no longer regarded as objective characteristics of the institution of medicine. These characteristics become ideological devices to establish autonomy, as the means to gain or preserve social status and privilege; see Freidson, Doctoring Together: A Study of Professional Social Control.
the idea of profession. Without some prior definition of profession, the concept of professionalization is meaningless. It is impossible to escape this definitional dilemma if we assume that "profession" is a generic concept discoverable as a universal, univocal idea.\textsuperscript{105}

To summarize this discussion, it is difficult to find agreement on a definition of the word "profession." The word is evaluative as well as descriptive. With this difficulty in mind, in the dissertation, the medical profession is defined as an institutionalized occupational-collectivity constituted by a formal body of theory, knowledge, and technical expertise, able to exercise power in society through control of its work. It gains power and prestige through control of its training and socialization, the development of expert technique, and its claims to maximum efficiency in delivering the services it represents. The profession's social and organizational structure "constitutes" the sense of reality which individual physicians share, and with which they approach their work. It also has developed and encourages a fiduciary commitment towards its clients which enables its members to perform their work (and earn a living).\textsuperscript{106} This "control" influences the way in which a physician conceptualizes his or her fiduciary commitment to medical "work."

\textsuperscript{105}Freidson, Professional Powers, pp. 29-36.

\textsuperscript{106}Phenomenologically, much of the structure and process by which the profession has gained and preserves its power is taken for granted and remains unexamined. Consequently, when this structure is criticized, the profession's accent of meaning is threatened with disruption.
Knowledge and Trust as Definitional Characteristics

Two of the necessary components delineating the definitional boundaries of the medical profession, and the identity of the physician who is a member of the profession, are expert medical knowledge and a fiduciary commitment to the welfare of the patient. The two foci balance each other in a reciprocally related fashion. Society allows medicine to develop its knowledge and skills, and grants the doctor great autonomy and social status, in return for the assurance that the doctor can be entrusted to use his or her knowledge only for the benefit of the patient. The long, arduous course of mastering medical knowledge and technique imparts to the physician a confidence in his or her ability, skill, and expertise. This expertise also serves to separate the physician from others and, in part, qualifies him or her as a professional. Along with expertise, trustworthiness becomes a key feature defining the meaning which the medical profession represents to the public. The physician comes to trust in the value of his or her work and in his or her own trustworthiness.

107 Freidson, Professional Powers, pp. 21-24; Kass, p.1306. In modern usage the word "profession" is defined in terms of technical expertise sold for a fee, but a more traditional meaning describes a group that professes a vow to some ideal of service; Allan Dyer, "Virtue and Medicine: A Physician's Analysis," in Shelp. Virtue and Medicine. pp. 223-235.

108 All doctors may not act disinterestedly (indeed, acting in a fiduciary manner can be in their self-interest), and an altruistic or benevolent concern may be a common moral duty to all people, not just professionals. However, in the relations between doctor and patient, moral concerns are emphasized since there is a great disparity in expertise and knowledge between doctor and patient.
The two components of knowledge and trust also establish the nature of the physician-patient relationship. Physicians' medical expertise and knowledge, coupled with the patient’s condition of illness, creates a disparate balance of power between them. Physicians and patients live in a common social world in which their assumptions about the asymmetry of their relationship are largely shared and have developed over time. By virtue of the authority vested in their professional role, physicians control the patient’s access to and understanding of medical information and their expertise. In this process, they function as “gatekeepers,” providing options to some and denying them to others. This gatekeeping power requires that the public trust the physician to act benevolently in the patient’s interests.

Ordinarily the public accepts this asymmetrical relation due to a need for help and a confidence in the professional’s dedication to a fiduciary interest in the client’s well-being. However, the profession’s fiduciary identity is of reciprocal importance to the profession. The physician’s authority and power is closely tied to the assumption of trustworthiness by the public. For the physician, the commitment to trustworthiness shapes his or her

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109 Patients have limited access to the medical knowledge and technical skill of physicians, and limited ability to question the need for medical procedures. They are dependent on their physicians’ judgments. Thus, it is important for patients to be able to trust their physician; see Sue Fisher, In the Patient’s Best Interest: Women and the Politics of Medical Decisions (New Jersey: Rutgers University Press, 1986), p. 4. However, it should be noted that physicians are caught in a double bind. They possess the knowledge and skills and, therefore, are given the social function and responsibility to make medical decisions. However, they are dependent on their patients in many ways: for truthful medical histories, for compliance with medical directives, and for the opportunity to practice the art of medicine. Therefore, it is important for a physician to be able to trust his or her patient.
perception of what it means to be a physician and becomes a virtue defining the value of his work.

Thus, the patient and the physician share a reciprocal (albeit asymmetrical) social world in which the physician's authority is assumed or accepted by both parties. It is an inescapable feature of the medical situation that other people's ill-health, misfortune, and disadvantage are sources of power, status, and income for those persons in society who offer their services as physicians. After all, the medical profession is an occupation, and the physician is a member of the economic division of labor. Therefore, the doctor has a self-interest in medical work. Because the patient's vulnerability makes him or her susceptible to abuse by the physician's self-interest, the relationship is one with moral connotations. Again, the way in which the physician understands and incorporates trust and trustworthiness shapes his or her self-conception. It has important repercussions for the nature of medical work. The physician is not encouraged to see this work as a "business" or to use the patient for his or her own gain. Rather, the profession and the public take for granted that the physician is a moral person dedicated to the patient's interest.

Most attention to the moral and ethical dimensions of medicine continues to focus on the needs and position of the patient. I do not deny that physicians assume a dominant attitude in regards to their patients, or


\[111\] For a discussion of the moral distinctiveness of medicine, see Larry R. Churchill, "Reviving a Distinctive Medical Ethics," Hastings Center Report 19 (May/June, 1989), 28-34.
that patients tend to accept a reduced or diminished status in an asymmetrical relationship. A corrective to this unequal relationship has been necessary. However, I maintain that attempts to articulate and enhance the patient’s position also work to limit the physician’s dominance.

By recognizing the way the profession is constituted by a series of social relationships, the foundation is laid for an understanding of the importance of trust in the medical profession’s definitional boundaries. I do not mean to argue that medicine’s interest in knowledge and service are reducible to social dynamics and power-relations. Given the authority and power of superior knowledge, mistrust of the medical profession occurs when a physician does not exhibit expected traits, does not fulfill an expected role, or is perceived by the patient as self-interested and controlling. Since the physician and patient are involved in an asymmetrical relationship, issues of power, authority, and control raise moral concerns. Each participant interprets and understands “physician” and medical “practice” from within his or her own horizon of meaning.

In chapters two and three, I will argue that physicians experience their profession as a horizon of meaning, within which knowledge and fiducial commitment to service are important values to physicians. At the same time, there is no final, essential definition of “physician” that can aid in discovering a basis for professional morality compelling to all rational agents. It is important to recognize the institutional and historical nature of the profession as an organization seeking to control its work. The physician, as a member of this organization, acquires the profession’s values and meaning structure, which shape the doctor’s identity and practice. The physician is involved in interactions which require attention to the issues of power and
authority in social relations. The historical dimension of the profession is
important as well. Institutions are not monolithic or universal; their
structure evolves over time. This evolution is created by the shifting power
structures within the evolving institution and its shifting relations with
others in its historical era. Values play a part in shaping this dynamic. They
also can be affected by it. Expert knowledge and a professed dedication to
trustworthiness do function to help doctors control the limits of their work.
If used in this way, however, these values become limiting to a relationship
of mutual dependency.

The Meaning of Trust

The first substantive definition of "trust" in the Oxford English
Dictionary is "confidence in or reliance on some quality or attribute of a
person or thing, or the trust of a statement." Such a person or thing is one in
whom confidence, faith, and belief can be invested because that person
exhibits the quality of reliability and trustworthiness. The person or thing in
which trust is reposed becomes a locus of belief, expectation, and hope.\textsuperscript{112} Of
course, the person on whom trust is bestowed may be of bad character, or
trusted knowledge in fact may be wrong. Trust may be a virtue, but it can be
misdirected. A review of the ways trust applies to the medical profession
illustrates a variety of meanings associated with the term. In this discussion,
the intention is not to evaluate the moral standing of trust. Rather, it is to
develop an interpretive understanding the effect of trust on social

\textsuperscript{112}David Good, "Individuals, Interpersonal Relations, and Trust," in Diego
Gambetta, ed., Trust: Making and Breaking Cooperative Relations (London:
relationship and social action. Therefore, it will be important to distinguish between confidence, faith, and belief as expressions of trust.

Trust is the concept representing the condition of confidence and expectation on which human life depends. If all people were invariably honest, and if there were no contingency in the world, we would not be concerned with the meaning of confidence and trust. We cannot live without forming expectations with respect to contingent events and, therefore, tend to bracket more or less the possibility of disappointment. The alternative is to withdraw expectations and live in state of permanent anxiety and suspicion. Both confidence and trust refer to expectations which may lapse into disappointments. Luhman suggests reserving the term "confidence" for "trust" when referring to the ability of a person, thing, or a social institution to function as expected. For instance, we are confident that the car will start when we place the key in the ignition. We show confidence in a doctor's technical competence and ability to diagnose and cure us. Confidence grows out of the satisfactory confirmation of our expectations.

However, Barber argues that trust, unlike confidence, depends upon a person's underlying disposition or motivation. It also must be invested in

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113 Niklas Luhman. "Familiarity, Confidence, and Trust: Problems and Alternatives," in Gambetta, pp. 94-108. Although he does not use the term, Luhman here seems to associate confidence with "habit." As long as a person, institution, or thing functions as expected, we tend, without direct or deliberative reflection, to take it for granted; we interact in a habitual fashion.
something that remains unseen or is beyond our control. It presupposes a situation of risk and uncertainty. One can avoid the risk, but only if willing to waive the associated advantages within the situation. The public is encouraged to have confidence in the medical profession's knowledge and ability; trust becomes a concern in the experience of uncertainty accompanying illness. After surviving by-pass surgery, a person may have confidence in his or her physician's skill. Before surgery, however, the person must trust the physician's recommendation that the procedure is indicated, and that he or she is able to perform it. A second opinion provides additional information on which a decision can be based, but agreeing to surgery represents a declaration of trust in the physician. We do not depend on confidence as we depend on trust, although trust often is portrayed as a matter of routine and normal behavior.

Trust behavior consists in action that: 1) increases one's vulnerability to another whose behavior is not under one's control, and 2) takes place in a situation where the penalty suffered if the trust is abused would lead one to regret the action. It is based on an individual's belief as to how another person will perform on some future occasion, as a function of that person's current and previous claims, either implicit or explicit, about how they will behave. Therefore, this belief (which creates and maintains

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114I certainly agree that we are encouraged to have confidence in the medical profession's ability to know what to do. I am saying that we distrust the profession's members when we begin to question their underlying beneficent disposition. Trust and distrust become a form of checks and balances on deviant dispositions.

certain expectations) arises both before the individual can monitor such action (or independent of his or her capacity to ever be able to monitor it) and in a context which affects his or her own action.\textsuperscript{116} A patient is not going to cut himself or herself open to see if the doctor actually performed the operation. The psychological notion of trust is related to the limits of our capacity to achieve a full knowledge of others, their motives, their responses to endogenous as well as exogenous changes in the relationship. In this last sense, trust is a tentative and fragile response to our ignorance, a way of coping with the limits of our foresight and the freedom of others.\textsuperscript{117}

There is another dimension to trust. Trust also is directed toward and is invested in something that is outside of ourselves which elicits our response. Relating to the Latin "fiducia" (trust or confidence), akin to "fides" (faith, also confidence), this term suggests that a fiducial relationship involves responsibilities founded on "faith," rather than on intellectual assent.

\textsuperscript{116}Another case where trust comes into play is when others know something about themselves or the world which I do not, and when what I ought to do depends on the extent of my ignorance of these matters. An agreement between myself and these others may call upon them to disclose their information, but can I trust them to be truthful? See Partha Dasgupta, "Trust as Commodity," in Gambetta, pp. 51-52. A patient must trust the doctor, i.e., rely on the doctor’s actions under conditions of identifiable risks. Also, the notion of trust has something to do with relationships of mutual dependency. Unfortunately, this sense of mutual dependency is transformed into patient dependency upon the physician; see Stanley Hauerwas, "Medicine as a Tragic Profession," in Truthfulness and Tragedy (Notre Dame: University of Notre Dame Press, 1977), pp. 184-202.

\textsuperscript{117}Trust (or, symmetrically, distrust) is a particular level of the subjective probability with which an agent assesses that another agent or group of agents will perform a particular action; see Diego Gambetta, "Can We Trust Trust?," in Gambetta, pp. 213-237.
or knowledge. Applied to the Roman law of "contractus fiducia," the partners
to the contract were bound by a sacred oath.\footnote{More specifically, the fiducia was a contract of sale to a person by
mancipation coupled with a sacred agreement or oath that the purchaser
should sell the property back upon the fulfillment of certain conditions. The
oath became the basis for trust on which the exchange relationship was
founded; see "Fiduciary," in Webster's New International Dictionary, 2nd.
Edition.} Hence, a fiducial relationship
or contract is a firm one, not to be violated without dire consequences. The
parties to this relationship, therefore, are trustful and trustworthy or
reliable, made confident by the nature of their fiducial pledge. An interesting
notion contained in this definition is the idea that such a social relationship is
imbued with a trustworthy or faithful nature, conveying the sense of an
enlivening "power." The participants are empowered by their relationship
with each other in mutual trustworthiness, by their involvement in a
relationship which is more than the sum of its parts.\footnote{It is this sense of trust or faithfulness that is represented by covenant
relationship as opposed to contract in medical relationships. Contracts, today,
generally are made because of a lack of or insufficient basis for trust. In a
contract arrangement, the "parts" of the relationship are carefully described
and proscribed. For a summary article on the covenant-contract discussion,
see K. Danner Clouser, "Veatch, May, and Models," in Earl E. Shelp, ed., The
Clinical Encounter (Dordrecht: D. Reidel, 1983), pp. 89-104.} Trust, then,
paradoxically, is the strongest and the weakest foundation on which reliance
can be based. Trust appears to engender an instinctive, less reasoned, and
more faithful reliance on its object than does confidence, which often
suggests somewhat less definite grounds of assurance and is more easily affected by changing conditions.\textsuperscript{120} This position can be developed into an understanding of trust linked to the theological virtue of faith. Theologically, faith can be construed as trust or loyalty. Also, it represents a necessary condition for authentic knowledge of God and of the human good. A dedicated response to God provides the human with a context for understanding himself or herself and the world. This context provides a benchmark for discussions of good and bad in human life.\textsuperscript{121} However, Julian Hartt argues that there is a tendency in modern thought to widen the gap between faith as belief and faith as trust. Accordingly, he claims that the cognitive mode is separated too easily from the dispositional.\textsuperscript{122} Such pressure, Hartt seems to suggest, leads to rebellion against the notion of God as Lord and to the tendency to seek a locus of loyalty in persons or social institutions.\textsuperscript{123} Here, faith can be monolithic and destructive of goodness. Strictly speaking, faith as a

\textsuperscript{120}Trust provides an element of certitude that extends beyond the vicissitudes of momentary experience. C.f., Heb. 11:1; Ps. 141:8.

\textsuperscript{121}Mcormick, pp. 5-6.

\textsuperscript{122}"[Faith] as trust, its ties with certifiable knowledge of God and of the human good loosened, is put under heavy pressure to posit in and for itself value absolutes -- ideals and/or beings worthy of unconditional loyalty"; Julian N. Hartt, "Faith," The Westminster Dictionary of Christian Ethics, pp. 222-224. Hartt believes that Barth's thought represents a critique of the tendency to split the cognitive and dispositional aspects of faith and play the two off against each other (p. 222).

\textsuperscript{123}Also see Reinhold Niebuhr, The Children of Light and The Children of Darkness (New York: Scribner's Sons, 1947).
theological virtue introduces a new dimension into the moral life with its natural virtues, and can call into question even manifestations of religious faith. From a theological position, faith allows one to respond to the contingencies and exigencies in life. It enables one to find a stability and unity in life, an "authentic selfhood" which is centered in God and in relationship with others.\textsuperscript{124}

Faith in God is unlike trust in a person or thing. Following Tillich, God is not an entity, however exalted, existing in addition to the things and entities of the world. For Tillich, God is not a being, but being itself.\textsuperscript{125} Although, as we have seen, this position is problematical (a problematic to which we will return in chapter five), it does indicate the movement of faith beyond an investment in "this world." Secularists would argue that stability and unity in life can be achieved in self-trust or trust in social realities of this world, that there is no need to speak of God at all. Religious faith, however, calls one toward a transcendence of the given, which is typical of self-critical religion. In the Christian ontotheological tradition, God is the ground of being beyond the immediate "reality," in relation to which life, with its dimensions of being and non-being, is given a meaningful basis. Ontologically, faith in this "other reality" serves to call into question faith as taken-for-granted belief in "reality."

Confidence, trust, and faith all express belief. Belief connotes the freedom of a subject to make commitments in the absence of full knowledge.


\textsuperscript{125}Tillich, \textit{Systematic Theology}, vol. 1, pp. 211-289.
with the possibility of changing belief upon receipt of subsequent knowledge. Confidence is a strong conviction or belief based on substantial evidence or logical deduction. Trust is an expectation or belief based on inconclusive evidence, and is tolerant of, indeed requires, the element of uncertainty or risk. Religious faith affirms the whole self by promoting reliance in "something more," in spite of, even because of doubt and uncertainty. On a psychological level, for this discussion, trust is located between faith as an unquestioning acceptance of the status profession's authority and confidence due to satisfaction of performance within contractual limitations. "Trust" stands in the middle of a continuum of words for belief, between confidence and faith.

The continuum is not bounded by unquestioning faith, on the one end, and skepticism, on the other end. If skepticism is introduced, there would be no need for a discussion of trust. What people ordinarily mean when they speak of trust between doctor and patient is confidence in the professional's ability and social function. Trust, however, implies a reliance beyond such

\[126\text{Faith is an emotionally charged condition which at the extreme becomes an unquestioning acceptance which excludes doubt. However, we cannot do without some perspective. Therefore, faith rests upon interpretation and relationship; see David Baily Harned, \textit{Faith and Virtue} (Philadelphia: Pilgrim Press, 1973), p. 63. Also, H. Richard Niebuhr, \textit{Radical Monotheism and Western Culture} (New York: Harper and Brothers, 1960), p. 118.}\]

\[127\text{Such a definition tells us that trust is better seen as a threshold point, located on a probabilistic distribution of more general expectations, which can take a number of values suspended between complete distrust and complete trust, centered around a midpoint of uncertainty; Dasgupta, pp. 51-52.}\]
confidence. The fiduciary dedication of the tradition points towards reliance, but this reliance is subverted in a relation of trust-as-control. Doctors have encouraged faith or belief in the power, authority, and promise of scientific medicine, but in an era of AIDS, abortion, and the persistence of chronic illnesses, this encouragement fails to satisfy. The continued presence of these concerns calls into question the profession’s ability to eliminate or control human finitude and suffering.

Inasmuch as trust is a dimension of all social relationships, first, trust involves attention to order and disorder in society.\(^{128}\) Second, actors’ expectations are the starting point for distinguishing between different kinds of trust. As Barber argues, trust is not a function of individual personality variables, nor of abstract moral argument, but a phenomenon of social and cultural variables.\(^{129}\) We have trust in someone’s character, but character is shaped by social institutions and cultural values. Therefore, broad social changes can affect the different meanings and interpretations of trust. Equally, changes in social institutions can be seen as responses to varying degrees and meanings of trust. As I will argue, both physicians and patients have expectations of each other due to their differing accents of reality within the natural attitude of the everyday world. Physicians interpret the


\(^{129}\)Barber, p. 5.
meaning of trust in particular ways due to their professional identity. This interpretation limits or defines their understanding of their work.

There is one more dimension of trust that requires attention. Drawing upon notions of Luhman and Garfinkel, Barber views trust generally as the background expectation that the natural and social order will persist.\textsuperscript{130} The more specific meanings of trust which underlie Barber's institutional analyses are the expectations that people will be technically competent and that people will carry out their fiduciary responsibilities. Taken together, these three expectations function to provide social actors with a sense of the world's orderliness, its cognitive and moral structure. Moreover, they also function as a mechanism of social control in regulating the exercise of power, and as a mechanism of integration by creating and sustaining social solidarity.\textsuperscript{131}

Barber argues that the logic and limits of trust suggest that when the balance of power between parties becomes unacceptable, distrust becomes the functional equivalent of trust in fostering social controls over the perceived dominant party.\textsuperscript{132} As Luhman points out, distrust is not

\textsuperscript{130}Ibid., p. 9. See Luhman, \textit{Trust and Power}, and Harold Garfinkel, \textit{Studies in Ethnomethodology} (Englewood Cliffs, New Jersey: Prentice-Hall, 1967). Thus, this sociological argument rests on the ontological presupposition that there is order upon which the natural and social world depends. This presupposition is necessary to make talk of trust meaningful; for a discussion of the ontological presuppositions or foundations on which society depends, see Paul Wiebe, \textit{The Architecture of Religion: A Theoretical Essay} (San Antonio: Trinity University Press, 1984).

\textsuperscript{131}Edward Tiryakin, "The Logic and Limits of Trust," \textit{Society} 22 (1984), 89-90.

\textsuperscript{132}Barber, p. 9.
necessarily the result of a breakdown in the social system. It can be a
functional alternative and complement to trust as a form of social control.\textsuperscript{133} Trust is the confidence in and/or reliance upon another. It cannot exist
where there is absolute control over the other, but many acts are a mixture
of trust and control.\textsuperscript{134} Barber argues that distrust functions as the
equivalent of trust in shaping and controlling social relations.\textsuperscript{135} Both trust
and distrust serve to reduce social complexity and anxiety, although
strategies of distrust convey negative connotations.

There are several limitations to Barber’s argument, especially when
applied to the medical profession. First, Barber basically limits his argument
to the public’s use of distrust to control the power of the professions. It
follows, however, that a profession’s members also could use distrust to
control relations with their clients. The profession’s cognitive and moral
structure, its sense of the world’s orderliness, its own social solidarity, and
the value of its work depend upon a trust or expectation regarding its work
in the world. This expectation may function as a mechanism of self-control in
regulating its own exercise of power, but we must stress that the profession’s
"expectations" also regulate its relations with the public.

\textsuperscript{133} Luhman echoes Parsons’ systematic analysis of trust and distrust in social
relationships; see Luhman, in Gambetta, pp. 94-108.

\textsuperscript{134} James Childress, “Trust,” \textit{The Westminster Dictionary of Christian Ethics},
pp. 632-633. The dialectical relationship between trust and distrust operates
like the "carrot" and the "stick." The use of one without the other will not be
as effective as the use of both.

\textsuperscript{135} Distrust is not just the opposite of trust; it is also a \textit{functional equivalent}
for trust. For this reason only, is a choice between trust and distrust possible
(and necessary)? Barber, pp. 21-22.
Second, although distrust may represent a functional means for sustaining relationships, it is also a condition or process that can dissolve relationships. Particularly in the case of trust qua fiduciary obligations, Barber does not discuss how the loss of trust can be restored for the one whose trust has been shattered, e.g., the person who finds that the surgeon has recommended by-pass surgery for lucrative fees rather than for actual physiological needs. Is trust once broken forever lost? This question is important when we examine the theological dimension of trust as a value in the medical relationship.

Finally, Barber fails to appreciate fully the complex and pluralistic nature of postmodern culture. Awareness of this condition highlights the issue of trust and distrust. As Barber argues, distrust is a functional equivalent of trust in the regulation and control of disparate peoples and groups in our society. However, he fails to recognize the extent to which this disparity draws distrust towards an anomic, paranoiac dysfunctional form. In the area of health care, for instance, the lack of a moral consensus is clear in the inability to resolve moral dilemmas and restore some sense of solidarity to social relations. This loss of a common expectation of orderliness and structure threatens to move beyond distrust as the means for the restoration of social balance to a stronger emphasis on distrust, suspicion, and control as forms of domination between people.

In a move to reassert its social control over the profession, society has resorted to distrusting the physician. In this climate, trust comes to be used as a form of social control as each party in the relationship seeks to maintain its authority through a process of self-interested negotiations. The climate of suspicion and the role of trust represent changes in the physician's and
patient's expectations of each other. Patients still "trust" physicians. However, what trust means to each has shifted. Trust is no longer conceived of as a free gift of concern passed between the two which operates to establish mutually satisfactory parameters of an asymmetrical relationship. We will see that while distrust or trust-as-control does provide a structure for the medical relationship, it also transforms the experience of physician (and patient) into one of alienation from one's self and others.

Mechanic and Relman argue that an erosion of public trust in physicians is due to the profession's drift away from its commitment to trustworthy behavior and beneficence to a concentration on profit and prestige. They argue that physicians must be more trustworthy to regain the trust of the public. However, distrust or the use of trust-as-control also is used to restore confidence between participants in a social relationship. A discussion of trust's importance in shaping the medical profession's horizons of meaning and the physician's habits of mind broadens recognition of the importance of fiduciary commitment for medical work.

Trust and Phenomenological Sociology

The striking feature of being human is that we experience ourselves as being at once an object in the world among other objects and a worldly subject for whom these objects are objects. Human beings are characterized, then, by a dual status. First, I am a subject who experiences myself as as subject and as object (as do you). My status as object is itself as much a matter of my experience as my status as subject. Second, the essential

condition for the possibility of experiencing and apprehending myself as
worldly object and worldly subject is that this experiencing and
apprehending is eidetically necessarily at another level of consciousness.\(^{137}\)

To explore this other "level" is the work of phenomenology. This level
does not present itself upon reflection about my status as subject and object
in the world. My own mental life (through introspection) is presented to me
as a reality, one among others, and it has many relations with other things
presented to me as also real: my own body, physical things, values,
memories, etc. To focus directly on the eidetic structure of consciousness
requires a rigorous methodology grounded in the phenomenological
reduction.\(^{138}\)

This method requires that I refrain from simply accepting my mental
life as it presents itself to me in the moment of reflection. I must take it as
merely one instance of mental life as such. I must disengage myself from the
entire framework of suppositions, beliefs, and interpretations which present
the "world" as "really there."\(^{139}\) I adopt a disengaged, critical attitude over

\(^{137}\)Richard Zaner, *The Way of Phenomenology* (Indianapolis, Ind.: The Boobs-

\(^{138}\)Husserl, *Cartesian Meditations*, p. 35. For a detailed discussion of the
phenomenological reduction, see Alfred Schutz, "Some Leading Concepts of

\(^{139}\)Zaner, ibid., p. 185. Unlike Descartes’ attempt at universal doubt, this
critical attitude does not affirm or deny anything, but seeks to make explicit
what has hitherto been implicit. In the disengagement, "...only our attitude
toward the world undergoes a shift; our attention shifts from that of
engagement in to that of focal concern for the sense and strata of the very
engagement itself" (p. 51).
and against the natural attitude which takes the everyday world (including
my ordinary reflection upon it) for granted.

Scholars pursuing phenomenological investigations involving the
medical profession have argued that the phenomenological "perspective" of
the physician differs from that of the patient, and that this difference must
be taken into account in physicians' moral considerations and decision-
making. For instance, Carlton has described a "clinical perspective" which
characterizes the approach of physicians to their work and their patients,
and which has an effect upon moral decision-making. This "perspective"
allows physicians to "set aside" the expectations of everyday reality and
engage in a medical "habit of mind" which determines their understanding of
the situation. It is this habit of mind which marks the medical profession
as a particular institution within society. As such an institution, medicine is
an amalgam of conceptual and social organization with an historical tradition.

140 Kay Toombs argues that physicians understand illness differently than
patients, and therefore, exhibit traits which they feel are consistent with
their horizon of meaning. Therefore, without an understanding of the
patient's experience, doctors will work on a different plane; Toombs, "The
Meaning of Illness: A Phenomenological Approach to the Patient-Physician
Mary C. Rawlinson offers a similar argument in "Medicine's Discourse and
the Practice of Medicine," in Kestenbaum, pp. 69-87. Also, see Zaner, Ethics
and the Clinical Encounter.

141 A doctor has confidence in the scientific province of meaning which
underscores, in Carlton's term, the "clinical perspective"; see Wendy Carlton,
"In Our Professional Opinion..." - The Primacy of Clinical Judgment Over
Through the medical accent of meaning, the physician sees his or her own
trustworthiness as a taken-for-granted ingredient in being a doctor. For a
discussion of the "habit of mind," see Victor Kestenbaum, "Introduction," in
Kestenbaum, pp. 1-38.
Following the general theory of the sociology of knowledge, a review of the medical profession as a finite province of meaning within the everyday world demonstrates the importance of the acquisition and control of objectified knowledge to the "reality" in which the physician operates. A phenomenological model of the structures of everyday reality has been developed by Alfred Schutz.\textsuperscript{142} According to this model, medicine is a social province of meaning, a "constructed reality," organized and regulated by social norms and institutional requirements. This reality is experienced by the physician (and the patient) as having a "history." It is assumed to have existed before one's birth and presumably will continue after one's death. Reality is experienced as "other" than the person, yet the relationship between the two is critical and reflexive: each serves to determine the other. The meaning of the term "physician" is determined by the totality of the profession's tradition and in relation to the society in which it exists. The physician, in turn, through his or her understanding of himself or herself-as-physician shapes the boundaries of the profession.

Ethicists need to recognize the physician's understanding of "reality." Physicians complain that ethicists too often leave the situation of everyday medical work to the doctors while developing "compelling arguments" drawn from ethics' first principles which they then apply to the physician's work. A phenomenological approach to medical "reality" stresses that moral issues

must be presented solely within the contexts of their actual occurrence -- moral analysis must begin at the bedside, with an appreciation and understanding of medical "experience." Therefore, the application of a phenomenological analysis to medicine must precede any discussion of moral principles. Work in this area has focused on the phenomenology of illness and on the phenomenology of the physician-patient relationship. In most cases, however, these analyses serve directly to highlight the experience of the patient and only secondarily the experience of physicians. Usually, physicians are depicted as intrusive to the patient's horizon of everyday life.

For instance, Zaner reconstructs clinical medicine with the benefit of phenomenological analysis to concentrate on the actual experience of illness and medicine as a therapeutic enterprise. He observes that symptoms are uniquely the patient's own, their meaning "being textured by that person's own biographical situation" and requiring a hermeneutics of daily life to reach the underlying context of that experience. However, Zaner, too, criticizes the profession for displacing the patient in favor of his or her symptoms. This movement, he claims, reduces the contextuality of the patient's (and doctor's) experience to one of medical terms.

143 Zaner, ibid., p. 27.

144 For instance, see the various articles in Kestenbaum.

145 Zaner, ibid., p. 69. He describes the phenomenological nature of medical work, illness, and the relationship between doctor and patient (pp. 53-91). Others who echo Zaner's critique of the physician's preoccupation with the medical habit of mind are Toombs, pp. 219-240; and A. L. Suchman, "What Makes the Doctor-Patient Relationship Therapeutic? Exploring the Connexional Dimension of Medical Care," Annals of Internal Medicine 108 (June, 1988), 125-130.
There is no doubt that illness, and often the medical response represented in the persons of physicians, is a disruption in the patient's everyday life. However, a point that needs to be reasserted is that illness is also a disruption for physicians even though it seems to be incorporated into the doctor's province of meaning. Medicine is the cultural attempt to domesticate the existential threat illness represents, often encapsulated in the person of the patient. This attempt is never fully successful. Illness and the response to it, either by the patient or the physician, is never one of dispassionate reason but involves an ambiguous and uncertain reaction. Here Zaner rightfully rejects concern with autonomy and beneficence as foundational values for medical ethics because they fail to illuminate the actual experience of illness and medicine as a therapeutic enterprise.\textsuperscript{146}

In a discussion of the experience of illness and what it represents for the physician, it is important to examine the profession's structure of meaning and its influence on the physician. Bensman and Lilienfeld state that "habits of mind" are approaches to the world (in phenomenological terms, attitudes towards everyday life).\textsuperscript{147} These habits are the result of instruction, socialization, or are learned through life experience and may be thought of as the past made present and available in horizons of meaning which give particular form and content typifying the physician's "world." The medical profession's habit of mind shapes the individual doctor's understanding of experience; he or she "trusts" the typified form and content

\textsuperscript{146}Zaner, ibid., p. 297.

of medicine. Trust then is valuable to the profession and the physician. The erosion of public trust in the profession affects the physician's perception and interpretation of this value, and affects his or her "experience" of medical work and relations with patients. The nature of this effect requires elaboration.

A phenomenological investigation of the medical profession and the effects of an erosion of trust is not an easy task. Freidson argues that the nature and limits of professional experience are not determined by any one group -- neither by the leaders of a profession, nor by the members, nor by the myriad other occupations with which they work, nor by their patients, employers, the state, nor by sociologists or theologians.148 These perspectives cannot be collapsed into an absolute description. If Freidson is right, that there are a number of different perspectives on a profession, none of which can be better grounded phenomenologically than any other, then there is no way of resolving the problem of definition that is not arbitrary. Consequently, any description of the nature of trust in medical work is created, not discovered. It remains temporary and, therefore, somewhat arbitrary. This difficulty is a reason why the profession's boundaries of "practice" remain uncertain and fluid, and why moral consensus in medical matters remains elusive. The irreducibility of definitional concerns to any one conclusion and the possibility of practices and definitions "other than" a taken-for-granted one provide the background for the problem of trust-as-control.

148Freidson, Professional Powers, pp. 35-36.
A Theological Repositioning

A sociological and phenomenological review of the medical profession’s fiduciary claims uncovers the roots of the use of trust-as-control by the profession in its attempt to retain power in order to fulfill its fiduciary commitment. However, the use of distrust “in the name of trust” reveals a dynamic in which alternative interpretations and possibilities tend to be ignored or repressed. This limitation may provide momentary control, but it threatens to restrict the human experience of and participation in a fuller understanding of reality. As a result, there is the temptation further to encourage trust-as-control. In its commitment to understanding the faith-response to God, theology seeks to elucidate human understanding of God, the relation of God to the world, and consequently, the relations of individuals within the world. Thus, a theological argument can be developed showing the inadequacy of distrust as a basis for relationship since it leads to a perverse domination of the other (often under the guise of benevolence).

From a sociological perspective, Christianity and medicine are two provinces of meaning within the world of daily life whose habits of mind and systems of relevance vary. For some believers, the fact that God commands or wishes something to be good establishes the ultimate criterion for moral actions and attitudes in all realms of life including the medical. To him or

—Theology itself can become representative of a specific social world and serve to constrict participation in reality. As with any other social construction, religion tends to develop fixed norms and structures of meaning the validity of which usually are not questioned, and which function in a seemingly a priori manner to condition the individual’s mode of being. See DiCenzo, p. 672. Thus, the necessity for occasional reformations or reinterpretations of the tradition.
her, these actions and attitudes are binding on all persons. In a faith-
response, the commands or revelations are self-authenticating. This accent of
meaning constitutes the believer's horizon. However, from the point of view
of others within the Christian tradition, moral authority is not simply
identified with the will of God. Aquinas argued that God commands certain
actions because they are right, yet these can be perceived as right in a sense
independent of the fact of God's having commanded them.\textsuperscript{150} As we have
seen, those outside the religious province argue that divine commands as a
basis for morality cannot be extended to those who do not share the
believer's presuppositions (or faith) regarding the criterion or the method by
which these commands are known. In the postmodern, pluralistic age, in a
purely logical sense, moral notions cannot simply rest on the doctrinal claims
of a religion.\textsuperscript{151} Therefore, critics claim that a theological world-view can

\textsuperscript{150}Gene Outka and John Reeder, Jr., eds., "Introduction," \textit{Religion and

\textsuperscript{151}Kai Nielsen, "God and the Basis of Morality," \textit{Journal of Religious Ethics} 10
(Fall, 1982), 335-350. It might be argued that ethical precepts theologically
elucidated from doctrine show what physicians ought to do in moral
dilemmas. However, Frankena points out that theology is based on two sorts
of beliefs: 1) "is" beliefs, which reflect the theological world-view, and 2)
"ought" beliefs, which are the ethical precepts growing out of this world-
view. Frankena concludes that the "is"-conditions of a theological world-view
cannot provide objective ethical principles; William K. Frankena, "The
Potential of Theology for Ethics," in Earl E. Shelp, ed., \textit{Theology and Bioethics},
pp. 27-44. In a pluralistic culture in which there are a variety of religious
and non-religious world-views, ethical ideas can have a variety of sources.
The authority of one (religious) ethics is clear to adherents of the religion,
but may not be necessarily acceptable to others outside that group.
have potential for bioethics, but it is limited to those who share that view. Of course, the same argument can be directed at theology’s critics. If the discussion remains on this level, moral discourse in a pluralistic society will continue to reflect a polarization between secular and (theistic) religious moral positions.

This concern sharpens the theological focus of the dissertation. Whether based upon logical argument, intuition, or the revealed nature of reality, both philosophical and theological work on bioethics encounters the impasse of pluralism and relativism. I will argue that a theological analysis of faithful giving and receiving in mutual interdependence offers one way in which theological ethics might be viewed as morally relevant and important for shaping attitudes in the area of medical decision-making.

In the face of the moral impasse present in secular society, the attempt to ground moral character in Christian narrative and symbols represents an approach rejected by critics of theological ethics: Outside of those committed to the tradition, Christian values and virtues have no more justification than any other argument. However, a theological interpretation of the “shock” that occurs between the finite provinces in the medical encounter serves to disclose the “hidden, yet revealed” meaning of new possibilities. In the postmodern world, a climate of uneasiness exists caused by a taken-for-granted investment in a particular understanding of God as transcendent, as “other.” This perspective reflects the human tendency to interpret experience in terms of his or her own self-actualization and to forget the contingent, historically relative nature of meaning structures. This

"image" or understanding of God provides a sense of reality which defines its limits and possibilities in particular ways. However, a re-examination of this concept awakens reflection on how we interpret meaning in our lives and the implications of this process for social relationship. To address the climate, consideration must be given to a reinterpretation of the meaning of the divine-human relationship.

Kaufman argues that God functions as an ultimate point of reference or orientation for all life, action, and reflection. As such, God cannot be conceived as one more item in ordinary experience or knowledge. God must be thought of as not restricted or limited by others. The concept of God functions as a limiting idea, in terms of which all else is to be understood, and which so transcends everything that it cannot be understood as gaining its meaning by reference to it.\textsuperscript{153} God is the idea of absolute aseity.

However, Charles Winquist and Mark Taylor, among others, have been critical of the metaphysical presuppositions which underlie this ontotheological conceptualization of God.\textsuperscript{154} Taylor argues that a post-modern "death of God" has disrupted an assumed relation between essence

\textsuperscript{153}Gordon Kaufman, \textit{An Essay on Theological Method} (Missoula, MO: Scholars Press, 1975), pp. 12-13. I accept Kaufman's assertion that ideas of God constitute a conception of the overall context within which human life is lived and in accordance with which forms of human existence are ultimately grounded. The basic thesis of his argument, however, is that theology finally is nothing but an imaginative construction of the human mind. It this sense, Kaufman's theology is reductionistic.

and existence in which existence is believed to mirror the eternal.\textsuperscript{155} This disruption breaks the fixed relationship of reality and appearance, and leaves humanity in the midst of pluralism and relativism. However, this disruption opens the way for a theological hermeneutics which penetrates the assumption that a single, universal meaning is discoverable in theological discourse.

This disruption, this loss of a commonly accepted reference point, exacerbates the human feeling of uncertainty and dependency. Specifically in the condition of illness, it unleashes a struggle for control between the physician and the patient in which trust becomes a bargaining chip, jealously bartered between self-interested parties. The physician's desire to obscure the interruption of illness, to impose and maintain structures of order and meaning, is thwarted by the continual presence of "otherness." A theological contribution to a discussion of medical ethics begins with the recognition of the "boundary" nature of medical practice. The physician constantly must struggle to constitute meaning in a changing and fluid situation caused by the interruption of everyday reality which illness represents. Even if God's aseity is bracketed, the significance of God as a limiting idea remains a potent issue in reviewing the constructed or created meaning of trust.

Finally, the postmodern dismay with talk of God raises an historical focus. The Christian conviction that a temporal course of events is plotted along a single line, which extends from a definite beginning, through an identifiable middle, to an expected end, is linked to a particular notion of God

\textsuperscript{155}Taylor, p. 175. Also see DiCenso, pp. 667-668.
and serves to define the self.\footnote{Taylor, p. 54.} For Gustafson, the historic tradition and historical character of the scriptures, and the historical character of the tradition of thought and life of the community of Christians, is assumed and accepted. However, when religious communities are in flux, as Gustafson suggests they are today, the criteria used to evaluate theological perspectives are less clear.\footnote{James M. Gustafson, "Theology and Ethics: An Interpretation of the Agenda," in H. Tristram Engelhardt, Jr., and Daniel Callahan, eds., \textit{Knowing and Valuing: The Search for Common Roots} (Hastings-on-Hudson, N.Y.: Institute of Society, Ethics, and the Life Sciences, 1980), pp. 182-183.} In the cultural pluralism of the postmodern age, any attempt to develop a theological perspective on the relation of trust and the medical profession's "practice" must examine the interruptions represented by the bracketing of the assumed coherence and structure of historical consciousness. Perhaps the linear form of conceptualization which has constituted Western science and technological development shapes the ways in which physicians "work."

In summary, some contemporary theological inquiries into the physician-patient relationship have been content to refute the medical profession's claim to special moral expertise and special prerogatives based upon their Hippocratic duty to benefit the patient. They seek to orient morality within the limits of the faith community.\footnote{David Ray Griffin, "The Holy, Necessary Goodness, and Morality," \textit{Journal of Religious Ethics} 8 (Fall, 1980), 330-349.} However, whether one appeals to intuition, the consequences of actions, the idea of an impartial observer, or revelation and the nature of reality as God-centered, there
appears to be no way to discover a universal, concrete character of the good life applicable over time and across communities. Nor is there a commonly acceptable method for delineating the goods, harms, duties, and obligations which occur in medical situations. Whether philosophically or theologically grounded, moral concerns in medical situations can reflect a plurality of arguments. Since one cannot be a fully detached, neutral observer, one cannot establish an universally accepted method to decide when one moral principle absolutely overrides another, or when those who deviate from one position are also the morally wrong. Since one must be a member of a tradition, its influence must be taken seriously. Those virtues which foster dialogical conversation among traditions or provinces of meaning become necessary.

Given an erosion of trust, and the resulting changes in the fiduciary context of health care, can theological ethics be brought to bear on the construction of a medical ethics which begins with an appreciation of the positive meaning of trust, and which recognizes the value of trust in the profession's accent of meaning? Answers to this question will vary according to the types of methodological commitments one brings to the task of theological ethics. I approach the dissertation with a methodological commitment to an hermeneutical exploration of the phenomenological and sociological structure of the medical profession's fiduciary commitment. This exploration reveals an avenue for the development of a medical theological ethics which articulates the distinctive contribution theology can make to the specific problem of the erosion of trust between physicians and patients.

Final Methodological Considerations

Social scientists, philosophers, and theologians have tended to apply to the clinical encounter the interpretive tools of their respective disciplines. Too often, the model used to bridge disciplines has been reductionistic, involving the strategy of explaining the phenomena in the domain of one discipline in terms of the principles of the other. Theologians can be guilty of imposing categories upon medical work, e.g., by asserting that what "is" in theology "ought" to apply in medicine. Consequently, the physician is sensitive to the outsider who wants to tell him or her what medical ethics means and how medicine should be practiced. However, theologians can be reductionistic in another fashion: they explain away their own discipline by failing to identify, claim, and communicate the distinctive contributions that theology can make to the discussion of moral questions in medicine. It is appropriate for the investigator to apply the conceptualizations and methodological tools of one discipline to a study of another, but he or she must be careful that physicians (or theologians) be able to recognize themselves and their work upon completion of the analysis. In other words, it is important to develop a methodology for understanding trust which accurately reflects the meaning of the term for physicians, and which also leads to an appropriate theological analysis.

The notion of trust-as-control expresses an existential problem: human beings tend to become confined in limited interpretive horizons of meaning. DiCenso writes, "Because such a condition... is endemic to the finite

160See William Frankena’s objection to this reductionistic approach in Shelp, Theology and Bioethics, pp. 49-64.
and perspectival character of human existence, it cannot be overcome by positing fixed notions of authenticity or fixed norms of behavior.\textsuperscript{161} In an era of declining trust in the medical profession, efforts to bolster trust through an emphasis on medical codes or moral principles runs afoul of these concerns. If theology is to make a contribution to the dilemma of trust among distrustful or suspicious agents, it must avoid the confinement which DiCenzo describes. A carefully proscribed hermeneutical inquiry addresses these concerns and prepares the way for a phenomenological theological discussion of trust-as-control and trust-as-faith.

A Hermeneutical Study

The practice of medicine is not a theoretical and value-free science, but an "hermeneutical" enterprise. Hermeneutics refers to the study or science of the act of interpretation. With roots in ancient Greek philosophy, hermeneutics has come into prominence again over the last two hundred years in the humanities and social sciences.\textsuperscript{162} Its application to medicine is clear, because the diagnostic situation is always an interpretive one. An investigation into the use of trust-as-control also requires an interpretation of the tension of perspectives which arise in the practice of medicine.

The physician is an interpreter who is constantly trying to understand data in the context of the particular clinical situation. A certain set of findings are "read" in the hope of uncovering the organic condition that

\textsuperscript{161}DiCenzo, p. 677.

constitutes its "meaning." Moreover, interpretation is always closely tied to application. The physician's best reading of the situation determines how diagnosis and treatment will proceed. Diagnosis and treatment are always open to alteration or refinement as a result of new developments. The physician-hermeneut employs a set of interpretive tools learned in school and subsequent practice for unravelling the "text" or a "living human document," that is, the actual patient at hand. However, Zaner observes that symptoms are uniquely the patient's own, their meaning being "textured by that person's own biographical situation." But modern medicine "displaces" the patient's "situation" and sees his or her symptoms as only significant in the physician's terms, according to the biomedical model.

163Gadamer, pp. 274-305.

164Many philosophers have come to recognize a hermeneutic dimension operating not only in the humanities and social sciences, but in the natural sciences as well. Scientific paradigms, from this perspective, are no longer seen simply as objectively true characterizations of facts, but as modes of interpreting the world arrived at historically, secured through appeal to a community, involving values and pragmatic goals. As such, the portrayal of medicine as a hermeneutic enterprise does not necessitate a denial of medicine's scientific foundations. Such a denial is the case only if we hold to a positivistic and increasingly outmoded philosophy of science; see Richard J. Bernstein, Beyond Objectivism and Relativism: Science, Hermeneutics and Praxis (Philadelphia: University of Pennsylvania Press, 1983); and Thomas Kuhn, The Structure of Scientific Revolutions (Chicago: The University of Chicago Press, 1970).

This displacement has contributed to the erosion of trust in relations between the public and the profession. Each participant in the relationship is subject to interpretive modes that shape human existence on individual and social levels. Each has a pre-conceived conception of what the physician "should" be like and of what trust means in the medical relationship. These covert value-judgments are present in the way people "see" and interact with the others they encounter. If the other does not match a person's expectations and cannot be incorporated into his or her interpretive schema, distrust or trust-as-control is utilized to ensure a sense of "reality." The physician/patient "sees" the patient/physician from within a horizon of meaning and seeks to fit the other into the anticipated frame of reference. To understand this dynamic, we require a hermeneutical approach which entails a double movement of regression and progression: a disclosure of or "making present" of the "hidden" structure of meaning. Thus, determining the situation requires a hermeneutics of daily life, or to use Gibson Winter’s term, a phenomenology of "the world of every day."¹⁶⁶ This re-interpretation brings new possibilities to light.

As a methodology for understanding meaning, hermeneutics developed into a method for interpreting texts, e.g., the exegesis of scripture. Although the traditional division between exegesis and criticism was retained in his work, Schleiermacher did not restrict hermeneutics to textual

interpretation. For him hermeneutics was the theory of understanding in
general in all forms of communication between people. He assumed that
individuals could understand each other by their commonality as historical
human beings. However, he did not appreciate the differences between the
understanding of face-to-face speech, in which "both speaker and hearer are
physically present at the moment of utterance and to that extent participate
in the same situation, and the interpretation of a text, where this is not
so."\textsuperscript{167} However, subsequent developments in hermeneutical theory build
upon Schleiermacher's appreciation of historical structures in the
hermeneutical process.

As Pannenber points out, hermeneutics draws a critical relation
between textual and existential "horizons." Dilthey developed hermeneutics
into the field of historical consciousness by arguing that the reconstruction of
the unity of the author's thought was necessary for an understanding the
meaning of his work. Such a reconstruction would transform past into
present understanding. However, he realized that this reconstruction
required a prior knowledge of the whole, by which the relation of its parts
could be determined. Without knowledge of the totality of an individual life,
given the historical conditioning of individuals (both the author and the

\textsuperscript{167}\textit{Wolfgang Pannenberg, Theology and the Philosophy of Science}, trans.
an excellent discussion of the problems raised by various rival views of
hermeneutics, see pp. 156-224. Also, for a recent discussion of hermeneutics
as a theory of interpretation, see David Klemm, ed., \textit{The Interpretation of
interpreter), any claim to understanding would remain momentary and subjective.  

Pannenberg writes that Heidegger attempted to resolve this dilemma by positing a structural concept of existence as the basis of hermeneutics in which a "being" in the world, aware of itself, outlines itself in terms of its possibilities. It thereby "places itself in advance in a position of possible understanding. In this process, the 'involvement' of its world is laid bare through an anticipation, which discloses the world as a totality of significance."  

The key term is "anticipation" which introduces the necessity of a future orientation to the process of understanding meaning in the world.  

Hans-Georg Gadamer argues that hermeneutics involves a conversation in which the interpreter and the text interact to produce a fusion of horizons. The first stage of this fusion is the recognition of the distinctness of the text from the present of the interpreter. The second is the search for a common horizon to link the interpreter with the text and its context and with tradition in general. The interpreter must be careful not to attribute to the person or text he or she is trying to understand the interpreter's own interiority of experience. Appropriate recognition of historical differentiation and context will create a tension of perspectives which allows new dimensions of meaning of a text to be disclosed through a

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168 Ibid., pp. 161-163.


170 Gadamer, pp. 271ff.
dialogical interaction. As this occurs, the initial interpretive horizons of the interpreter are also disclosed and placed at risk.\textsuperscript{171} This critical self-transformation involved in the hermeneutical process raises the ethical dimension of hermeneutics.

Such a critical self-transformation subverts “worlds” and disrupts one’s assumptions regarding the nature of reality. Ricoeur recognizes the necessity of acknowledging the historical differentiation that requires the disclosure and transformation of the interpreter’s standpoint. However, he argues that emphasizing the presence of the interlocutors to each other does not go far enough. Ricoeur creates a notion of the “world” of the text which is distinct from the subjectivity of both author and reader. “The text thus produces a double eclipse of the reader and writer.” Both parties participate in “worlds” that are not apprehensible to them as present-at-hand, but which reflect the meaning structures that give shape to their interpretations of reality.\textsuperscript{172} The problem remains of identifying and penetrating one’s pre-understanding as a representation of one’s cultural reality. If this attitude can be bracketed, the world of the text can be disclosed. A “shock” occurs in “the encounter between the initial world that shapes and informs the self of the interpreter with the world disclosed by the text. This serves to displace critically the closed world that shapes the self as it creatively reveals new meaning.”\textsuperscript{173}

\textsuperscript{171}Ibid., p. 266.


\textsuperscript{173}DiCenso, pp. 676–677.
Therefore, hermeneutics has importance for a study of the fiduciary aspect of professional identity. The physician must interpret the meaning of being a physician within the world of the medical tradition and within the everyday world of working. He or she is part of the medical profession's ongoing tradition. This tradition constitutes his or her understanding of the meaning and value of medical work. At the same time, the profession is part of the totality of human culture and represents a "closed world" of structured meaning the accent of which shapes the doctor's self and his or her relations with others. Finally, the physician also is involved with the "living human document" or "text" of the patient. The physician's pre-understanding of medical work (including the doctor's understanding of knowledge and fiduciary responsibility) govern his or her response to the patient who also possesses a particular pre-understanding of the nature of the physician and medical work. The encounter of these "world" raises the issue of trust both as the confident investment of meaning in one's understanding, but also as the possibility of encountering new meaning in the risk of relationship.

Because both the physician and the patient are "living documents," and because the physician is a member of an historical tradition, it is important to wrestle with the interrelationship of the whole and the part in constructing an understanding of trust-as-control and trust-as-faith. It is impossible to escape the contextuality of existence. Humans are linked to the finitude of historical experience and perspective. Consequently, attempts to achieve an objective perspective separate from the subjective position of the interpreter is impossible. Thus, there can be no final understanding (none that all persons would be rationally compelled to accept) of the "essential"
nature of the profession or of the meaning of trust for the physician in establishing the boundaries of medical identity.

In the natural attitude, meaning may appear to be present-at-hand. Insofar as an accent of reality is constituted by past interpretations, however, it must be approached "archeologically." To the extent that it prefigures what is to come, it must be interpreted "teleologically." The investigation of trust remains an interpretive adventure requiring an archeological excursion into the profession's pre-understanding of fiduciary commitment. As a hermeneut, Ricouer points out that such an archeological regression requires a teleological progression towards another meaning.\(^{174}\) This attitude of mind is the "second naivete," a return to an immediacy of belief (an accent of meaning) following the "distancing" of the phenomenological method.\(^{175}\)

The study will seek to uncover or disclose a theological interpretation of trust-as-faith "hidden" in the taken-for-granted habit of mind and horizon of meaning constituting the medical profession. This disclosure entails a deliberate dispossession of the medical accent of meaning. It is this accent which constantly is threatened by encounter with others who do not share the physician's frame of reference. The deliberate phenomenological bracketing reveals a "wounded" Cogito that results from this hermeneutical adventure -- "a Cogito that posits itself but does not possess itself; a Cogito


that sees its original truth only in and through the avowal of the inadequacy
and illusion of actual consciousness.\textsuperscript{176}

Even in the reflective mode we cannot bring ourselves before
consciousness in "vivid immediacy," as actively engaged in the world.\textsuperscript{177}
What we apprehend is the self as already formed, the sedimted self, not
the self moving into an open future with not-yet-realized potentiality. This
retrospective movement, however, does enable us to uncover the bases of
action in the stabilities and continuities of the self.\textsuperscript{178} These structures
enable us to act and to assess our actions in a meaningful fashion.

In other words, the hermeneutical investigation of trust will show the
immersion of the physician within a fixed, collectively-derived interpretive
world which dominates individual existence.\textsuperscript{179} In this condition, the
physician's self (Cogito) desires self-possession and self-control. The wish
results in the inadequacy, illusion, and lying of "actual consciousness," or an
understanding of trust and trustworthiness which is assumed in the
physician's approach to everyday reality. This attitude of trust-as-control
abrogates acknowledgment of the reflexivity that allows for critical and
transformative reflection upon the constructed nature of medical work.
Repressed by this fixed interpretive mode of existence is the possibility of

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\textsuperscript{176}Ibid., p. 439.
\textsuperscript{177}Schutz, \textit{Collected Papers} 1, pp. 172-175.
\textsuperscript{178}Ogletree, pp. 21-22.
\textsuperscript{179}Heidegger refers to this state of being as "falling" or the state of
fallenness; p. 219, quoted in DiCenso, p. 672.
\end{flushleft}
trust-as-faith. The dispossession or displacement of this illusion inaugurates a progression towards a new possibility of relationship.

**Sociological and Phenomenological Investigation**

In order to develop this reflexive hermeneutics of the life-world, I will follow a two step process. First, as preparation for the second part of the essay, chapters two and three describe the definitional boundaries of the medical profession from a sociological and phenomenological perspective. A social model of the medical profession can be established by the discussion of finite provinces of meaning within the construct of social reality. The profession can be described as a finite province of meaning, possessing a certain "accent of reality" through which it views itself and the world. In particular, I will argue that the physician as a member of a profession encounters his or her work from within a "horizon of meaning" -- what Heidegger refers to as a "fore-structure of understanding." This horizon of reality is constituted by a tradition, partly institutionalized and partly informed by an individual's biographical situation. It represents a certain

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181 For a discussion of the term "horizon" in this context, see Toombs, p. 220. For a discussion of the "fore-structure of understanding," see Heidegger, pp. 188-195.
way of understanding, determining, and acting in and on the world, as well as certain habits of mind and relevances, all of which give meaning to the work of the physician and give to him a sense of identity and authority in the world of everyday life. The profession as a community is structured around a central focus and a commitment to other members of the profession. The community's horizon of meaning shapes the perspective of its members regarding the purpose and value of their work. It also shapes the social relationships that its members have with the world of everyday life. Their accent of meaning bestows a sense of "immediacy" or "reality" to their province.

For the most part, the contemporary physician tends to understand the condition of a patient through a single interpretive paradigm -- the biophysical model. The roots of this model rest in the anatomical-physiological understanding of the human body as a causally-determined machine. When, for example, a pulmonary specialist is called in on a case, he or she comes armed with a set of hypotheses, techniques, and principles that orient the physician's interpretation of the situation, even if these are never made explicit. For the pulmonary specialist, this horizon of meaning includes general cultural assumptions concerning the nature of the material world and the human body, as well as more specific knowledge concerning the physiology of the lung, its relation to others organs, and the lesions and modes of decompensation to which it is susceptible. While a given case may be ambiguous, the conceptual universe within which the pulmonary

specialist operates seems to form a coherent, self-consistent, and unified structure.

Within the profession's horizon of meaning, there also exists a fundamental understanding of the characteristics of the doctor-patient relationship and the appropriate roles each party is to play. The physician sees himself or herself as the primary, if not final, authority in the care of his or her patient. The physician tends to resist criticism of this interpretation of the relationship, arguing on the basis of his or her superior knowledge, technical competency, and the profession's sense of its traditions and values. Criticisms of the profession's interpretation often are perceived as threats to the authority which enable the doctor to do his or her work and do it well (in the best interests of the patient and public). An eidetic interpretation of this model of the medical profession will support the claim that a climate of distrust has developed between the "technically competent"

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183 This professional view of the physician's authority has a certain legitimacy that must be acknowledged, even as it is critiqued. Legitimacy rests on acting in the patient's best interests; at least, in doing no harm. Often this claim to authority is grounded in the superior knowledge and experience of the physician in matters of health and illness. The structures of meaning within which physicians practice "place" them in the position of acting sometimes as if they know "best."
physician and the patient which undermines the fiduciary dimension of the
doctor-patient relationship.184

Following the general theory of the sociology of knowledge, a review
of the phenomenological dimensions of the medical profession as a finite
province of meaning within the everyday world demonstrates the
importance of the acquisition and control of knowledge in the "reality" in
which the physician operates. Although in the 1980s the physician's field of
knowledge extends beyond a mere commitment to the biomedical model of
illness, this model still remains fundamental to the "practice" of medicine.
The particular nature of the model shapes the profession's accent of
meaning, its clinical vision, within which the physician approaches his or her
work and relations with the public. The analysis of the role of knowledge in

184I do not mean to claim axiomatically that all doctors are suspicious of all
patients, or that all patients mistrust all doctors. Lionel Trilling claims that
there is a modern tendency "to locate evil in social systems rather than in
persons"; quoted in Denis Donoghue, "Insincerity and Authenticity," The New
Republic 198 (February 15, 1988), 26. However, I am arguing that many
patients are distrustful of physicians, that society as such does not take for
granted that the profession's interests are paramount. A reconsideration of
the way in which health care providers view their work is not a bad idea.
One danger of a taken-for-granted attitude regarding his or her work is the
domineering role of a physician in the health care relationship, the very
relationship that the physician claims to know best. My approach, then,
begins with a bracketing of the medical profession's natural attitude. It
"shocks" or threatens the paternalistic doctor-knows-best attitude. There
seems to be little question that doctors possess an ever increasing technical
expertise which grows out of and leads back to an active concentration on
providing a cure. It is well to question the attitude that such expertise can
engender, fearing both the effect on health care of a certain "superiority" and
the danger of the "medicalization" of society as the area of expertise comes to
extend beyond a strict definition of medical boundaries; see Ivan Illich,
shaping the profession’s accent of meaning will introduce the importance of trust in shaping professional identity.

I do not argue that trust as a representation of fidelity in the medical relationship is the preeminent virtue, nor is it the only virtue important to interactions between doctors and patients. However, the importance of community and tradition to moral reasoning and conduct, and the role played by the virtue of trust in this on-going process, offers a context for a theological reconstruction of the medical profession’s accent of meaning and the affect on the physician’s fiducial commitment of using trust-as-control. An exploration of the role of trust in the physician’s accent of meaning and in shaping the physician’s interpretation of the experience of medicine opens a conversation with theology.

The Transition from Phenomenology to Theology

Having set up a model of the profession as a finite province of meaning within a social matrix of multiple levels of reality, chapters four and five will be a theological exploration of the dynamics of giving and receiving exhibited in the primary health care relationship between physician and patient. I will argue that the present model of the relationship, grounded in the biomedical model of illness and the climate of distrust, results in a relationship in which the giving and receiving of trust are brokered by self-interested, self-seeking adversaries alienated from each other and from themselves. A theological inquiry contributes to a reinterpretation and appreciation of trust-as-faith in physicians’ work.

A phenomenological "bracketing" of the taken-for-granted accent of meaning that characterizes the medical profession raises the theological
focus of the dissertation. As human beings, what we ordinarily assume to be meaningful in our lives largely is constituted by the horizon of our particular province of meaning. However, a phenomenological analysis of the nature of social reality reveals any province to be an artificial construct. On occasion we are shocked to discover the "facticity" of our natural attitude -- that the world can be other than it appears to us. It is a peculiar feature of human nature to desire to extend this facticity beyond the limits of our province, to deny our essential dependence upon what is beyond our control, to deny our social existentialism.\textsuperscript{185} Inasmuch as the arena of health care, and primarily the physician-patient relationship, deals with issues of life and death, well-being and dis-ease, it reflects this desire to control our human neediness. Health care becomes an effort to satisfy our desire to deny our human condition. Due in part to the promise of biomedical science to cure our ills (our needs) if given more money, more support, and more trust, the technical knowledge and skill of the physician increases. The promise of a "remedy" for human neediness, of course, remains unfulfilled because it cannot be satisfied.\textsuperscript{186}

\textsuperscript{185}See Niebuhr, Christ and Culture, pp. 234-256. Theologically, Niebuhr argues that the desire to deny our finitude is always inadequate and results in a sinful response to God. We must accept a relativism of faith, our social existentialism, and our freedom in dependence.

\textsuperscript{186}The medical profession, supported by medical science, is trapped. As it accomplishes its goals, it increases the public's expectations that its goals will be accomplished. Such success causes more pressure for success. One feature of the impact of AIDS on our society may be the fear that medical science cannot deliver a "cure." In this respect, AIDS may be seen not as a punishment by God of sexual immorality or sexual orientation, but a punishment of technological and scientific "pride."
The medical profession shapes and is shaped by its relation with the world of everyday life. The development of medical science and the corresponding emphasis on knowledge and expertise have come to mark the "work" of physicians in our society. Unfortunately, under the demands of distrust, if we are to trust the profession's work, the physician subtly is forced to become all things to all people. The medical profession is indeed a tragic one if the physician is expected to play an omniscient and omnipotent god with whom we can negotiate our neediness. The god represented by such a model is an inauthentic one. The trust demanded by such a god leads to existential "death," not life. If physicians deny their existential dependency on dialogical interaction with others and struggle to wrap themselves in an aura of power and expertise, the trust they seek to elicit from patients will be built upon an inadequate foundation.¹⁸⁷ This foundation for the physician-patient relationship will continue to create resentment, shame, and suspicion in health care instead of a sense of mutual well-being. It is through an appreciation of the eidetic characteristic of existential dependency that a shared world of meaning can be established between physician and patient, and a measure of mutual trustworthiness restored.¹⁸⁸


¹⁸⁸Toombs, p. 235.
Peter Homans has argued that theologians cannot ignore or dismiss the work of Freud.\textsuperscript{189} "[He has] robbed us of the last illusion of the Enlightenment -- the illusion that if we are autonomously conscious and rational we need fear no further illusions.... All the expressions of consciousness possess not only their manifest meanings but conceal and distort a series of latent, overdetermined meanings that demand new modes of analysis."\textsuperscript{190} As a result, people are suspiciously aware of disguise, of distortions based on social or personal interests, repression, or resistance. In making this statement, I am not claiming that Freud is correct in his critique of religion. The claim that religion is an epiphenomenon of psychic forces itself may be "illusory." However, I am saying that the postmodern, post-Freudian culture clearly is influenced by his theory. It is difficult to trustfully assume that "reality" can be taken for granted, or that others are as they appear to be. Cynicism and skepticism grow more pervasive.

As we have seen, theology from time to time must reconsider its own interpretative schemes, how it is to understand the divine-human relationship, and how it thereby constructs a world of meaning. Theological world-views can become taken for granted, fixed, and run the risk of


becoming ideologically bound. The encounter of theology with the structures of science can "shock" this theological natural attitude into a reworking of its taken-for-granted conceptualizations. In the postmodern culture, in considering issues of faith and trust in medical matters, this issue becomes important. How is the term "God" being used in a discussion of the role of a fiduciary commitment in defining the boundaries of medical authority?

My interest is not with the truth of God's existence or nature, but with the meaning of religious claims about God. Christian religious language tries to convey the "something more" which characterizes the religion. However, because these words are spoken in a world of rationality and human experience, they often appear paradoxical and contradictory. Generally, arguments at this point among theologians and between theologians and their critics are attempts to resolve the apparent or real contradictions contained in religious language. However, paradoxes do show something -- if only that certain concepts do not apply when referring to God.\footnote{\textit{Ninian Smart, The Philosophy of Religion} (New York: Oxford University Press, 1979), p. 43.} For instance, to categorize God in modes of human experience would reduce or falsify the ultimacy which is associated with God. An appeal to supernaturalism, that God is just beyond any human understanding and that there is no necessary connexion between the transcendent and the mundane, would seem to address this concern. However, why then even concern ourselves with the issue. Any claim of an experience of God could be explained, for instance, as a type of psychological event. Yet, in the Christian tradition, it is explicit that
between the indescribably transcendent and the manifest has occupied the
theistic tradition since its inception.

According to the tenets of classical theism, God is the supreme creator,
who brings the world into being and directs its course. This First Cause
(Arche) is also the Final Goal (Telos) of the world. Utterly transcendent and
thoroughly eternal, God is represented as totally present to Himself (sic). He
is the omnipresent source, ground, and uncaused cause of presence itself.¹⁹²

The term "God" as used in Western culture stands for or names the ultimate
reference point or orientation for all life, action, and reflection. The self, it is
believed, is made in the image of God and, consequently, is also a centered
individual, both self-conscious and freely active. Together, self-consciousness
and freedom entail individual responsibility. History is the realm in which
divine guidance and individual responsibility meet. It is believed that
history is not dominated by individual randomness, but begins with a
definite event, extends through an identifiable middle to an expected end.
History becomes a purposeful, teleological process whose meaning can be
coherently represented.¹⁹³ God, self, and history are thus bound in mutual
and interactive relationship, one to the others. It is the solid, common
understanding of this interrelationship, this "reality," that is threatened in a
culture of criticism. The dimensions of this issue are much broader than the
limits of this project. However, I maintain that in the postmodern culture of
criticism, the depiction of god as an entity, albeit exalted and supreme,
remains a common characterization for people involved in medical matters.

¹⁹²Taylor, p. 7.

¹⁹³Ibid.
This crisis focuses our attention on the heart of the theological purpose. From the theological perspective, our understanding of God orients human life. However, while a religious symbol does gain its specific content from particular cultural traditions, it stands for more meaning than it can convey. As a limiting idea of reality, therefore, an understanding of God can be approached but never literally grasped. Human understanding of God is a historically conditioned construct, but is subject to continual criticism and reconstruction in light of changing perceptions and understandings over time. The task of theology is the investigation, elucidation, and exposition of the historical center of the faith of the Christian community. As such, theology raises ontological issues because it does not dwell completely within the pre-interpreted "givenness" of things as ontic. It seeks to call into question the normative conceptions which are taken-for-granted in the natural attitude. In doing so, it opens the possibility for critical reflection upon, and transformation of, the way in which meaning is construed. Theology becomes the "wound that heals" in a double movement of uncovering what is present, although hidden, and disclosing what is absent, yet revealed. A taken-for-granted conceptualization of a transcendent God, the relation of which to the experiential world is unclear, threatens an understanding that faith entails a commitment beyond the moment. Rather,

See Douglas Ottati, "Reconstructing Christian Theology," Religious Studies Review 9 (July, 1983), pp. 222-227. The idea of God may be a human construct, subject to reconstruction, but this statement is not intended to mean that God is merely a construct of the human mind.


DiCenso, p. 672.
people seek trust (as control) in that which they can see and control. They seek to make the world "familiar."

In a theological review of the definitional or "limiting" meaning of trust for physicians, an examination of the importance of knowledge and trust in shaping the fore-knowledge with which physicians approach their world focuses on the "moment" in which familiar reality is called into question. Medicine represents a process, a continuous series of relational moments, in which the content of knowledge must undergo occasional revision. This moment becomes the starting point for a medical theological ethics which seeks to recover human relationship in trust-as-faith.

**Implications for a Medical Theological Ethics**

In concluding the dissertation, I argue that, there are more hopeful possibilities for a medical theological ethics in a postmodern culture. Inasmuch as Christian theological ethics seeks to elucidate the relationship of God and humankind, reflection on the theological nature of giving and receiving in relationship offers a means of re-establishing a fragile climate of authentic trust-as-faith between the members of the primary health care relationship. Moreover, a revised view of the divine-human encounter becomes a model for the human struggle for equilibrium in order that resentment and suffering might be mitigated.

This theological approach to bioethics emphasizes relational and conversational ethics as opposed to "idle-talk." Idle talk always assumes the givenness of reality; it is always based upon taken-for-granted
presuppositions about what is valid and meaningful. These fixed interpretive modes of existence result in an economy of domination in the world of human existence. If God is posited as transcendent-other, in relation to whom humans are "fallen" from a purer and higher status, the exchange of trustful giving and receiving becomes distorted by resentment and alienation. In trustful, dialogical conversation with others and, therefore, with God, we can be open to surprise and the transformation of previously taken-for-granted interpretations.

Hermeneutics opens the way to a meaning which is not hidden, but something disclosed. "What gives rise to understanding is that which points toward a possible world, by means of the non-ostensive reference of the text. Texts speak of possible worlds and of possible ways of orienting ourselves to these worlds." If we replace Ricouer's term "text" with the phrase "living human documents," it is in the encounter between humans, specifically in the medical encounter, that possibilities of transformation become "real." The central issue in a critical hermeneutics is neither what "texts" or "living documents" say about us nor what we say about them, but what we can learn from the forms of otherness they mediate to us. Thus, the question is not how to "fix" the the "profession," the "physician," or the "patient" in conceptually stable or ethically absolute terms, but how to appreciate the differences they can make to each other when the world of experience is constructed and construed from perspectives (privileged

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197 Ibid., p. 673.

epistemic standpoints) other than their own. Through an uncovering of trust-as-control and a movement toward trust-as-faith, a hermeneutical inquiry raises a variety of possibilities for a theological bioethics.

In a theological reading of the text of relationship, it may be that the way the physician "cares" is as important as the "cure" he or she seeks. The fiduciary dimension that connects caring and curing must enable these concepts to evolve in meaning. Otherwise, an effort to maintain and control the paradigmatic "reality" of the biomedical model will obscure the important role of the caring and "sustaining presence" that is the correlate of cure. By questioning or re-viewing the limits of the profession's horizon of meaning, we come to a renewed appreciation of trust and caring, and, perhaps, then are better able to cure. This review of the profession's horizon of meaning begins with its dedication to knowledge.

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Chapter Two

Expert Knowledge as a Focus of the Medical Province of Meaning

Introduction

In the previous chapter, I established that the medical profession qualifies as a status occupation because it is a social institution wielding great power over its work. Certain "traits" associated with physicians express, as well as perpetuate, the profession's power and function in society. These traits may change from time to time, and the function played in society by doctors may be reinterpreted. However, for status professions such as medicine, the possession and control of expert knowledge is a consistent characteristic. Expert knowledge is deployed in different institutional forms, and used as the basis of individual and collective power and privilege. The development of additional knowledge is a natural consequence, and leads to further efforts to control the expertise on which, in part, the power of the profession rests. In part, the parameters of medical "work" are created by the possession, development, transmission, and control of theoretical and technical knowledge. The importance of knowledge to the physician's work plays a part in delineating the values attached to that work by physicians.

Of course, many occupations are groups of people sharing certain relatively arcane knowledge and skills. Therefore, there are two foci consistently stressed in the literature as characteristic of status professions: in addition to the possession of theoretical and technical knowledge, and the expectation of a fiduciary relationship with a client. The medical profession has a long tradition of espousing service to clients as part of its self-identity
and its identity in the eyes of the public.\footnote{This tradition commonly is believed to originate in the Hippocratic Corpus, especially in the Hippocratic Oath, which stresses "primum non nocere," and indicates that the patient's good is to be placed before the physician's self-interest. A few other historical examples of the obligation of physicians to serve the public or patient are Perceival's \textit{Medical Ethics} (1803) and the American Medical Association's first code of ethics (1847); see Stanley Joel Reiser, \textit{et al.}, \textit{Ethics in Medicine} (Cambridge: MIT Press, 1977), pp. 18-24, 25-33; Jay Katz, \textit{The Silent World of Doctor and Patient} (New York: The Free Press, 1984); and Allen R. Dyer, "Virtues and Medicine: A Physician's Analysis," in Earl E. Shelp, ed., \textit{Virtue and Medicine} (Dordrecht: D. Reidel, 1985), pp. 229-230.} The reason for the fiduciary focus is the knowledge gap between expert and lay person, and the possibility of harms to the client if the physician uses this power for personal gain or aggrandizement.

In this chapter I will examine the component of knowledge from a phenomenological point of view building upon the sociological work of chapter one. The medical profession is comprised of like-minded people.\footnote{The description of a profession as a like-minded group of people is taken from "Medicine, Profession, and Society," editorial, \textit{The Journal of Medical Ethics} 11 (1986), 59-60.} I will explore the "like-mindedness" of the natural standpoint that serves to distinguish physicians' work, and will develop a model or typification of the medical profession as a "finite province of meaning." I argue that the technical expertise and knowledge which shapes and is shaped by the profession's "accent of reality" is grounded in the biomedical model of illness. These concerns reflect an epistemological issue: What are the structures and
limits of medical knowledge? Second, these concerns raise a question from the sociology of knowledge: How does a commitment to medical knowledge affect the physician's work?

It is the second question that forms the basis for this chapter. A phenomenological response requires that focus be placed not on the specific organizational structure of the medical profession, but on the way in which its members interpret their own organizational world (a special sphere of the


4The sociology of knowledge is "the study of the functional correlations which can be established between the different types, the differently emphasized forms within these types, the different systems or hierarchies of these types, and, on the other hand, the social frameworks such as global societies, (or) particular groupings..."; Georges Gurvitch, *The Social Framework of Knowledge* (New York: Harper and Row, 1971), p. 17. The sociology of knowledge also claims that there is a relationship between the hierarchy of the types of knowledge and the hierarchy of other cultural products and different social regulations called social controls. If I assume that the medical profession, a social organization, possesses an investment in certain types of knowledge (and that there is a correlation between these types and the social framework of medicine in its relations within its own ranks and with those outside its ranks), I can assume that social control will play a role in the way in which this knowledge is put to "work."
individual's Lebenswelt or everyday life-world). The phenomenological concept of the life-world refers to the fact that in any real-life experience, something is pregiven, taken for granted, and passively received by a person's consciousness. This taken-for-granted world includes our cultural world, and whatever prejudices and interpretations may derive from it. An important part of this experience is its organization into typical forms from which the individual derives his or her sense of the world. The "typical" is a deeply rooted feature of the very organization of experience into knowledge. The medical profession achieves, in part, its power and authority from control of the knowledge necessary for its work. Therefore, the concept of "typification" is useful in depicting the way in which physicians "know" or

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experience their world, their work, their relations with patients, and the way in which they see themselves in relation to these concerns.7

If commonsense knowledge of the everyday world is organized and distributed according to structures of meaning in our social relations, which are pregiven and shaped by typifications, then the question of the structure and limits of medical knowledge implies several other questions: What is the role of the profession's social structure in the development, control, and transmission of medical knowledge and expertise? What social relations are presupposed by the forms and structures of medical knowledge? Finally, what part does knowledge play in shaping the "horizon of meaning" or standpoint of the physician quas professional?8

Thus, the physician's understanding of knowledge contributes to the way in which he or she finds the profession meaningful.9 How does this knowledge shape, and how is it shaped by, the limits of the profession's


autonomy, power, authority, and social relations with the everyday world? I argue that the basic epistemological model by which physicians make sense of their work is the biomedical model. If there is a correlate between the social structure of the profession and the system of knowledge it endorses and reflects, the emphasis on scientifically grounded knowledge shapes the social relations of the profession with its clients.\(^{10}\)

The biomedical model is one particular typification of medical knowledge and derives from an investment in a scientific approach to medicine. The development of the biomedical model of illness and the concomitant development of medical technology reinforce the adoption of a scientific ideology by the medical profession. Given that typification is a natural component of the life-world, I demonstrate that the biomedical model matches closely the structure of typicality which is found in medicine. In fact, many physicians assume it to be the typical model outlining the limits of medical work. Its use shapes the physician's "accent of reality," thereby affecting the nature of the fiduciary component of medicine.

To open the discussion, I will review briefly my definition of "medical knowledge." Second, I will develop a description of the medical profession as a finite province of meaning whose accent of reality regarding its work in the world has become grounded in scientific overtones. The characteristics of such a province resonate with the sociological issues previously discussed

\(^{10}\)The relations may shape the system of knowledge as well. The awareness of this correlate can reveal the inefficiency of systems of knowledge ill suited to the social frameworks in which they are maintained. The sociology of knowledge cannot serve to invalidate false knowledge since it cannot decide on the veracity of the content of knowledge (it is not a replacement for epistemology). Nor can the ties between knowledge and social structure be dissolved; Gurvitch, pp.12–13.
and prepare the way for chapter three, in which I will focus on physicians' use of trust as a means of controlling relations with patients.

**Knowledge as a Definitional Component of the Medical Profession**

A number of modes of knowledge operate in medicine. As Toulmin writes, "In medicine, more than any other discipline, our task is... not to define 'medical knowledge' restrictively but to recognize the plurality of different types of medical knowledge."¹¹ Perceptual knowledge of the external world, knowledge of the "other," common sense, technical, political, philosophical, and scientific knowledge are all types of knowledge with social

¹¹Toulmin, p. 41. Also, Gurvitch presents an analysis of different types and forms of knowledge. He recognizes that any list is somewhat arbitrary since there always is the possibility that other types and forms may arise in the future (p. 21). Among the many types he mentions, predominant ones penetrate all the others in some form. For instance, philosophical knowledge and perceptual knowledge are ingredients in scientific knowledge (p. 23ff).
or intersubjective importance. In medicine there is a correlation among these various types. All play a role in some combination of theoretical (both philosophical and scientific) and practical (both empirical and clinical) knowledge.

Generally speaking, in medical knowledge, this combination is focused on a particular patient's clinical treatment. The doctor's understanding of medicine relies on general physiological or psychological principles which have medical significance only insofar as they can be related to a personal understanding of the particularities of clinical practice with actual patients. Thus, the distinction between theoretical or formal knowledge and practical knowledge is reproduced in the medical field as the distinction between

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12Gurwitsch, pp. 23-36. There are many types of knowledge. Perceptual knowledge postulates a coherent ensemble of images, placed in concrete and specific time and space. The ways in which images are perceived, conceptualized, or quantified may vary. Knowledge of the "other" is inherent in any social framework since it must be constitutive of the social reality itself. Awareness of the other are not uniform among systems, however. Common sense knowledge (the knowledge of everyday life) will be elaborated during the course of this chapter. Technical knowledge is not applied scientific knowledge, but rather, the constitutive part of praxis or the desire to dominate, control, shape the natural or social world. Political knowledge involves the strategy of social action or the knowledge born of social interaction in which people confront each other with their various desires, goals, and actions. Scientific knowledge is a type which tends towards openness, organization, and a conjunction of the conceptual and the empirical. Its constructed frameworks are justified by experimental verification. The more developed the knowledge, the more developed are the social correlates which accompany scientific knowledge. Finally, philosophical knowledge strives to integrate and validate these other types into coherent totalities. Gurvitch does not refer to theological knowledge although he refers to a mystical form of knowledge as the supernatural element which can originate in judgment or experience. To him this form usually falls before other forms such as the rational and the empirical (p. 38).
biomedical science and general clinical medicine. The practice of medicine relies on a coalition of different theoreticians, researchers, specialists, and general practitioners, for whom knowledge is a different commodity and the patient a different "object" of knowledge.

In this dissertation, "medical knowledge" refers primarily to the formal knowledge of general biomedical science, to technical information, and to factual information grounded in the empirical method on which the practice of modern medicine is based. In addition, it incorporates the experience gained from the application of medical knowledge in concrete situations. Medical knowledge is in large measure a constructed competence which results from formal reflection and practical experience. It includes generalized intellectual skills, the various areas of knowledge outside of any one specialty, skill in handling interpersonal relations, and "commonsense." Thus, such knowledge derives from many sources and can cover a range of applications.

Medical knowledge is a complex, evolving, dynamic concept, both theoretical in general and specific to the circumstances and demands of each clinical encounter. Medical knowledge might be envisioned as stretching over a continuum from a research orientation with no direct patient contact (although experimental involvement is possible) to the immediate knowledge of the condition of a particular patient. Because the profession is oriented around the relief of suffering, all medical knowledge rests finally on providing service to the client.14

13Toulmin, p. 40.

14Ibid., p. 45.
It is with this last dimension that the chapter is concerned. In any age a patient must trust that his physician possesses the theoretical and technical knowledge of his or her profession which the patient does not possess or understand. The context of this confidence is most immediately pertinent in the clinical encounter between patient and physician when the professional’s knowledge is put into practice. The nature of medical knowledge and the goals to which it is applied both determine and reflect the spirit in which patients are concurrently treated.\textsuperscript{15} Thus, biochemistry may be important to the clinician, but the knowledge gained in the laboratory is several times removed from the examining room and the patient. It becomes important to the degree that it has an immediate relevance to the concerns and questions of the patient. The physician is responsible for knowing the larger parameters of his or her field and the way to apply this knowledge to the needs of any one patient. The emphasis placed by the profession on a scientific basis for medical knowledge largely determines and reflects the spirit in which patients are “treated.” Even the commonsense knowledge of physicians, as part of the stock of knowledge which doctors bring to their work, is shaped by and placed within the structure of formal and empirical knowledge.

The sociology of knowledge examines the ways individuals and social institutions master, transmit, and in doing so, shape the knowledge that forms their understanding of reality (and in the way that these individuals and institutions are shaped in turn by this understanding). The medical profession, as a social institution, has a reservoir of knowledge gained from

\textsuperscript{15}Ibid., p. 41.
its tradition, a commitment to biomedical science, and a long history of practical experience. This knowledge is organized, evaluated, and transmitted by means of a process characteristic of medicine. Medicine "classifies" and "evaluates" knowledge according to the definitional boundaries of the field. Knowledge becomes a factor in the profession's social, economic, and political power to define and control its work.

Medical knowledge is dedicated to the values of saving lives and relieving suffering. However, the expert knowledge which enhances these goals also serves to separate the physician from those people who come to him or her for help. Through education and socialization doctors modify their understanding of the everyday world to develop a particular or "typical" knowledge of the life-world as they join the profession. The idea of knowledge implies a consensus, shaped by an accepted base of knowledge, which determines the typical understanding the physician brings to concrete situations. The acceptance, the utilization, and the modification of such knowledge invests the physician with the power of his or her expertise. This

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16 Whatever tasks a doctor performs, whether routine or unusual, are measured against the standard of what Gordon Horobin calls "the great save." A peculiar characteristic of medical work is that the successful action, the most dramatic evidence of work performance, i.e., the saving of a life, is seen to be brought about through the use of esoteric skills for which the physician has trained and yet, by and large for many doctors, remains unused and untested; see Gordon Horobin, "Professional Mystery: The Maintenance of Charisma in General Medical Practice," in R. Dingwall and P. Lewis, eds., The Sociology of the Professions (London: The Macmillan Press, 1983), pp. 84-105.

expertise provides an "accent" to the reality of a physician's work in the world by organizing experience according to coherent patterns of meaning.

The Medical Profession as a Finite Province of Meaning

Humans operate within a life-world that is pregiven and already organized. This Lebenswelt (life-world) is not only prestructured, but the meanings of the elements contained within it are also pregiven. Each person incorporates an understanding the world which existed before his or her birth, is passed on to the individual, and within which he or she acts upon the world. The language we learn, the culture we acquire, the social structures within which we live provide a stockpile of typifications -- of recipes for interpreting and acting. The stock of knowledge provides the actor with rules for interpreting interactions, social relationships, organizations, and institutions.¹⁸ This stock of knowledge forms the basis for even imaginative exploration of courses of action other than those we

¹⁸ Alfred Schutz, "Some Structures of the Life-World," in Collected Papers III (The Hague: Matinus Nijhoff, 1966), pp. 118-139, 261. These rules apply to the organization as well as to the individual: "Whether we happen to act alone or, cooperating with others, engage in common pursuits, the things and objects with which we are confronted as well as our plans and designs, finally the world as a whole, appear to us in the light of beliefs, opinions, conceptions, certainties, etc., that prevail in the community to which we belong"; Aron Gurwitsch, Studies in Phenomenology and Psychology (Evanston, Ill.: Northwestern University Press, 1966), p. 420. The disruption of the natural attitude forces one to entertain alternative interpretations. See Helmut Wagner, "The Scope of Phenomenological Sociology: Considerations and Suggestions," in George Psathas, ed., Phenomenological Sociology (New York: John Wiley & Sons, 1973), pp. 61-87; also see Psathas, "Introduction," ibid., p. 9.
already know. Each of us typically believes that the world is not one's own private affair but is a world shared with others. It is intersubjective, constructed over time, and "obvious." Due to the constructs of typicality which characterize the everyday world, the doctor possesses a "commonsense" stock of knowledge of the world and its items (including other persons). He or she assumes that the world is experienced by each of us as a common, shared, and intersubjective world of objects, events, values for acting, aims, goals, and recipes for solving typical problems. The typicalities that we experience and the way in which we interpret the world are characterized by an attitude of "taken-for-grantedness." We may bring into question one or another taken for granted aspect or construct of the life-world (e.g., in dreams, theoretical reflection, or fantasy). However, the fundamental theses constitutive of the life-world remain unthematized or unreflected upon by us in the context of our daily


lives.\footnote{M. Natanson, "Introduction," in Alfred Schutz, \textit{Reflections on the Problem of Relevance} (New Haven: Yale University Press, 1970), p. xii. Also see Alfred Schutz, "On Multiple Realities," \textit{Collected Papers} 1, pp. 229-259.} Within the natural attitude, the existence of the life-world and the typicalities of its contents are accepted as unquestionably given until further notice. Therefore, doubt in the reality of the world of working is suspended.

If the natural attitude of the world of everyday life is bracketed by employing the phenomenological epoché, multiple or finite provinces of meaning are revealed.\footnote{Schutz, "On Multiple Realities," ibid., p. 230. Also see, "Common Sense and Scientific Interpretation of Human Action," ibid., pp. 3-47. Following William James, Schutz acknowledged the term "sub-universes," but rejected the psychologistic grounding of James' theory. He referred instead to the "finite provinces of meaning" since it is the meaning of experiences and not the ontological structure of the objects which constitute reality; see Natanson, "Introduction," ibid., p. xli.} A finite province is defined as a certain set of experiences, all of which show a specific cognitive style or "accent of reality."\footnote{Schutz, "On Multiple Realities," p. 230.} Examples of these provinces are the world of physical things, scientific theory, religion, madness, music, and medicine. Each province represents a different social construct consistent within itself but distinct from another construct.

Everyday experience is encountered, attended to, and rendered thematic and meaningful in terms of a person's unique biographical situation.
and the provinces he or she shares.\textsuperscript{25} Under the natural attitude of the
paramount reality of the everyday world, these provinces ordinarily do not
conflict. Each province has its own cognitive style according to which
experiences in the world are structured and made inter-consistent. We are
not equally interested in all the strata of the working world at every
moment, nor in all of the other provinces of meaning simultaneously.\textsuperscript{26} For
instance, a person may be simultaneously a father, husband, Episcopalian,
golfer, and a doctor. While attending to any one of these provinces of
meaning (through the selective function of interest), the person will act
under the influence of the relevant accent of reality.

As a finite province of meaning, the medical profession is
categorized by its own "style."\textsuperscript{27} The physician shares with other doctors a

\textsuperscript{25}Husserl and William James noted that the manner in which a object is
experienced is correlative to the way in which an individual explicitly
attends to it. The meaning of the objects experienced will change as the
attentional focus varies. Ultimately what the individual attends to depends
upon his or her biographical situation and upon the complicated texture of
choices, decisions, and projects that make up his or her life plan. Experience
is encountered, attended to, and rendered thematic in terms of the
individual's unique status: in light of his or her special interests, motives,
desires, religious and ideological commitments; see Husserl, p. 108. "Each
world whilst it is attended to is real after its own fashion; only the reality
lapses with the attention"; William James, \textit{Principles of Psychology} 2 (New

\textsuperscript{26}Natanson, "Introduction," in Schutz, \textit{Reflections on the Problem of
Relevance}, p. xix.

\textsuperscript{27}According to Schutz, in a province there are six characteristics of style: a
specific tension of consciousness, a specific epoche, a prevalent form of
spontaneity, a specific form of experiencing one's self, a specific form of
sociality, and a specific time-perspective; Schutz, "Multiple Realities," pp.
207-259.
particular mind-set or medical vision (a clinical perspective). They suspend
doubt in the meaning and validity of their work, its presuppositions, and the
knowledge on which they base their work. Their inculcation in method and
decision-making serves to make their actions "second nature," and thus
appear spontaneous in situations where others would not act. As a result,
physicians take on an identity as members of the medical profession. Their
relations with other physicians, with patients, and with the public possess a
particular tone. Finally, as a member of a finite province of meaning, the
doctor is divorced from the time horizon of the everyday world.\textsuperscript{28}

The public may form a picture of doctors' attitudes and behavior,
supporting the expectation that all doctors should act a certain way at all
times. However, physicians view themselves and their work from within
their own biographical situations and their life plans. Any sense of a common
identity results from the profession's style which they incorporate from its
tradition and training. Therefore, they view themselves, their colleagues,
their relations with the public, and the meaning of their work from a
"medical" point of view.

Every province of meaning contains a system of relevances which
determine the selective function of a person's interests. The social

\textsuperscript{28}The physician's sense of time is not the same as it is for patients and their
families. He or she defines a problem in light of certain goals of medicine:
diagnosis, treatment, and prognosis. Outside of a medical emergency, these
goals are accomplished over time. The patient, however, seeks explanation,
cure, prediction, and a qualitatively immediate return to the normalcy of
daily life; R. J. Baron, "An Introduction to Medical Phenomena: I Can't Hear
You While I'm Listening," \textit{Annals of Internal Medicine} 103 (1985), 606-611.
The time it may take for this process to be accomplished is viewed
differently by each party. The doctor views his or her time perspective as
typical for all people. The patient cannot understand what is taking so long.
typification of the medical profession incorporates and reflects systems of relevance for its members which establish interests and priorities, and define the particular problems which are worth attending. In medicine, the physician attends or focuses on experience distinctly. He or she is trained to see illness essentially as a collection of physical signs and symptoms which describe particular diseases. A physician thematizes the illness as a particular or a typical case of multiple sclerosis or cancer.²⁹ Given the medical province of meaning's stock of knowledge and systems of relevance, the doctor adopts a typical focus or way of attending to reality and, therefore, a method of relating to people.

For the physician as a status professional, the medical accent of reality is fundamental. It circumscribes the nature of medical work and determines the tone of relations with other provinces within the world of daily life.³⁰ The relations between physician and patient become complexly


³⁰For instance, an illness such as AIDS is a construct of meaning-compatible experiences which has become typified according to diagnostic criteria established by the Centers for Disease Control. Illnesses also impose on people social roles in terms of general expectations which have come to be a part of the taken-for-granted store of knowledge that all possess in the everyday world. Within that world, having cancer, heart disease, or AIDS is experienced as typically involving expectations of certain sorts. The social roles of doctor and patient come to have an expected form, and people will act according to their perception of that role; see H. Tristram Engelhardt, Jr., "Illnesses, Diseases, and Sicknesses," in Victor Kestenbaum, ed., *The Humanity of the Ill* (Knoxville, Tenn.: University of Tennessee Press, 1982), pp. 142-156, esp. p. 152.
choreographed. Any variation to the expectations of each party becomes unsettling.

The motivation for focusing is related to the physician’s place in the familiar world of medicine. For example, in professional practice, habits develop according to which reality is interpreted. Such habits represent a distinct approach to the world and compose the profession’s culture. These habits determine the manner in which an object of experience is rendered thematic and made explicit through the typification process. Thus, given the systems of relevance and the habits that result, the physician operates within an horizon of meaning which, in turn, becomes a motivation for constituting reality according to the profession’s frame of reference. The profession contains its own specific tension of consciousness or horizon of meaning which determines a person’s typical behavior or "purpose at hand."\(^{32}\)

Under the medical profession’s accent of reality, there is a process of self-typification through which physicians define the nature of themselves.

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\(^{31}\)Toombs, p. 223; Kestenbaum, ibid., pp. 6–7. Bourdieu speaks of "habitus" as a distinctive mode of perception, of thinking, of appreciation, and of action associated with any collectivity. The habitus defines the "taste" of a group -- its character and its taken-for-granted view of the world. Applying this idea to the medical profession, the habitus of medicine is the accent of meaning adopted and endorsed by the profession which establishes its "style" of acting, thinking, and valuing; see P. Bourdieu and J. C. Passeron, *Reproduction in Education and Society* (London: Sage, 1977), quoted in Atkinson, "The Reproduction of the Professional Community," in Dingwall and Lewis, p. 237.

\(^{32}\)The “problem” or "purpose at hand" is a definition of what a person considers relevant in a situation; Schutz, *Collected Papers I*, p. 249; also see Natanson, "Introduction," in *Reflections*, pp. xx–xxi. For a discussion of the medical clinic as a life-world, see Engelhardt, ibid., pp. 149-153.
and their work. The roles, codes, and traits considered valuable by the profession represent a construct of identity which physicians absorb: "I am a doctor; doctors think in this manner. Traditionally, doctors behave in these ways." The physician also is a man or woman, husband or wife, father or mother, friend, and human being -- a member of the world of everyday life. The accent of reality can shift from one to another of these areas depending on the attention of the person. Being a physician does not make a person necessarily a better mother, father, friend, or human being. However, in matters of medicine the accent of reality of the medical profession is very strong.\textsuperscript{33}

In short, the medical profession represents a finite province of meaning characterized by an accent of reality establishing the habits, relevances, and focuses that are taken for granted in a doctor's work. This accent is to be found in the profession's tradition and knowledge passed on in the training and socialization accompanying membership in the collectivity. The role of knowledge in shaping the medical accent of meaning can be disclosed by bracketing the usual assumptions about the way students are

\textsuperscript{33}A doctor may come to see herself as the physician-who-is-also-a-mother. Physicians argue that the "medical" accent, given the nature of their work, functions most effectively in rendering reality meaningful. Thus, the medical accent is very strong one and colors the doctor's "standpoint" in the everyday world. When different provinces' values collide, the doctor's view is strong. It is hard for a doctor to "bracket" the profession's accent. After all, the doctor "knows" that he or she knows more than the patient. The professional takes for granted the belief that he or she can be trusted with that knowledge.
socialized or assimilated into the boundaries of the profession through their education, training, and experiences in medical school.34

The formal knowledge (the theory, techniques, models, and the "facts" held to be significant by the profession in terms of its work) transmitted in medical school identifies important characteristics of medicine. In medical education, this knowledge may take the shape of an essential "core." Other knowledge becomes optional or peripheral knowledge. Thus, medical knowledge reflects a given order in the larger domain of knowledge and the world of work. Hence, the status of formal knowledge as a cultural artifact, as constructed by a particular province of meaning and taken for granted by its members, remains hidden to the public (and to many doctors, as well).35

Functional and interactionist sociological studies of medical education assume a distinctive institutional ethos into which students are assimilated. This assumption portrays the socializing agency as homogeneous and segregated from the outside world.36 However, there is no "typical" medical school, curriculum, faculty, or student. Medical students do not learn


35Atkinson, pp. 235-236.

"medicine" in any absolute sense. They do not assimilate a single package of
knowledge and skills which are then applied throughout the course of their
subsequent careers. There is no ideal medicine which exists universally,
absolutely, and independently of everyday practice in clinical and social
settings.\textsuperscript{37} Medical knowledge is organized knowledge -- the way in which it
is organized and thereby taught depends upon the specialty and the medical
model chosen.\textsuperscript{38} The accent of reality does not derive from a universal set of
data, but it does create a generally typical way of regarding medical work.

\textsuperscript{37}All knowledge transmitted through education is in a sense arbitrary in that
there exists no absolute, pre-given corpus of knowledge which self-evidently
presents itself as a curriculum, inherently endowed with order and
sequential organization, acceptable to all experts in any field. Curriculum is a
device of cultural imposition whereby knowledge is classified and combined.
There is no ideal medicine "out there" to which the curriculum corresponds
as a mere reflection or copy; Atkinson, ibid., p. 235. Yet medical students do
learn some medicine -- or some version of it -- through their absorption into
the accent of meaning, the habitus, the relevances, habits, horizon of
meaning, and the knowledge and skills which characterize the profession
during a particular historical period.

\textsuperscript{38}It is important to note that there is professional segmentation within a
medical school. A faculty claims "professional autonomy" in the conduct of its
work, and exercises that autonomy in light of segmented interests and
allegiances. A medical school's curriculum is organized and divided according
to specialized bodies of knowledge. It reflects the specialized segment's
position in the order of knowledge and social relations; R. Bucher, "Social
Process and Power in Medical School," in M. Zald, ed., Power in Organizations
(Nashville: Vanderbilt University Press, 1970), p. 70. Therefore, it must be
recognized that medical knowledge varies among physicians. For some, it
represents technical expertise; for others, it is bedside manner or knowing
how to manipulate the health care system. All share knowledge relating to
medical matters in the broad sense and in this possess more knowledge than
the patient-public.
Granted these variations, two characteristics of the profession's accent which indelibly mark the physician are an emphasis on "personal judgment" grounded in a "clinical perspective."\textsuperscript{39} There has been a tendency to regard these emphases as an individual's psychological adaptations to the conditions of his or her work. However, an investment in personal judgment and a clinical perspective allows the physician to maintain a position of authority even as knowledge and work conditions change.\textsuperscript{40} Medical knowledge is the key to power and authority within the field of medicine and of the field in the social structure. It is in the self-interest of the profession to foster the attitude that this power is beyond the ability of laypeople to understand. The emphasis on the physician's personal judgment maintains the importance of personal knowledge and personal experience as a component of the doctor's authority and professional persona. The prerogative for decision-making thereby remains in the doctor's hands. The assumption of a clinical perspective serves to separate the physician from the patient and reinforces the value of the physician's expertise. The emphasis on a clinical

\textsuperscript{39}See Atkinson, pp. 236-237.

perspective determines the way knowledge, techniques, skills are selected, mastered, and applied in the world of working.41

Medical education perpetuates and reproduces this view of medicine. The practice of clinical instruction reproduces the characteristics of empiricism and the distinctive approach to disease and doctoring of hospital-centered medicine.42 The emphasis on medical knowledge separates the profession from the lay public, but it also legitimates a partial version of professional work and interests (e.g., a hospital-centered versus home-centered medical care). Emphasis on knowledge as a primary focus in medicine promotes a consensual view of the legitimacy of that knowledge while masking the social differences it serves to promote (between doctor and patient or doctor and doctor).

The development of typical knowledge and the accent of meaning it generates represents a process of "boundary maintenance" which acts reflexively to distinguish the medical profession from other institutions. The medical profession, as a status profession, and the physician's claim to membership in it, revolves around the knowledge and the skills which it

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41See Schutz on science in "The World of Scientific Theory," Collected Papers I, pp. 245-259. There is a marked social barrier between students and faculty. Training is characterized as "trial by ordeal"; Atkinson, pp. 224-241. Armstrong argues that the typical preclinical phase is informed by principles of strong classification between subject contents (or a collection code). The clinical phase of training is marked by a shift towards an "integrated code." The former is based on more explicit bases for authority and control. The latter is based on implicit orders of meaning and control; see D. Armstrong, "The Structure of Medical Education," Medical Education 11 (1977), 244-248.

holds to be important because they separate it from other occupations in the world of working. The medical profession presents the knowledge it possesses as the best available knowledge for its work. The outward face of the profession is homogenous; it encourages the public to assume that all doctors share the same knowledge, expertise, and values. However, the dedication to knowledge by the profession promotes the appearance of consensus while actually masking segmental perspectives. The profession's accent, which stresses a dedication to knowledge, is seen as incorporating intraprofessional interests and specialties, as well as reproducing the esoteric expertise which is held to be the preserve of the profession as a whole.\textsuperscript{43} The fact that medical knowledge is socially constructed and controlled obscures the multiparapharious nature of knowledge and conflicting claims which exist within the profession.

Thus, the "like-mindedness" of the medical profession can be elucidated by the application of phenomenological concepts. A discussion of focusing, habits of mind, relevances, finite provinces of meaning, and accents of reality illustrate the manner in which an individual physician actively constructs the meaning of his or her experience from within a particular horizon of meaning. While there is recognition that physicians' conceptualizations differ from their patients' experiences, the difference is often assumed to be simply a matter of different levels of knowledge with the physician's conceptualization being regarded as the more accurate. However, as Toombs points out, a phenomenological analysis of the "reality" or meaning of illness reveals more than a difference in knowledge levels.

\textsuperscript{43}Atkinson, in Dingwall and Lewis, p. 239.
between patient and physician. There is a difference in understanding or interpreting illness, as well.\textsuperscript{44} The doctor's understanding is shaped in significant degree by the profession's horizon and accent of meaning. This professional understanding becomes typified as part of the knowledge necessary to the physician's work, but it may not correlate with the patient's experience of illness-as-lived.

The physician adopts the stance of a disinterested observer, armed with knowledge and practical skills, who subscribes to the clinical perspective, and who interprets experience from a particular point of view. Within the medical province, the doctor is the center of his or her own existence while dedicating himself or herself to the welfare and well being of his or her patient. Selfless service or altruistic service is presented as an ideal of professional work. The medical accent of reality includes the value that the physician is one who transcends the intentionalities of the everyday world to be of service to those who need help. This value distinguishes the medical professional attitude. However, it also places doctors in a position of power -- the power to help -- and allows them the social license to control the limits of their work.

Doctors do not entirely transcend everyday intentionalities, however. To do their work and to do it "well," they impose their preconceptions and values on everyday reality. Physicians easily become concerned not so much for the particular individuals who are the objects of their work, but with the "types" they represent. They attempt to see through the particulars to that

\textsuperscript{44}See Toombs, pp. 219-240, for a discussion of the difference in interpreting the meaning of illness by physician and patient.
which is essential to the type. This activity of typification is common to all people. The expression "the human body," for example, does not refer to any particular body but to the image of "body" created in our minds. However, to the patient or family encountering the conditions of illness, the human body has become a crucial item in their world. The disruption of the natural attitude of well-being caused by illness threatens the integrity, the sense of wholeness, or the health of the body which previously had been taken for granted.

45 As another example, diagnosis is the effort to organize particular symptoms into "typifications" of a particular illness.

46 Schutz, Collected Papers 1, pp. 28. Also, see Peter Manning and Horacio Fabrega, "The Experience of Self and Body: Health and Illness in the Chapas Highlands," in Psathas, pp. 251-301.

47 The terms integrity, wholeness, and health in this context broach the controversial subject of appropriate definitions of health and illness; see Tom L. Beauchamp and LeRoy Walters, eds., Contemporary Issues in Bioethics (Belmont, CA.: Wadsworth, 1982), pp. 44-86.
Thus, the physician and patient understand and experience health care from very different horizons of meaning.\(^4\) Ordinarily, a person takes health and well-being for granted. The ability to act, move, and make choices, to be autonomous within the limits of the everyday world, is assumed. Illness disrupts this aspect of the natural attitude. Suddenly, the person becomes a patient, and moves rapidly into the province in which meaning is established and largely controlled by the physician. Given that the physician’s expectation of social relations depends on his or her accent of meaning, it is necessary to investigate the way in which this accent is shaped by the scientific attitude which characterizes medicine.

The Influence of the Biomedical Model on the Medical Accent of Reality

In the following section, I make the observation that scientific knowledge, as represented by the biomedical model, is a major component of the physician’s definition of “knowledge.” This knowledge, and this way of

\(^4\)Toombs, p. 220. For instance, there has been much attention given to informed consent in recent years. For many bioethicists and doctors, the patient’s autonomy is acknowledged and upheld by having the doctor explain procedures and receive the patient’s permission to proceed with therapy. One aspect of the debate over informed consent revolves around the definition of adequate “information” — when is a patient adequately informed? Some doctors believe that patients are unable to adequately understand the information presented, argue that one responsibility of the physician is to act in the patient’s best interest, and conclude that paternalism is not a bad thing. Others counter by arguing that patients can understand if an attempt is made to make them more “knowledgeable.” Toombs’ essay makes it clear that the issue is more complex. The two parties occupy different horizons of meaning and thus experience the “reality” of their relationship differently. “Knowledge” is not the issue. Focusing on informed consent as if the issue is a matter of objective “facts” can distort the underlying meaning of the relationship.
knowing, separates the physician from the general public. I am not arguing that all doctors possess the same knowledge, scientific or otherwise, nor am I engaging in a fashionable critique of the medical model. However, because of its influence on the profession's accent of meaning, scientific knowledge affects the manner in which physicians typically define their relations with others. Thus, the biomedical model and the behavior it engenders are assumed by doctors in their evaluation of competence in themselves and their colleagues, and affect their relations with patients. The typical patient, or member of the public, ordinarily does not share this perspective. This difference in "horizons" represents the potential for conflict and misunderstanding, even as it serves to delineate the physician's personal and social identity.

Pellegrino argues that in the twentieth century, medicine stresses clinical observation, careful study of natural history of diseases, and the cultivation of a fund of empirically verifiable data as the basis for its work (and its claims to authority). An "empirical" science describes the particulars of objects in the everyday world and forms generalizations referring to and based on these typifications. Generalizations refer to all occurrences of a type or class of object. Wedded to a scientific and clinical vision, modern medicine

is based in the conviction that human illness can be described in physicochemical and quantified terms. The increasingly close alliance of clinical medicine with physiology, biotechnology, biochemistry, pharmacology, and other biomedical sciences in the last several generations has resulted in great advances in the armaments of clinical medicine. These advances also raise philosophical and theological questions as the alliance shapes the habits, focusing, and relevancies of doctors, and, thus, the meaning of "medical care."

Philosophically, science is a "public" enterprise. It endorses a method based on the communal and empirical verifiability of its claims. In another crucial sense, however, science represents a perspective and an investigational method distinct from the attitudes of the everyday world. Its isolation from the world stems from the revolutionary nature of its search for truth and is one of its most distinctive features. By seeking a unified and internally consistent interpretation of meaning of the world and the relations of objects within the world, science requires a fairly strict demarcation from the fuzzy, ad hoc, and heterogeneous meanings of everyday life, in which

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"reality" is taken for granted, ordinarily unquestioned. Science brackets the natural attitude of the everyday world and incorporates careful and systematic questioning as a basic component of its "work."

In this demarcation or bracketing, the orientation of science lends itself to a certain "style." When applied to medicine, this style (or horizon of meaning) creates: 1) parameters of meaning for each physician; 2) parameters of meaning for the profession itself (of which each doctor is a part whether closely or distantly); and 3) parameters of meaning for the image of the physician presented to clients, government, or the public at large. The alliance of biomedical science (and the scientific horizon, generally) creates a "perspective" not shared by the public or the patient. Science "sets off" physicians and the medical profession from other people and other institutions. This distinction creates certain expectations of medical work on the part of both doctors and patients.

The world of scientific contemplation is quite distinct from the naively experienced, immediately perceived reality of the everyday world. While engaged in a scientific project, scientists detach themselves from their biographical situations and adopt the accent of meaning relevant to the scientific province. Relevancy in scientific work may be quite irrelevant in the scientist's daily life and vice versa. By stating the problem at hand the scientist defines relevant considerations and guides the process of inquiry.


52 Schutz, Collected Papers 1, p. 232.

53 Ibid., pp. 37, 249.
Doctors attend to their work in the "disinterested attitude" of the scientist. They distance themselves from their own existential situation to achieve objectivity, and establish their decisions on clinical observation and a stock of empirically verifiable data.54

Such an attitude claims an autonomy and freedom in work. To accomplish the goals established by science's horizon of meaning, the scientist believes he or she requires and deserves some special dispensation from the ordinary demands of everyday life. From within the medical field's horizon of meaning, the physician is working to help the patient and, therefore, deserves the autonomy and authority necessary "to do the job." The pursuit of additional medical knowledge and expertise is for the benefit of present and future patients (thus, the public at large). As medicine moves to an alliance with science, the physician's accent of reality shares this expectation of autonomy and freedom in matters of clinical work or research.55

The medical accent of meaning readily adopts a scientific orientation. The phenomenological concepts of a finite province of meaning, focusing, relevances, and habits of mind provide a model for the way medical science is organized, and, thus, constitute the horizon from within which physicians

54Toombs, p. 226.

55Under the medical province's horizon, the physician feels that he or she "deserves" these freedoms. He or she "expects" and "requires" autonomy and authority -- they are "necessary" to medical work. Without them, this work would suffer; see Samuel Gorovitz, "Baiting Bioethics," Ethics 96 (January, 1986), 356-374. Thus, those who question this taken-for-granted attitude are perceived as outsiders, as threats to "professional" work.
see their "work" and their relations with others. The habits of mind which render experience thematic define a doctor's emphasis in regard to his or her practice. The scientific habit of mind provides a horizon of meaning, a motivation for focusing, and a means of constituting reality quite distinct from other interpretations. According to the medical profession's habits of mind, illness and relations with people are rendered thematic in terms of the "objective," quantifiable data.

Yet the very procedures science maintains also serve to limit and curtail scientific investigation. The "best" scientific writing is practical, precise, orderly, and both usable and disposable. It serves not as literature, but as an aid to collegial communication. A "good" diagnosis, a clear medical chart, and assertive treatment establish the reality of a situation by reducing its ambiguity.

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56 Even alternative points of view take on meaning in relation to a particular horizon of meaning. Counter-opinions are given meaning in terms of the accent of reality accepted by a person. See Thomas Kuhn, The Structure of Scientific Revolutions (Chicago: University of Chicago Press, 1970). This particular focusing and objectivity determines the meaning of physicians' understanding of health, illness, and of their "work." The physician is trained to see illness essentially as a collection of physical signs and symptoms which define a disease state as a "typical" case. The physician is trained to "take for granted" a certain typical way of thinking, attending to, or focusing on the "reality" of illness. The values of medicine (drawn from and passed on in its tradition, its codes, and its training) come to shape the doctor's attitudes towards life and death, the autonomy of the patient, and his or her own sense of self-worth and authority. The doctor's understanding of "the way things should be" is shaped by the province of meaning in which he or she operates.
However, the everyday world is interesting to the members of the scientific world, whether as an object of study or an object of practice. The world outside of the scientific province of meaning remains the world of paramount reality, even for scientists, and trades more freely in ambiguity. Therefore, it constantly intrudes into the finite province of science in a process that continually threatens either the rigor of the analyst or the faith of the practitioner.

Specifically, scientific knowledge ineluctably derives from questions largely determined socially and culturally rather than by the object of study itself. For instance, there is a general public belief in the scientific basis of medicine precisely because disease and illness are perceived as natural, malignant phenomena. Thus, the knowledge gap between patient and doctor ordinarily is not resented by patients because doctors are seen to use their

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57 Strong, pp. 71, 74.

58 It is the complexity and ambiguity of the everyday world, the ambiguity of meaning between provinces of reality, that gives rise to the disciplines of phenomenology, hermeneutics, and medical science.
knowledge and skill against a natural enemy. The demands and interests crystallizing in professional practice constitute one of the mechanisms through which such determinations take place. If the concerns of everyday reality change, as they will over time, the constructs, typicalities, and meaning systems of science and medicine also will change.

Scientific knowledge is always preliminary and is contingent on paradigms of fundamental concepts, assumptions, accepted modes of investigation, and standards of empirical adequacy. These paradigms change over time. For example, it was once believed that uroscopy, an ancient diagnostic procedure that involved the visual examination of a

59 Horobin, pp. 84-105. When illness was characterized by demonic possession, the questions of the "expert" were formulated differently, and the role of the practitioner was conceived accordingly; see William May, The Physician's Covenant: Images of the Healer in Medical Ethics (Philadelphia: The Westminster Press, 1983). In a different example, Horobin argues that the knowledge gap between doctor and patient is not greater than the one between lawyer and client. The gap is less resented in medicine. Lawyers seem to create the circumstances under which their skills are needed (p. 94). I would say that due to an erosion of trust in physicians, many people are beginning to resent doctors. Illness may still be regarded as a "natural" enemy, and certainly the physician is perceived as an ally. However, the anxiety and fear occasioned by illness also is associated with the doctor. People feel that the "expert" creates the circumstances under which his or her skills are needed, if only because the physician cannot fulfill the "promise" to cure; see Stanley Hauerwas, "Medicine as a Tragic Profession," Truthfulness and Tragedy (Notre Dame: University of Notre Dame Press, 1977), pp. 184-202.


patient's urine, provided a viable means to gain knowledge of the patient's illness. Paracelsus challenged this prevailing paradigm by arguing that chemical analysis could reveal signs of disease hidden from visual examination. Although this proposal was criticized and strongly resisted by those practitioners who stood behind traditional, authoritative diagnostic knowledge, over the next few centuries the introduction of chemistry into medicine established the laboratory as an important element of diagnosis.62

Scientific work leads to its own eventual modification. This revisionist quality does not lead to the abandonment of science and the scientific method. Instead, it reinforces science's authority in the eyes of its adherents.63 Most practicing physicians take for granted the structures of typicality offered by the biomedical model. Any call for revision becomes a


63Reflexivity serves to reinforce itself; see Hugh Mehan and Houston Woods, The Reality of Ethnomethodology (New York: Wiley, 1971). Also, Kuhn's discussion of the process of normal science shows that the emergence of anomalies does not erase a scientist's allegiance, trust, or faith in the scientific method, but, rather, reinforce his or her commitment to the pursuit of a more adequate paradigm; Kuhn, pp. 66-110.
challenge to the accent of meaning which is the basis for their autonomy and authority and is resisted.64

Problems of a Scientific Approach to Medicine

There is a changing perception among physicians that the biomedical model of illness and an emphasis on curing represent necessary and sufficient conceptions of medicine.65 However, the taken-for-granted value of "scientific medicine," rooted in its commitment to expertise and technical skill, remains an essential component of the medical professional's sense of


identity and meaning. As I will show in the third chapter, the way the physician gives and receives or accepts trust is determined by the medical province’s horizon of meaning, and, thus, shapes the manner in which he or she relates to others and understands and reacts to moral dilemmas. The climate of suspicion surrounding medicine creates the illusion of trust within the health care relationship. This climate results from problems caused by the biomedical orientation to medical care.

Due to the demand for theoretical detachment, the scientist’s primary role is that of commentator rather than practitioner in the everyday world. Within science, one’s audience and judges are solely one’s colleagues who, ideally, share a purely disinterested commitment to truth. The everyday world, however, has an interest in work that is both more practical and more immediate. In attempting to be a scientist-physician, the doctor is caught between the demands of the scientific orientation within which he or she operates and the immediate concerns of the people whom he or she professes to serve. As we have seen, the set of rules and practices by which the boundaries of scientific medicine take shape have a special form. Since

66 Few practicing physicians find the biomedical model satisfactory in caring for patients. By emphasizing the scientific province and the accent which this focus places upon medical practice, the biomedical model does not allow a doctor to deal with his own concerns as a person dealing with other people in the world of daily life. See Michael Schwartz and Osborne Wiggins, "Science, Humanism, and the Nature of Medical Practice: A Phenomenological View," Perspectives in Biology and Medicine 28 (1985), pp. 331-334; Eric J. Cassell, The Healer's Art (Cambridge: MIT Press, 1985), pp. 20-23; and Toombs, p. 235. However, medical education and curriculum established by academic or research oriented professionals still is influenced by the model; see Carlton’s discussion of clinical inculcation, pp. 65-83.

67 Strong, p. 72.
medical work takes place in the world of paramount reality, it must be practical and have practical effects. However, physicians' work involves interactions with others who do not share the profession's accent of reality and horizon of meaning. The goals and values of doctor and patient may not coincide and may lead to struggles over autonomy and authority in medical care.

The medical profession's claim that autonomy and authority are necessary to the work of physicians is understandable, inasmuch as the profession is a social institution interested in controlling the parameters of its work. While maintaining nominal control through licensing, society allows the medical profession great latitude in defining and conducting its "business." We issue licenses to ensure that professionals are qualified, yet these licenses also allow the medical profession to police its own ranks, to be the judge of its limits of expertise and knowledge. Rights and privileges are granted to physicians by both statute and popular approval in return for specific duties and responsibilities.

However, if the profession's claim to autonomy and authority is based on expert knowledge gained from the alliance of medicine with science, certain problems result. The activity of "doing science" has no general

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68Biomedical science and its role in the medical accent of reality has an effect on doctors' perceptions of their work. Although controlled by the standards of the scientific community, scientists generally are not licensed or controlled by the public. This "autonomy" influences the physician's claim to authority. See Stephen Toulmin, "The Meaning of Professionalism: Doctors' Ethics and Biomedical Science," in H. Tristram Engelhardt, Jr., and Daniel Callahan, eds., Knowledge, Value, and Belief (Hastings-on-Hudson, NY.: Institute of Society, Ethics, and the Life Sciences, 1977), pp. 254-278.
statutory restraints. Those who work in the natural sciences are not subject to the same types of formal regulations, public restrictions, or controls as the professions. When allied with medicine and the professionals who practice it, biomedical science creates a powerful impetus for the pursuit of knowledge and an accompanying desire to put that knowledge to use. The combination of biomedical knowledge and technological proficiency enables physicians to characterize themselves as gatekeepers and controllers of power and expertise. This combination encourages them to feel less restrained by social control mechanisms such as regulation. It also encourages a tendency towards objectivity and exclusivity on the part of the profession in its relations with the public. Physicians take for granted the expectation that great latitude in autonomy and authority is necessary in their work.

However, science is only one theoretical province within the world of daily life. Within the boundaries of the scientific horizon of meaning, premium emphasis is placed on working with objective, clear, and precise

69 Toulmin, ibid., p. 257. Of course, the organizations through which scientific research is applied may be regulated. Heavy government financial investments since World War Two have led to some informal controls. As medical science moves into the area of genetics, there are signs of increasing government concern. However, scientific investigation itself has generally occurred without stringent government controls. The feeling has been that scientific knowledge rebounds to the benefit of society, and restrictions would limit the possibilities of scientific gains.

technical data. It becomes easy to place an emphasis on technical proficiency and argue for value-neutral technical judgment independent of moral considerations. The clinical perspective, or the concentration on technical matters, helps isolate the physician from the pluralistic concerns of everyday life. However, medicine, at a fundamental level, involves persons interacting in the "real" time and bodily nature of everyday life. A clinical judgment, e.g., to prescribe Demerol or Darvon for a compound fracture, is partly a technical matter, but the decision is not value-free. Given a similar medical situation, two doctors may prescribe different analgesics depending upon their understanding of human values, attitudes towards pain and suffering, and compassion for the patient.71 Therefore, medicine cannot be reduced to a value-neutral science, although the expert knowledge upon which it builds largely derives from the scientific accent of meaning and the scientific method. Medical work involves the physician with the physical lives, beliefs, expectations, and values of people who occupy the multiple realities of the world of daily life. The physician knows more than a patient about medicine, but biomedical knowledge is not all there is to medicine.72

Natanson argues that the world of immediate experience has a precedence over the derivative world of science. The world is experienced first in its immediacy, and only upon reflection do we thematize experience

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71 Dyer, p. 224.

72 Again, the physician’s knowledge can encompass more than pure technical or biomedical scientific knowledge. The doctor must know his or her patient, that person’s wishes, feelings, and desires.
in theoretical terms and scientific constructs. Husserl states that the lifeworld is the "foundation of meaning" for science (as it is for all of human existence), but that this basis of meaning has been forgotten because of the "pervasive spirit of abstraction" which dominates science. All scientific experience necessarily presupposes pre-scientific experience. A cardiologist is concerned with "heartbeats" only because he or she already knows in a pre-scientific fashion how important the heart is in human life-experience. Each province of meaning within the world of everyday life, e.g., science, medicine, or religion, filters everyday reality through its own accent of meaning. It is from the struggle of "perceptions" that the lifeworld forms a "consensus" regarding the reality of human existence, and in turn, this filtering comes to shape the lifeworld. This process is fundamentally social, slow in evolving, and, thus, "created" in every act of abstraction.

An eidetic analysis of the taken-for-granted accent of the medical profession as a province of meaning reveals that one basic component of physicians' claim to autonomy and authority is their expert knowledge. Through use of the phenomenological device of "bracketing," we can peer beneath the accent of meaning which sets the boundaries of the ideal-type on the medical profession and its work. The second foci of the profession, the fiduciary component of medical practice, is revealed.

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75 See Schwartz and Wiggins, pp. 331-361.
Summary

The modern practitioner possesses knowledge of and access to medical techniques, procedures, and medications that far outstrip the practice of fifty years ago. The marriage of medicine and biomedical science has been a remarkable success. The medical accent of meaning's investment in the scientific method, clearly, provides physicians with a degree of quantitative and qualitative knowledge of health and illness that is superior to the general public's knowledge. At the same time, the particular characteristics of a clinical perspective or medical vision are rooted in this accent. The organization, control, access, and transmission of medical knowledge is structured by the profession and serves to shape the attitudes of the profession's members. The medical profession becomes the institutional repository of knowledge and skills, and controls admittance to its ranks through a credentialing process, as well as maintaining some degree of control in the licensing of its work. Thus, the cultivation and possession of superior knowledge is a necessary professional trait, but such a trait is acquired (and required) to enable the physician to practice an occupation. A status profession is a social category for distinguishing an occupation whose members have in common credentials testifying to a degree of higher education which is the prerequisite for work in the world. Inasmuch as

Freidson, Professional Powers. Through the history of medicine, the everyday world gradually gave over to doctors the control of the medical province. However, medicine is one among multiple realities. The world of daily life, the world of working, is the world of paramount reality. Thus, medicine exists in a tension with other elements in society; see Schutz, "On Multiple Realities," pp. 226-233.
physicians "work" in the everyday world, their knowledge and expertise represent elements of social, economic, and political power.

The phenomenological method consists in uncovering the meaning-structures through which the objects of the social world are presented or given to us. We apprehend objects in the social world not as individual and unique objects, but as "physicians" or as "patients." These noematic unities of meaning through which we grasp the objects of the social world are called "typifications."\(^{77}\) These typifications are, by necessity, socially derived (i.e., socially shared, transmitted, and reinforced). Thus, they are fundamental to our perceptions of present reality, derive from earlier typifications, and shape our expectations of the future.\(^{78}\) Although we assume these entities to be "typical," there can be no one fixed, essential nature of the physician or the patient.

Nor can there be a typical doctor-patient relationship. The socialized meaning-structures, the typifications, of social reality appear to be "discoverable," invariant over and against their concrete manifestations in their divergent social milieux. At the same time, however, these typifications are "socially derived."\(^ {79}\) Thus, while we may speak of a typical doctor,

\(^{77}\) Refusing to follow Husserl's transcendental reduction which places in brackets the existence of the "other," Schutz argues that the social world is constituted by individuals who typify the world; see Collected Papers 1. Also, see Edmund Husserl, Ideas, trans. by W. R. Boyce Gibson (New York: Collier Books, 1964). For Husserl's discussion of typicality and the transcendental reduction, see Sections 18-21, 82-85.

\(^{78}\) Barber, pp. 58-59.

\(^{79}\) Ibid., p. 59.
patient, or physician-patient relationship, we must realize that these are
"created" phenomena.80

The medical profession is an example of a finite province of meaning.
It reflects or typifies a particular way of focusing, habits of thought, and an
accent of reality which are taken for granted by its members and determine
their view of "work." The technical/scientific component of medical "work" is
a primary determinant of the accent of reality that characterizes the natural
attitude of the medical profession. This attitude reinforces the view that
more knowledge and more expertise is a basic "good."81 Thus, a doctor
thinking about bioethics or humanistic medicine remains influenced by a
biomedical model taken for granted as constitutive of the knowledge he or
she requires to do "good work." Recent attempts to balance the empirical and
scientific side of medicine with an emphasis on humanistic medicine shape
the physician's understanding of the meaning structures which lie behind his
or her work. However, these attempts do not suddenly and thoroughly
transform medicine.

Medicine's movement towards a biomedical, scientific base has led to
the evolution of a particular accent regarding the meaning of its work and
the structure of its relationships with those within and without its

80 It is well to realize that the medical profession has undergone a long
history of evolution in arriving at its present typification. Likewise, the
nature of the doctor-patient relationship has changed over time, forming and
reforming itself in various ways.

81 Looking ahead to ch. 3, this attitude in and of itself is not an "evil." It is a
"natural" result of a particular accent of reality. It comes to grief when it
leads to inauthentic giving and receiving of trust between physician and
patient.
boundaries. While their biographical situations and their specialties within the profession vary, doctors see themselves, their colleagues, their patients, and their "work" from a general perspective created by the cumulative tradition and horizon they share as members of the medical profession. Criticism of a particular medical model or construct of reality is seen in terms the accent of that construct. Such criticisms are "explained away" in terms of the model. When such reductionism fails, a genuine crisis of meaning results until an acceptable accent of reality is restored. The critics of the biomedical model, and the professional behavior it shapes, come to their criticism over and against the prevailing model.

The biomedical model has been a major influence on the physician's accent of meaning and the medical province. Even as criticism has been directed at the effect this model has had in shaping the typifications of the physician-as-professional, the medical profession will not return to its pre-scientific days. First of all, the scientific orientation leads to increased knowledge and expertise. Second, a scientific orientation in its work results in therapeutic tools to enhance caring and curing. Third, the development of a scientific orientation within the profession has led to increased power and authority for physicians. People trust doctors, at least in part, because there is a scientific basis to medicine. They assume (and want to assume) that doctors know what to do (and know what they are doing). The profession's investment in knowledge and expertise is designed to enhance the public's trusting attitude. It also fosters the granting of power and autonomy to the medical profession (in a mandate for research and the exercise of knowledge-as-power). The profession's commitment to scientific knowledge is fundamental to its work and its identity as a province of meaning.
According to phenomenological theory, the world of working "is the archetype of our experience of reality. All the other provinces of meaning may be considered as its modifications."\textsuperscript{82} The province of science is more theoretical. When allied with medicine, however, it has practical applications and effects in the everyday world. Therein lie the roots of the public's present crisis of confidence. The strength of the accent of the biomedical province has created strong organization, attitude, and purpose among physicians. The result is a great advance in medical "formal knowledge" and the expertise based upon it, and the taken-for-granted claims by physicians to professional autonomy and authority.

In the next chapter, I will argue that, unfortunately, the professional and social commitment by physicians to knowledge also fosters an uneasiness, a suspicion, on the part of the public in its contact with the medical province. The basic orientation in medicine towards biomedical science nourishes an inverse psychological and social relationship between doctor and patient. The greater the drive towards knowledge, the more power and authority the profession exhibits. In spite of additional knowledge, medical technology, and miracle cures, the public feels less satisfied and more uncertain in relation to physicians.

Even as the clinical perspective or accent of meaning leads to medical advances, medicine cannot resolve the questions its success creates. The very success of biomedical science produces a concomitant public desire to reassert social control over the medical profession. Since the public cannot truly compete on the level of professional knowledge and expertise, there

\textsuperscript{82}Schutz, "On Multiple Realities," p. 233.
arises a natural desire to use trust as a form of social control. This state of affairs leads to "shock" and disease as suspicion and an erosion of trust grows within the health care relationship between physician and patient. This development reflexively affects the physician's sense of the fiduciary focus which gives meaning to his or her work.
Chapter Three
The Fiduciary Focus of the Medical Province of Meaning

Introduction

A dedication to expert knowledge forms a fundamental component of the accent of meaning which defines the physician as a professional. A fiduciary commitment also is fundamental in characterizing the physician, and is the second focus that marks the medical profession’s accent of meaning. In the previous chapter, I discussed the influence of the scientific natural attitude in shaping the boundaries of the medical profession as a province of meaning within the everyday world. In this chapter, I will examine the role of trust and trustworthiness in anchoring the medical profession’s accent of meaning.

The medical profession is a social institution whose members possess the knowledge which allows them the power and authority to control their work. The justification for this social power rests on the profession’s claim of fiduciary service to the public.1 The fiduciary dimension of professional identity serves to define physicians’ understanding of their colleagues, of their patients, and their self-awareness or self-consciousness of themselves as physicians. The claim to trustworthiness is a taken-for-granted value which has become an aspect of the medical profession’s accent of reality.

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However, even if physicians are wholly committed to certain professional values (such as trustworthiness), goals, and rules, they must be given the general public's trust to practice their skill and their art.² The public generally perceives physicians as trustworthy. Thus, in conjunction with its efforts to monopolize its service, the profession's stress on a fiduciary commitment to service shapes the public's view of physicians' performance. The public regards physicians as trustworthy because it accepts the profession's claim to a fiduciary commitment. This particular claim, and the public's acceptance of it, also shapes doctors' work attitudes and behaviors.³

By self-definition, and in the eyes of the public, the physician is dedicated to placing the good of the patient before his or her own benefit.⁴ The public believes, or wants to believe, not just that the physician's knowledge and skills are superior, that he or she is competent, but that he or she can be trusted to use this superior knowledge and competence for the


⁴The expression which epitomizes the profession's ethics is "primum non nocere," not "caveat emptor."
good of the person in need. As a result, people who enter the
phenomenological province of the ill are encouraged (indirectly by their
everyday natural attitude and directly by the medical profession) to assume
that the doctor is trustworthy. The patient expects that the physician will act
in his or her best interests, or at least not use superior knowledge to harm or
exploit him or her. The expectation of trustworthiness is part of the public's
accent of meaning regarding the medical profession.

This expectation is understandable. With the explosion of biomedical
technology, and with the publicity and infusion of government monies into
health care and research, the public has great expectations of physicians.
However, knowledge consists not merely of knowing what to do in a given
situation, but also includes knowing what should not be done.Given the
alliance of medicine with science, the gap between the specialist's knowledge
and the public's knowledge is wide. The public must trust that doctors are
masters of their "craft," but also that physicians know their limits. Since a
gap of knowledge exists between the physician and the patient, and since the
consequences for a patient can be mortal, the physician is not given
unlimited power and control by society.

There is a reciprocal or correlative relationship between knowledge
and trust. Because people trust doctors, the physician is given license to put
his or her knowledge into practice. In turn, because the profession does
control superior and powerful knowledge, rather than the exercise of
unadulterated power, authority, and expertise, people expect care, concern,
and compassion from their physician. In terms of social relations and
dynamics, the trust which the profession advances and claims to represent is
given to it by the public with several limitations.
First, credentialing and licensing are forms of control or limitations designed to ensure the profession's qualification and competence through the satisfaction of educational requirements and state regulations. However, as we have seen, the medical profession is involved with licensing and credentialing standards through its advisory capacity in government matters and accrediting bodies. As long as it is the physician and not the patient, consumer, or government who defines standards of professional practice, the patient is forced to trust the doctor. Therefore, second, self-policing or disciplinary action by the profession, historically rooted in its codes of ethics, is demanded by society as a form of social control over physicians. However, in the peer review of medical boards, the profession retains the balance of power to evaluate and judge the conduct of its own members. A third, more indirect means for social control of the medical profession is public trust, or the willingness of people to place themselves, their bodies and their lives, in the hands of physicians.

The unequal balance of power between physicians and the public in terms of knowledge and the development of professional standards clearly places the latter at a disadvantage. Unable to impose ordinary social and economic controls upon the monopoly of the profession, through the

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centuries an emphasis has developed on the essential ingredient of trustworthiness in relations between doctor and patient.\textsuperscript{7} The health care relationship fundamentally is founded and held in trust and confidence. As the profession's knowledge, expertise, and, consequently, power grow, people begin to demand more exemplary performance, more certainty, and more guarantees as prerequisite for their trust and confidence. If trust begins to lose its efficacy as a form of social control, a second dimension of trust as a form of social control is revealed: The public may begin to distrust the profession. Other forms, such as litigation, regulation, and accountability

\textsuperscript{7}"Ordinary economic controls" refers to an organized alternative to the physician and to restraints on traditional market forces. Faith healers and alternative medical practitioners do exist, but are carefully proscribed by governmental regulations; see Paul Starr, \textit{The Social Transformation of American Medicine} (New York: Basic Books, 1982), Bk. One, Ch. 3; Bk. Two, Chs. 1 and 3. The stress on quality assurance, or assessment may indicate a movement to assert social control over the profession by way of economics and non-professional involvement; see Glenn A. Melnick and Jack Zwaniger, "Hospital Behavior Under Competition and Cost-containment Policies," \textit{The Journal of the American Medical Association} 260 (Nov. 11, 1988), 2669-2675; John Kelley, editorial, ibid., 2715-2716.
increasingly are emphasized as the means for control of the profession's power.8

Often with physicians, there is an implicit demand that patients should trust their doctors and accept their superior knowledge and the authority it represents.9 Often physicians believe that if the patient accepts their authority, the person will regain an authentic responsibility and autonomy (If you follow my orders, you will find that I am right). This conceptualization of trust can be paternalistic (I trust you will follow my orders; after all, I know what is best). Physicians (and patients) also use trust as a weapon of control or manipulation to induce compliance (I trusted you to follow my advice, or I trusted you to cure me, and you let me down). Trust can be used by both parties as an implicit threat to end the relationship (If you disappoint me, I will withdraw my trust from you).


9For instance, Talcott Parsons stresses the element of authority which is part of the relationship in discussing "doctor's orders"; The Social System (Glencoe, Ill.: The Free Press, 1951), p. 464-465. An example of the assumption underlying this authority is, "You can trust me, I know more than you."
Since World War Two the appropriate use and limits of the medical profession's power and authority have concerned many people within and without the profession.\textsuperscript{10} This discussion of limits has resulted in practical benefits for clinical care. During this same period, however, a climate of distrust has developed in which many people seeking help from physicians approach relationship with them more cautiously. In addition to government involvement in medical matters, legal restrictions on the actions of physicians, and an emphasis on auditing and monitoring physician performance, distrust serves as a "functional equivalent" of trust intended to promote effective social control of the medical profession.\textsuperscript{11} These developments affect the fiduciary component of the medical relationship. Many doctors deplore this distrust, claiming that it represents an attitude of anti-science, and an attempt to undermine physicians' authority and

\textsuperscript{10}Following the Nuremberg era, in which the integrity of the profession was tainted by the conduct of Nazi physicians, and coupled with the advances of scientific medicine, various groups within health care have attempted to regain the confidence and trust of the public in their ethical commitment. See the American Medical Association, "Principles of Medical Ethics" (1980); the American Hospital Association, "Patients' Bill of Rights"; and the American Nurses' Association, "Code for Nurses" (1976), in Tom L. Beauchamp and Leroy Walters, eds., \textit{Contemporary Issues in Bioethics} (Belmont, CA.: Wadsworth Publishing Co.), 1982, pp. 122-127. The focus in bioethics on the limits of physician conduct grows out of a methodological commitment to the primacy of moral rules and principles as resources for moral guidance. Recent developments displace the focus on physician conduct in favor of a focus on character; Earl E. Shelp, ed., \textit{Virtue and Medicine} (Dordrecht: D. Reidel, 1985), p. vii-viii.

\textsuperscript{11}Barber, p. 22. Indeed, the recent increase in government involvement, legal and insurance restrictions, auditing, and monitoring has occurred because of the growth of distrust between the public and the medical profession.
autonomy. Such distrust, they claim, hampers doctors' efforts to do the work to which they are dedicated -- to fully serve in the best interests of their patients.\textsuperscript{12} I argue that the public's use of distrust as a means of social control is nurtured by the profession's commitment to medical science. Due to the profession's zealous dedication to the cultivation and utilization of knowledge, ironically the expectation of confidence in the physician's beneficent trustworthiness is disrupted.\textsuperscript{13} As a result, the profession's fiduciary commitment to the well-being of the client is in danger of becoming an illusion of trust.

The place to begin an assessment of the profession's fiduciary commitment is with the meaning of the word "trust." As with the terms "profession" and "knowledge," trust and its seemingly related concepts -- faith, confidence, distrust, and suspicion -- are not well defined in much of the recent literature on professional ethics. "Trust" is used to refer to different things, and different words are used to refer to it. There are different psychological, social, phenomenological, moral, and theological conceptions of trust. The chapter will begin with a discussion of the term

\textsuperscript{12}For a discussion of the importance of "professing" and its ethical implications for the medical profession, see Leon R. Kass, "Professing Ethically: On the Place of Ethics in Defining Medicine," \textit{The Journal of the American Medical Association} 249 (March 11, 1983), 1305-1310. Since the client is not a true judge of the value of the service he or she receives, he or she must trust the doctor's judgment and skill; see Everett C. Hughes, "Professions," \textit{Daedalus} 92 (1965), 655.

\textsuperscript{13}Specifically, the biomedical model fails to insure trust due to an inverse correlation between knowledge and trust: the more knowledge claimed by the medical profession, the more uneasiness or distrust on the part of the public is directed towards the profession.
"fiduciary" as a fundamental focus in defining the medical profession's phenomenological boundaries.

The Profession's Fiduciary Commitment

One attribute or characteristic used to qualify the physician as a status professional is his or her fiduciary relationship with a client. As an adjective, fiduciary conveys the meaning of "the nature of a trust." A fiduciary relationship, then, involves a relationship "holding, held, or founded in trust."\(^{14}\) As a noun, a fiduciary is a person in whom confidence, faith, and belief can be invested because that person exhibits the quality of reliability and trustworthiness. The person or thing in which trust can be reposed becomes a locus of belief, expectation, and hope.\(^{15}\) A more careful analysis of trust's synonyms (e.g., confidence, reliance, and faith) and antonyms (e.g., distrust, uncertainty, and suspicion) further elucidates the meaning of "fiduciary," and points towards "trust" and "trustworthiness" as definitional concepts in the medical accent of meaning.

The patient who asks the doctor for help has a "practical" interest in the world. This person is not interested in theoretical matters, e.g., the philosophy of medicine or in the nuances of molecular biology. The patient wants to "get well" and return to the everyday reality for which illness is an

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\(^{14}\) The Oxford English Dictionary.

\(^{15}\) David Good, "Individuals, Interpersonal Relations, and Trust," in Gambetta, p. 33.
intrusion or interruption. The patient expects the physician to share this practical goal. However, theoretical reflection and practical problem-solving are separate activities. The patient concentrates on the practical because he or she "knows" or believes that others, physicians, have these theoretical matters as their practical concerns. The social distribution of knowledge is predicated on the assumption that no one member of society need know all of society's knowledge to interact with each other. To function in everyday life, each must rely on the fact that some people have some knowledge of matters within the world while others have different knowledge, and that in their interaction, some mutual benefit will accrue. This confidence is represented by the natural attitude of everyday life, in which, until proven otherwise, people assume confidence in the reality of the social world. The event of social interaction possesses a depth of meaning for both participants which represents more than either one can say; both know in common what cannot be said in so many words.

However, a shock to the natural attitude occurs when one's taken for granted confidence in "reality" is upset, and typical responses fail to restore

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the epoche of the natural attitude. Ordinarily a person works to reconcile the anomaly in his or her horizon of meaning so that confidence (the familiarity of the natural attitude) is restored. During the period of anxiety or uncertainty, a person perceives the risk and dependency inherent in social interaction. Rather than trusting that the intentions and disposition of others is mutually beneficial, and not merely advantageous to the more powerful person, he or she realizes the fragility of relationships with others.

It is in this dimension that trust has implications as a virtue. As a factor in social cohesiveness, as the condition on which rests a certain naivete of interaction, trust acts to enhance social relations. The term takes on moral connotations: If one is trustworthy, one is granted a license of power in interaction with another who may be of diminished capacity. The expectation of trust and trustworthiness represents more than mere social and psychological confidence. It becomes highly prized as a valuable and necessary feature of human relations. In a relationship as fraught with emotional and power-laden issues as the medical one, the fiduciary component achieves a depth of meaning that is fundamental in its implications. This fiducial quality assumes a boundary-forming (a protean) dimension. Physicians’ self-identity and self-awareness, as well as their expectations of their work and of their patients’ response of their work, is shaped by regard for trust and trustworthiness. It influences their expectations of themselves (as technically competent professionals), their profession (its tradition of service), and of the patients they “serve” (as people who, in turn, have obligations to doctors).

The medical profession’s claim to trustworthiness rests on the grounds that physicians provide explanation, security, and confidence, a sense of
protection to those in need of comfort and consolation. To earn the public's confidence, the doctor must give the impression of possessing the certainty of expertise and knowledge. However, in order to earn the trust of patients, the physician must possess and demonstrate an ability to be relied upon which lies beyond the minimal levels for psychological confidence. The non-expert expects a great deal of physicians, and as part of this expectation, grants to the doctor the duty, task, or charge imposed in faith and confidence that his or her skills will be used or cared for in the interests of others. Here, trust is an aspect of the virtue of beneficence governing the medical relationship.  

In return for wide latitude in defining the limits of its work and the knowledge which supports its autonomy, the medical profession undertakes trustworthiness and incorporates the fiduciary dimension into its own sense of identity. As this expectation has been incorporated by the profession, doctors endorse certain traits which support and reflect this claim. Those traits and actions which undermine the claim to trustworthiness are disavowed. However, that which makes for a "trustworthy" doctor may mean one thing to a doctor, something else to another doctor, and something altogether different to a patient.  

If there seems to be a decline in the public's trust in social institutions such as medicine, what is meant by trust must be carefully considered. The

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19 See McCullough's discussion of the moral commitment that transforms the physician's subjective beliefs and convictions into the "professional" character; Laurence B. McCullough, "Modern Anglo-American Medical Ethics," in Shelp, The Clinical Encounter, pp. 56-57.

20 See, for example, Toombs, pp. 219-240.
image of the medical doctor as an autonomous authority figure dedicated to the service of humanity is changing. Since medicine involves primarily a social relationship between physician and patient, trust must embrace at least two different meanings when the term is applied to the relationship between a member of a profession and the public. The first meaning links trust with the expectation of technically competent role performance. Patients expect or want confidently to believe that a physician knows his or her business, and thereby is technically competent. The second sense of trust, however, is the expectation that some persons in social relationships have the moral obligation and responsibility to demonstrate a special concern for others' interests above their own. In this latter sense, patients trust that their physicians care about them and have their best interests at heart. In this way patients place a great deal of faith in their doctors and, beyond the individual, in the profession. Because of the public's trust in the profession's technical and fiduciary reliability, the patient places himself or herself in the physician's hands.

Within such a relationship, there is a mutual confidence between or among the parties. Each person is considered to be dependable because each is given and assumes the responsibility to be trustworthy. The meaning of "fiduciary" as a trustworthy person or as a condition of trust has social, psychological, phenomenological, and moral connotations. These connotations


22The first meaning of trust is from Barber, p. 14. The second meaning of trust is what Talcott Parsons calls the "other-orientation"; see "The Professions and Social Structure," Social Forces 17 (1939), 457-467.
allow for social interaction by serving to minimize uncertainty for the everyday world and for the medical accent of meaning which gives definition to the physician and his or her work.\textsuperscript{23}

Therefore, the difficulty in defining trust illustrates the highly personal and social nature of the concept. Words contain an archeological stratigraphy representing the continuing evolution of meaning and usage. Words do not stand still, and any attempt to define them finally will fail.\textsuperscript{24}

In its linguistic origin, however, trust refers to an experience explicitly found

\textsuperscript{23}Without trust, the everyday social life which we take for granted is simply not possible; Niklas Luhman, Trust and Power (New York: Wiley, 1979), ch. 1. Harold Garfinkel demonstrated the importance of trusting another's claims about the nature of social reality in rule-breaching experiments; see the discussion in Good, p. 32.

\textsuperscript{24}The connotation of trust changes over time and from culture to culture. For example, the Germanic stratum of the English word "trust" stresses the active voice of "ich"; it is personal and transitive. Latin-based constructions yield agency to abstractions, masking the speaker's voice in passive or intransitive constructions. Modern English frequently collapses the distinction between persons and things; trust can refer to a person, an idea, or an object. Linguistically, modern English usage has lost the emphasis on the personal nature of relationships. Nothing stands between an individual subject and the depersonalized, abstract world. Contemporary language exposes us to anonymous phenomena like "health care" or "the profession" which remove from sight the intermediate pattern of human interdependence that gave rise to the words we use; Hart, in Gambetta, p. 186.
in concrete human relations, in activities and passions involving love, persuasion, and coercion.\textsuperscript{25}

Also, there are fluctuations between the notion that trust is something specific within a society (dealing with relations between particular persons) and a broader notion that trust is coextensive with the very existence of the social order (that trust functions as the cohesive factor fundamental to any discussion of social order). This ambiguity may be an inherent characteristic of everyday reality. Given the diversity of social orders, how can trust be said to establish social order?\textsuperscript{26} Introducing the social nature of trust carries the discussion to the phenomenological dimension of trust.

\textbf{The Fiduciary Aspect of the Medical Profession's Natural Attitude}

The fiduciary attitude generally is characterized by the expectation that some in our social relationships have a moral obligation and responsibility to demonstrate a special concern for others' interests above

\textsuperscript{25}Hart, ibid. Eisenstadt and Roniger use the concept of trust as roughly equivalent to relational solidarity and participation. They argue that unconditional trust can be found only in families and small-scale societies such as friendship and patron-client relationships. Trust cannot be invested in complex institutions since more personal relations tend to break down in this situation; see Shmuel N. Eisenstadt and L. Roniger, \textit{Patrons, Clients, and Friends: Interpersonal Relations and the Structure of Trust in Society} (Cambridge: Cambridge University Press, 1984).

their own. I have argued that a status profession such as medicine is entrusted with power and authority inasmuch as the public believes that the profession is acting in a client's best interests. Doctors certainly have other interests and roles which may conflict with a fiduciary attitude (they belong to other finite provinces of meaning besides the medical one), but the profession's accent of meaning includes the moral duties of beneficence and non-maleficence to the sick.


28 The "physician as such studies only the patient's interest, not his own"; (Plato, The Republic, Bk. 1:342). For Plato, physicians did not have a special duty of benevolence (love of humanity) towards patients. Such an understanding comes from the Stoics. Nonetheless, as physicians they necessarily had a special moral duty of beneficence -- of doing good for patients; see editorial, Journal of Medical Ethics 11 (1987), pp. 59-60. Thus, it is not part of the concept of "physician" for doctors to have a love of humanity (although many do have a basic sympathy for the sick), but it is part of the physician's accent of meaning to have a duty to help the sick. "Service to clients" is not a profession's only moral objective. Such an attitude does not always take precedence over other considerations (including other moral considerations such as the duty to the profession or a duty to the law or to society as a whole).
If a fiduciary component is ascribed to the professional identity, the physician becomes a trustee of the patient's trust, a person whose work rests upon public confidence for its value. Faced with a situation of illness in which the ordinary boundaries of their everyday world are disrupted, patients enter into a special relation with their physicians. To maintain the expectation, hope, confidence, and faith that the doctor knows what he or she is doing and will act in his or her interests, the patient is willing to suspend doubt in the profession's technical competence and fiducial commitment. Trustworthiness becomes a characteristic of the "good" doctor and is expected of any physician. The physician becomes a figure whose authority and trustworthiness is accepted by others to a remarkable degree.29 Trust has a particular significance within the medical province of meaning.

Within the medical accent of meaning, the doctor assumes that others share similar preconceptions, values, knowledge, sense of time, and language.30 A physician studies the life-world from the perspective of the profession and his or her speciality within it, with the knowledge he or she has learned and gained from experiences of similar situations. A doctor assumes that other health care professionals share, more or less, a similar

29We are all at once egoists and altruists, occasionally rising to the moment and doing what is "right," not what is in our personal interest. Furthermore, the mere fact that one places trust in us makes us feel obligated, and makes it harder to betray that trust. The problem of trust would not arise if we were all trustworthy all the time. A minimal non-congruence between individual and moral values is necessary for the problem of trust to be a problem; Dasgupta, in Gambetta, p. 53.

understanding. This clinical stance is represents an accent which accepts a
certain way of seeing the world, and which determines the meaningful
structures within which the doctor operates. This accent involves the
assumption of a "reciprocity of perspectives" and the "typicality" of others in
the world.\textsuperscript{31}

Under the reciprocity of perspectives, I assume, and assume that you
assume, that the various objects and events in my world are as accessible to
others, in general, as they are to me, or can become accessible to others. In
our daily lives we surmount initial differences of perspective by means of
two idealizations: a) the idealization of the interchangeability of standpoints;
and b) the idealization that we can, "for all practical purposes," unless
counter evidence presents itself, ignore the differences in our respective
biographical situations.\textsuperscript{32} Thus, I assume that the matters about which I am
talking also can be understood by you, within certain limits. I also assume
that differences in our respective stocks of knowledge and biographical
situations can be ignored in general for our specific purposes in the task at

\textsuperscript{31}See Schutz's discussion of the "general thesis of the alter ego" in

\textsuperscript{32}Richard Zaner, "Theory of Intersubjectivity: Alfred Schutz," \textit{Social Research}
28 (1961), pp. 84-86.
hand. Ordinarily, in other words, we assume that objects and events mean something similar to both.

Further, I know and assume you know that only a small part of my knowledge is unique to me. After all, for the most part, what I know is handed to me by others. Such knowledge includes not only ideas and values, but also how to define and interpret the world, how to find my way in the world, how to think, to act, etc. This knowledge is contained in the typifications prevailing in any group sharing the same "common language." Such language reveals the prevailing texture of "definitions of situations" and typifications in any specific group. For instance, "gomers" is an expression used by resident doctors to characterize a type of patient. The expression

33The Hippocratic Oath stresses physicians' obligations to the profession to share his or her learning only with their sons, the sons of their teachers, or those who had taken the oath; see "Selections from the Hippocratic Corpus," in Stanley Joel Reiser, et al., Ethics in Medicine: Historical Perspectives and Contemporary Concerns (Cambridge, MA.: The MIT Press, 1977), p. 5. Berlant argues that it is this aspect of the professional identity that is spoken of as a monopolistic "brotherhood" with the rights and privileges appertaining to self-interest and advancement of the organization; Jeffrey L. Berlant, "Medical Ethics and Monopolization," in Reiser, et al., ibid., pp. 52-64.

34Richard Zaner, "Solitude and Sociality: The Critical Foundations of the Social Sciences," in George Psathas, ed., Phenomenological Sociology (New York: John Wiley & Sons, 1973), p. 39. In the relationship between doctor and patient, many patients assume that the doctor "knows it all." Upon reflection it may be obvious that physicians are people, too (e.g., fathers with marital problems), but in the context of medicine, we want to see them as supra-human. Medical language reflects this power differential. There is common ground in the everyday language of a culture, but the medical province of meaning has a language all its own. It has to be "translated" if the patient is to understand. I argue that such translation is necessary if authentic sociality is to be present. However, by taking for granted that the language of the medical province has common meanings for patients, or by refusing to take time to translate adequately, the physician's power is reinforced.
reflects the doctor's view of that "type" of patient, and defines the way in
which a doctor may respond to that person.

Physicians experience, interpret, and act in and on the world with the
assumption that not merely are there "others," but that these others are
different types -- strangers, friends, the sick, the healthy, patients, and other
doctors. To each of these types are correlated expectations which are taken-
for-granted typifications in the doctor's daily life. The physician expects
particular expressions of thought or action from "typical" individuals (e.g., a
hospital accountant will be unable to understand the necessity for additional
lab tests; a person with a rotator cuff injury typically will experience pain in
the shoulder). Since not only the physician but everyone belongs to the life-

35 Not all possible types are "present" before the physician. For instance, a
doctor's own patients and associates, who are encountered face to face, are
"consociates." Second, while not known by the doctor personally,
"contemporaries" are other people who may become patients or members of
the medical profession. Third, "predecessors" may be known to the doctor in
the past as consociates, contemporaries, or historical figures (who have
helped to shape the world in which he or she lives). Fourth, the physician's
actions bear indirectly or directly on future consociates, contemporaries, and
those who will be "successors" in the profession. Finally, there are those who
are effective in the doctor's world although they are mythical or fictional
characters whose actions and thoughts can influence his or her lives,
opinions, and expectations of doctors on the part of others. For a discussion of
consociates, contemporaries, predecessors, and successors, see Zaner, ibid., p.
38; also see Roger Jehensen, "A Phenomenological Approach to the Study of
Formal Organizations," in Psathas, pp. 219–247. Fictional characters can
affect the living, e.g., the T.V. shows "Marcus Welby" and "Dr. Kildare"
revolved around the personal and professional lives of fictional physicians.
The popularity of these characters helped shape the image and expectations
which people have of doctors and of what medical care "should be," and,
therefore, had an effect on the profession generally. Indeed, Drs. Welby and
Kildare also may have served as role models for people who decided to
become doctors.
world, and therefore is endowed with the same activities of consciousness as he or she is, doctors assume that other people in similar situations also have the same expectations of these types.

To summarize, a reciprocity of perspectives and typicality are tacit features of social knowledge. An unspoken and common understanding of "the world" is assumed to be shared until otherwise apparent. These idealizations build a mutual sense of reliance and normality into everyday interactions. Personal disparities in knowledge are less threatening in these interactions (it is accepted that some know things that others do not). Finally, people take the world for granted by assuming that the real world exists independently of one's knowledge of the world, and that these two are in direct correspondence (i.e., that knowledge and world mirror each other).36 The assumption of a reciprocity of perspectives and typicality allows people to rely on their perceptions of others in social reality.

In the doctor-patient relationship, and in health care matters generally, these idealizations are complex. Doctors, other health care workers, and patients do not share a complete interchangeability of standpoints, nor can they ignore the differences in their respective biographical situations. The reciprocity of perspectives is not absolute. I can accept the possibility that objects and events mean something different to others, since our biographically determined situations, with their respective relevancy-systems and other contents, may differ. For instance, an ambulance siren is a signal to pull over both to the layperson and the physician, but the physician reacts to the siren in a certain way due to his or

her biographically determined situation and the particular meaning that emergency systems elicit.\textsuperscript{37} The call, "Is there a doctor in the house?," is a commonly understood call for help, but a physician's response is different than the response of a lawyer. The patient's biographical situation is precisely what has brought him or her to the physician. It is their difference in biographical situations and stocks of knowledge that creates the relationship. In addition, the two people do not share a fully common language since the medical profession's language is quite specialized.

However, given the reciprocity of perspectives outlined above, the doctor often assumes that the patient can understand him, and can "check the doctor out," confirming for himself what the doctor says -- despite their various differences.\textsuperscript{38} Of course, the patient can question the doctor or obtain a second opinion. But part of the taken for granted perception of doctors, and of patients by doctors, is that doctors know what they are doing and that patients should trust them. To ask for a second opinion or to question the doctor is to suggest that we do not trust them fully. Doctors assume a

\textsuperscript{37}Medical history-taking is another example of the constraints imposed by individuals' biographically determined situations. Although we are consociates and contemporaries in time and place, in the health care relationship the patient’s biographical situation is open to the doctor in a way that is not reciprocated.

\textsuperscript{38}By means of these idealizations, there is formed the "We," the "Us," and correlative, "They" who do not share our assumptions, ideas, and relevance-systems; see Zaner, in Psathas, pp. 38-39.
reciprocity of perspective because they believe that they do know what they are doing and that patients should trust them.\textsuperscript{39}

As we have seen, everyday knowledge of the world is knowledge of typicalities, the world is experienced as commonly shared, and this knowledge is taken for granted.\textsuperscript{40} Within the standpoint of the natural attitude, which assumes that the everyday world is as it appears to be typically, the individual is not motivated to question the meaningful structures of his life-world. His or her interest is a practical one, his task to live in rather than to make a study of the life-world. Ordinarily we suspend doubt that the world and its objects can be other than they appear. The patient assumes that the physician is trustworthy and suspends doubt in the professional's expertise, even in the face of contrary evidence. The alternative, that the physician is untrustworthy and "incompetent," is too

\textsuperscript{39} These idealizations are operative within the province of the medical profession. Two doctors of the same specialty, for instance, may share similar attitudes, assumptions, and similar medical language. They can "check each other out" to establish a mutual ground for working together.

unsettling. It introduces risk and anxiety into the already uncertain situation of illness.\footnote{The patient who asks a doctor for help has a "practical interest in the world" (the patient's concern is not a matter of theoretical interest, e.g., such as in the philosophy of medicine). Theoretical reflection and practical problem-solving are separate activities; Mehan and Wood, pp. 104-105. The patient can concentrate on practical concerns because he or she "knows" that others (doctors) have these theoretical matters as their practical concerns (i.e., their business). According to the social distribution of knowledge, no one member of society need know all society's knowledge in order to interact with other people. To function in everyday life, each person must rely on the fact that some people have some knowledge of the world, and that others have other knowledge. Therefore, we must trust each other in situations where our respective knowledge and control is limited or incomplete. This taken-for-granted trust may not be acknowledged in so many words. An event means for both people more than either one can say. Garfinkel calls this aspect of social knowledge "tacit" knowledge; Garfinkel, p. 56.\footnote{Katz, p.166. Trust is both a more or less consciously chosen policy for handling the freedom of other human agents. As a modality of action, it is essentially directed toward coping with uncertainty over time; John Dunn, "Trust and Political Agency," in Gambetta, pp. 73-93; p. 73. Also see Luhman, \textit{Trust and Power}, p. 30.}

Due to its accent of meaning, the profession takes its own expertise and trustworthiness for granted to reduce the uncertainty inherent in medical work.\footnote{Katz, p.166. Trust is both a more or less consciously chosen policy for handling the freedom of other human agents. As a modality of action, it is essentially directed toward coping with uncertainty over time; John Dunn, "Trust and Political Agency," in Gambetta, pp. 73-93; p. 73. Also see Luhman, \textit{Trust and Power}, p. 30.} The profession's fiduciary commitment represents a defense against the awareness or acknowledgment of uncertainty. Fox argues that there are basic types of uncertainty for medical professionals. The first results from incomplete or imperfect mastery of available knowledge. No one can have at his or her command all the skills and knowledge of medical lore. The second depends upon limitations in current medical knowledge. There are innumerable questions which no physician, however well trained, can answer. A third source of uncertainty derives from the first two. This
uncertainty consists of the difficulty in distinguishing between personal
ignorance or ineptitude and the limitations of present medical knowledge.\textsuperscript{43} The physician must confront and come to grips with these types of
uncertainty. The doctor who begins to question his or her own knowledge
and abilities can be overwhelmed by doubt and second-guessing.\textsuperscript{44}

Casting for coherent forms is an interpretive procedure performed in
all knowledge systems. Medical science, clinical technique, and professional
tradition provide the doctor with an horizon of meaning and an
interpretation of events. This interpretive procedure is called "searching for
a normal form."\textsuperscript{45} The doctor must transform the swirl of stimuli in every
medical situation into a meaningful whole. The physician searches for and
selects features of the world that can be placed into familiar schema.

Confronted by swirling data and driven by the need to impose order
and explanation, the doctor has the sense of the presence of a causative
agent, though its specific makeup may be absent and unknown. The assumed
presence of an objectively verifiable disease entity enables the physician to

\textsuperscript{43} Renee Fox, "Training for Uncertainty," in Robert Merton, et al., eds., The
208-209.

\textsuperscript{44} I do not mean to suggest that a doctor who appreciates that medical
knowledge cannot be perfectly mastered, or who recognizes the limitations
of medical knowledge, will succumb to uncertainty. However, the physician
who seeks the certainty of complete knowledge is controlled by uncertainty.

\textsuperscript{45} Mehan and Wood, p. 103. In the face of the shock of the unexpected,
humans have a tendency to deny and to attribute blame. See the discussion
of blame-shifting by physicians when the adverse side effects of DES on
pregnant women became known; Susan Apfel and Roberta Fisher, To Do No
Harm: DES and the Dilemmas of Modern Medicine (New Haven: Yale
University Press, 1984), pp. 63-64.
look for features that help him or her identify the patient's condition. Unclear data is set aside or held in abeyance while the physician seeks clarification or confirmation of other data. He or she assumes that subsequent events will clarify any present ambiguity.46

Although a symptom may not have precise meaning when initially apprehended, it has some meaning -- it is assumed to be a sign or a trace of disease or physical disturbance.47 Specific meaning becomes clear with subsequent events and investigation. For example, the expectation of medical tests is that they will provide clarification and certainty, to the point of formulating therapy. In retrospect, with the formulation of diagnosis or following treatment, a doctor develops an explanatory history of the patient's condition. This retrospective "filling in" is an interpretive process. Thus, doctors will acknowledge medicine's uncertainty once its presence is forced into their conscious awareness, yet at same time they will continue to conduct their practice as if uncertainty did not exist. Of course, the now specific meaning is also subject to subsequent reinterpretation. The meaning

46 The young physician must come to trust him or herself and his "knowledge" of his "work" and patients. The purpose of medical education and socialization into "clinical" perspective is to foster within the medical student the profession's system of relevances. See Wendy Carlton, "In Our Professional Opinion..." - The Primacy of Clinical Judgment Over Moral Choice (Notre Dame: University of Notre Dame Press, 1978), pp. 82-83.

of an object, event, or utterance is "prospective." Subsequent events may alter the "normal form" assigned to it.48

Doctors, even in the face of the uncertainty inherent in their work, take it for granted that their skills, knowledge, experience, and dedication to the well being of their patients elevate them to trustworthy status. Thus, trustworthiness is a key component of the accent of meaning which serves as a touchstone for the physician’s sense of “reality.” At the same time, however, such status is also due to the trust which doctors are given by the public. The public accepts the assumption of a reciprocity of perspectives, assuming that physicians do share similar goals and expectations with patients. This public expectation largely exists because the doctor believes in the power and efficacy of expert knowledge. Claiming professional expertise and beneficence, the physician accepts the public’s expectation of reliability. For the profession, the careful cultivation of knowledge and the acquisition of clinical expertise and perspective enhances the care of the patient which further anchors public trust. Simultaneously, the commitment to service

48Mehan and Wood, p. 103. A similar interpretive procedure occurs in matters involving a fiducial relationship. A person may choose to trust another, interpreting actions according to a "normal form," until the epoche of distrust can no longer be maintained or reconciled in the face of contrary evidence. Once a situation is identified according to the normal forms provided by the medical province of meaning, due to the "reciprocity of perspectives" a physician assumes that when presented with similar data, another doctor will concur. The professional’s opinion, if reached through normal forms, "should" be shared by any other who sees it. This expectation often is extended to non-professionals, as well. If a patient asks for information, doctors often provide a set of explanations or directions grounded in the understanding (or clinical perspective) defined by their province of meaning. The assumption is made that the patient shares with the doctor "constant objects" (or a mutual understanding).
provides a rationale as well as a sanction for the cultivation and control of “powerful” knowledge.\footnote{Such commitment can also lead to paternalistic attitudes on the part of physicians. After all, to the doctor who is convinced of his or her own trustworthiness, “enlightened” patients will acknowledge the superior expertise of the physician and follow his orders. For the unenlightened patient, paternalism is the only viable alternative; see the reference to Benjamin Rush, in Katz, p. 16.}

The profession’s dedication to the obligations of service serves a variety of purposes. First, as part of the medical accent of meaning, trustworthiness is elemental to the physician’s self-understanding. A physician’s self-identity comes from membership in a profession or group which represents the virtue of trustworthiness. The physician sees himself or herself as trustworthy and is identified as trustworthy by colleagues and patients. The fiduciary aspect of professional identity acquires a moral tone.\footnote{See Zaner, \textit{Ethics and the Clinical Encounter}, and Edmund D. Pellegrino and David C. Thomasma, \textit{For the Patient’s Good} (New York: Oxford University Press, 1988).} Doctors profess to be fiducial people, to be trustworthy, because it is expected of them. As long as the profession’s fiducial claims serve to satisfy
people's expectations, they will suspend doubt in physicians' intentions and dispositions.51

As long as this epoche of mistrust holds, the physician can have trust or confidence in his or her beliefs and actions.52 Clearly, if a profession owes its "status" in social life to its fiduciary or fiducial nature, trust is an essential ingredient in "limiting" or defining its claims to authority, autonomy, and power. It is this latter sense of trust that raises the issue of trust as a form of social control.

Second, a dedication to fiduciary relations serves as a form of social control on the part of a profession seeking power and prestige in its work. If the public can be convinced that the medical doctor possesses knowledge and skill, and can be trusted to act in the public's best interest, the profession offers itself as a benevolent alternative to its competition. A cycle of expectations is established: the more the profession dedicates itself to a fiduciary expertise, the more society will accept its claims and the more

51The natural attitude of everyday reality acts to create a social cohesion without which we would be forced to question or doubt every aspect of our lives. I believe that the natural attitude is a pre-commitment to trust. In its various bilateral and unilateral forms, this pre-commitment is a device whereby we can impose some restraint on ourselves and thus restrict the extent to which others have to worry about our trustworthiness. The constraint is relevant not only for us in deciding how far we need to trust others, but also for others to decide how far they can trust us. It is important to trust others, but it may be equally important to be trusted; see Gambetta, p. 221.

52The Oxford English Dictionary states that when applied to physics, fiducial can be taken as a standard of reference; as, a fiducial point around which other factors take their meaning. God can be viewed as a fiducial being in the classical theological understanding of God as creator, the point around which all else takes its meaning; see Taylor, p. 7.
reliant the public will become upon it. The public expects, or trusts, that the physician is trustworthy and dedicated to service. This trust allows the professional to pursue his or her work while enjoying high social status. In turn, public expectations compel doctors to feel an allegiance to the profession's ongoing tradition of service.

This professional attitude has contributed to a faith in and a commitment to medical science and an endorsement of the promise of success. Physicians place their confidence in science, in their medical training, and in their experience because these generally produce results, as calculated from within the boundary of the medical province of meaning. In return, physicians ask that public give them the autonomy to do their work, claiming that this approach will lead to the best outcome for the patient.

In recent years, however, the promises of medical science have brought some remarkable successes -- and led to a sense of public uneasiness with the profession. There have been accusations that physicians' power and authority are out of hand, and that limitations must be imposed to restore "good" medicine. Given the accent of the medical province, that expert knowledge and trustworthiness are foundational to their work, it is hard for physicians to understand or accept these calls to redefine the limits of professional power. This professional accent is taken so much for granted that doctors become upset if their expertise and trustworthiness is questioned. The use of distrust to create an acceptable balance of power between the profession and the public creates shock among physicians, and leads to suspicion and distrust in turn.
The Breakdown of Trust in the Fiducial Relationship

The medical profession's authority in society appears strong. Polls show that the profession is rated highly in terms of trust and social prestige. If the profession is held in high regard, why has there been much debate recently about the nature and legitimacy of professional power and its role in relations with clients?

One possible explanation for the debate is that trust in all professions generally is declining. Trust in medicine remains high only in relation to trust in other professions or occupations. Another possibility is that people are forced to trust physicians, given the alternative, yet are uneasy in doing so. Faced with the vulnerability created by illness and neediness, it is difficult for people to question the physician's role, authority, and fiduciary tradition. Finally, it may be that the nature of the social matrix from which trust arises is undergoing revision, and consequently, the public's definition of trust is changing. I believe that concern with the nature of professional power and identity results, at least in part, from the influence of the scientific accent of meaning and its effect on the medical province of meaning. As this influence has shaped in a reciprocal fashion the doctor's

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work and his or her approach to that work, a misapprehension of the nature and meaning of trust has developed on the part of doctor and patient.54

I am not arguing that the medical relationship is moving in an historical decline, from a "golden age" of mutual trust toward an age of mutual suspicion and distrust. The uneasiness felt by patients at the interruption of illness in their lives, and the corresponding need to place one's body and being in the hands of another, is ages old. The Hippocratic Oath indicates that a concern with trust between physician and patient was present in the 4th century B. C. The therapeutic relationship always has been a fragile alliance, and depends on an époque of doubt and anxiety which allows one to trust the physician. The profession's fiduciary commitment, advanced and developed over centuries, is necessary (although not sufficient, as we will see) for this époque to occur.

It is not surprising that trust is a fragile social condition. Socially extensive and enduring trust is not an easy condition to create. There can be individual motives which aim to accomplish an end other than the individual's strictly selfish interests. It is not unreasonable to suppose that such motives exist at least some of the time. However, these motives cannot be expected to provide for more extensive and properly social trust (such as the fiducial claim made by the medical profession in regards to its commitment to its clients).

54Certainly the public, too, misapprehends the nature of trust. The emphasis on patient autonomy is indicative of an effort to use trust as social control over the power of the medical profession. Each participant in the relationship can be guilty of misusing trust in order to protect and serve its own interests. As a result, each party comes to be suspicious of the other.
Four assumptions must be met if social trust is to exist. We must assume: 1) that people know what each other’s motives actually are; 2) that they know that they know; 3) that this knowledge is not too expensive or difficult to obtain and maintain; and 4) that the outcomes of any course of action are not too difficult to achieve. Unfortunately, especially given the predilection within the scientific attitude towards clear and univocal perception, these four conditions imply that interpersonal trust is easily obtained.\textsuperscript{55} Although the medical profession is dedicated to knowledge and expertise as a means of controlling its work, and access to social prestige and power serves to reinforce both professional and public expectations that social trust is easily obtained, such an assumption does not form a firm foundation for authentic or deep seated fiduciary relations between doctor and patient.

In a discussion of the taken-for-granted value of “trust” as part of the medical province of meaning, a review of the rationalization and monopolization process of professionalization by means of education, expertise, and “codes of ethics” shows the complex structures of power and authority that link the profession of medicine and the public it professes to serve.\textsuperscript{56} The profession’s efforts to achieve a monopoly regarding its formal knowledge and control of its work has moved it toward a close relation with


\textsuperscript{56}Jeffrey Berlant discusses the theories of Talcott Parsons and Max Weber in Profession and Monopoly (Berkeley: University of California Press, 1975), pp. 6-63.
science and the biomedical model of health and illness.\textsuperscript{57} Science's promise to wipe out disease, added to the profession's vow to fiduciary service, has contributed to the public's willingness to turn away from other healers and allow allopaths, whose handful of scientific brethren had been associated with discoveries beneficial to health and recovery from illness, to take charge of the nation's health needs.\textsuperscript{58} The subsequent development of medical science has resulted in increased specialization and more research and growth in knowledge and resultant biotechnology.

The implications for the physician are profound. Lewis Thomas describes a time less than fifty years ago when the general practitioner could provide little beyond his presence in caring for the ill.\textsuperscript{59} Today the physician possesses a vast array of technological and therapeutic weapons to be used in the attempt to cure the patient. As the possibilities for health care have grown with the developing momentum of scientific medicine, the public


\textsuperscript{58}Katz, p. 40. Also, for a discussion of the competition between allopathic and homeopathic medicine in America, see Starr, p. 100.

expects medical "miracles." It expects that the physician can do something in the face of the existential anxiety that illness creates.

Coupled with a faith in the authority of the medical credential, scientific medicine's success has created unrealistic expectations on the part of the public. This success has led to promises that cannot be kept, and eventual discouragement and backlash by the people whom the physician professes to serve. The medical profession is responsible, in part, for encouraging this expectation since the public's trust necessarily accompanies the profession's efforts to ensure, maintain, and further the expertise that marks its power and identity as a profession.60

The status of medical knowledge at any point is a historical observation about the practice of medicine in particular time and place. In the period since World War Two, the biomedical model has prevailed over alternative paradigms through attack and defense.61 The uncovering of "typifications" by a phenomenologically based sociology of knowledge

60Jeffrey Berlant, "Profession and Monopoly," in Reiser, et al., pp. 52ff; William May, "Code and Covenant or Philanthropy and Contract?," ibid., pp. 65-67. To enter into the health care relationship, a patient needs to know that there are people who legitimately can be asked for help and direction; that there are places where directions legitimately can be obtained; and that there are times when questions legitimately can be asked. This is knowledge that "everybody knows" or takes for granted about the medical profession. The profession itself has cultivated this assumption to control the parameters of its work and establish its authority. Of course, the individual doctor also accepts the assumption. Thus, opinions that question the legitimacy of who, where, and when are viewed as critiques of the profession, as attempts to undermine physician authority. See Mehan and Wood, p. 105.

supports the biomedical model's acceptance and staying power. The search for "normal" forms, the effort to establish categories of disease states, and the focus on predictability and control of medical testing and experimentation create a preference for epistemological objectification. As a result, particular values of relevant physical magnitudes and parameters become the significant focus of medical attention, and so earn the title of "facts." This focus lends itself to quantifications to settle disputes or differences in diagnosis and treatment. The facts used to settle differences in opinions are themselves based in theory grounded in empirical study.

Under the general impetus of an age in which the accent of science largely dominates, facts are taken for granted as arbitors of certainty in the everyday world. To tell scientists or physicians that their model and the knowledge it produces is "only" of a certain form accomplishes little since it does not alter the experiential validity of that knowledge and the biomedical model's success. Physicians assume the validity of the scientific accent of meaning since it demonstrates its power daily. Problems or objections are resolved within the biomedical province of meaning as a course of "normal science." This taken-for-granted validity is hard to modify.62

Scientific knowledge does remain open to modification. However, under the scientific model for investigating reality, doctors enforce a set of rules which limit the outside world's entry into their realm. In principle, every diagnosis makes a claim about and builds upon, in logical and verifiable fashion, knowledge of the remainder of the natural and social

62Mehan and Wood, p. 221. Also, see Thomas Kuhn on the relationship between normal science and crisis science; The Structure of Scientific Revolutions (Chicago: The University of Chicago Press, 1970).
world. In this fashion, the outer world is admitted to the corpus of scientific knowledge only after it has, in theory, undergone a most rigorous scrutiny.\textsuperscript{63}

The careful control of medical knowledge represented by the process of scientific investigation limits the influence of those outside the profession and enables physicians to control their work. Doctors tend to seek clarity and certainty in diagnosis and treatment because their credibility and authority are at stake. For this reason, physicians rarely criticize or challenge colleagues and certainly not in public. By presenting a solid front, they want to appear competent and knowledgeable.

I am not arguing that doctors as a group are locked into an absolutist biomedical model that treats the scientific method as the ultimate authority for knowledge. First, any community of scholars constructs findings by comparing them to standards that exist at that time. Propositions are moves in the scientific game; they are not direct reflections of nature. Second, scholars do not merely match observations with propositions. They decide truth through discussion, argument, and practical human activities. An organized consensus, reached in accordance with established procedural rules, decides what is and is not warranted as knowledge. Thus, "good reasons" may be offered about why an observation validates or invalidates any particular proposition. Decisions are based on the scientific situation in effect at the particular time. Of course, the scientific situation changes with time. For instance, leeching is no longer accepted as a valid medical

\textsuperscript{63}Mehan and Wood, p. 211.
proposition. Truths of science (and medicine) are argued and determined in praxis; they are not revealed truths.\textsuperscript{54}

However, within the medical accent of meaning shaped by the biomedical model, traditional patterns of relationships slowly become reorganized. The demand for clarity and objectivity determines the way in which reality is presented to people (it provides the meaning by which they interpret lived experience), and shapes the way in which they re-present themselves to reality. People begin rearranging the patterns of their lives in light of an increasingly technologically oriented world in which choices continue to proliferate.\textsuperscript{55} A demand for additional technology inevitably follows. People believe that if they accumulate further knowledge about an issue they will understand it conclusively, and thereby be able to choose correctly in any circumstance. Unfortunately, each conclusion, each technological development, creates new questions and the need for more

\footnote{Ibid., p. 226.}

\textsuperscript{54}Technology means more than the development and utilization of machinery. I use the term to designate an aspect of culture that can shape the institutions and the morality of a society. For instance, changes in medical technology, such as saline abortion or vacuum extraction of the fetus, effected changes in the law regarding abortion. These technological changes coincided with changes in public morality that made abortion acceptable for many; see Carlton, pp. 69-70. However, more recent advances in neonatal technology effect the moral understanding of “viability” and may create a review of the legal basis for abortion. Also, see Childress, p. 100. Generally, every society is influenced by technology. We have become a more self-consciously scientific and technological society during this century. As a result, we are guided by a worldview governed by a techno-economic value system; see David Tracy, \textit{Analogical Imagination} (New York: Crossroad, 1986). There is an corresponding effect on “embodiment,” on the ways in which we view the everyday world and our bodies as part of that world.
knowledge. This phenomenon exacerbates an anxiety or need to know more, to do more research, or to solve the new problem. It can lead to the specialization of society.66

The practical effect of this paradox of typification and modification creates an expectation for successful outcome. Due to its very success, medicine is pressured to pursue the scientific direction, which results in more knowledge, more drugs, more technology, more specialists, and some measure of success. The limits of what is possible keep changing, yet the limits remain. The public expectations remain unfulfilled.

Scientific meaning must remain within the particular province or paradigm which determines the meaningful boundaries of the theory or procedure. The universe of science represents a finite province of meaning that is quite distinct from the naively experienced, immediately perceived reality of everyday life. Within its own boundaries the scientific view possesses its own sense of shared activity, language, and meaning based upon a confident evaluation of the authority of reason.67

66Ivan Illich writes of the medicalization of society in arguing that physicians have extended their area of "expertise" beyond its appropriate limits into other areas of social life; Medical Nemesis (New York: Pantheon, 1976). However, the phenomenon of specialization acts to narrow a person's focus to a part of the whole even as the specialist assumes that he or she is an "expert."

67Schutz, Collected Papers 1, pp. 228-229. As the scientific model became prominent in the last century, it began to shape the social structures of meaning which today "typify" the medical profession. The orientation of objectivity over subjectivity, of facts over feelings, remains a primary value in health care. Crisis medicine, with its heavy technological investment, has become the taken-for-granted, most easily followed, approach to health care. Preventive medicine continues to be viewed as an "alternative." As a result, the perception persists that a sense of the human element is submerged in a technological orientation to health care.
As science shapes the natural attitude of the everyday world, its boundaries have begun to overlap with other provinces of meaning such as law, religion, and philosophy. However, science cannot provide meaning which cuts across multiple realities. It can give the knowledge of how to do something, but cannot answer the question, what shall we do?68 The scientific perspective provides knowledge about the world, but it cannot provide a final perspective. As the scientific orientation dominates the medical profession, it carries with it the seeds of the current crisis of trust: the desire and the drive for more knowledge serves to emphasize choices rather than to resolve them.69

From the expert's point of view, one consequence of this proliferation of medical knowledge is the inability of non-professionals to make meaningful choices without the aid of "experts." A specialist is required to


69Along with the development of a scientific focus within medicine has come an explosion of knowledge, accompanied by an increase in the possibilities of choices. Existentially, a choice always involves risking and trusting. The development of scientific knowledge has increased the power of the medical profession in terms of expertise and formal knowledge, but it has also led to the correlative social attention to control of the profession. More choices are possible, more awareness of patient's autonomy has placed more pressure on patients to participate in choices, which creates more anxiety (and the need to place more trust in the physician while raising the anxiety of choosing for oneself). Combined with the increased range of choices in health care, one result of the emphasis on informed consent, patients' rights, and autonomy is to place the burden for choice more fully upon the patient or public.
understand a particular medical technique. Because the expert's knowledge is greater than that of the uninformed person, an unequal relationship can develop. The patient becomes dependent on the information given to him or her by the professional. He must trust his doctor's knowledge, and hope that the doctor has the patient's interests at heart.

Unfortunately, as with any situation in which such an unequal power relationship exists, there is a possibility of domination or paternalism. The expert, who by virtue of his or her superior knowledge and the values of his or her professional identity "knows best," feels compelled to act on the patient's behalf but not at his or her behest. The attitude may develop (may even become part of the profession's natural attitude) that the more educated one is, the more responsibility one has to care and decide for the less competent person. The gap between the uninformed and the expert

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70See John Colombotos and Corinne Kirchner, Physicians and Social Change (New York: Oxford University Press, 1986), p. 12. As the fields of knowledge increase, the expert becomes locked into a particular speciality. His or her horizons become shaped by the limits of his or her expertise. This movement to specialization within medicine produces physicians who are "typical" of their speciality. Interested in a particular facet or problem of health care, these doctors typically concentrate on a structural or functional part of the whole patient; see Melvin A. Casberg, "The Effect of Specialization on the Treatment of the Whole Man," in Dale White, ed., Dialogue in Medicine and Theology (New York: Abingdon Press, 1968), pp. 81-96. However, "specialization per se does not exclude the art of medicine as an ingredient in its practice; but essential to the fruition of the art is an appreciation and understanding of the whole patient" (p. 86).

feeds paternalistic attitudes, and can produce an attitude of cynicism and resentment which works to devalue the therapeutic relationship.72

The fiduciary component of the professional accent rests on the premise that the physician is trustworthy. As previously discussed, trust is present if a person is vulnerable to another whose behavior is not under that person's control, and if the relation involves a situation in which the penalty suffered if the trust is abused leads the person to regret the action. Trust presupposes decision-making in risky situations, where risk is attributable to the behavior of others or to the possibility that they will behave opportunistically. Opportunistically can mean stealing and lying, but also

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72 It may be argued that this gap is inevitable and works to benefit the relationship, since it is the doctor's responsibility to act in the patient's best interest and that patients accept and want this. Dostoevsky makes the point that people are afraid of "true freedom" and seek someone to make decisions for them; see Fyodor Dostoyevsky, The Brothers Karamazov, trans. Constance Garnett (New York: W. W. Norton, 1976), pp. 227-245. Others argue that the recent concern with patient autonomy is a reaction against the paternalistic point of view and the monopolistic tendency of the medicine which defines the limits of the profession; see Berlant, in Reiser, et al., p. 63. The unfortunate tendency in the face of unclear lines of authority and ambiguous possibilities is a retreat into ideology. The true anguish of bioethical issues often is obscured by the movement to the clear and easy answers offered by ideological "camps." In most decisions, someone stands to gain in some way while someone stands to lose -- this ambiguity haunts all decision-making (a choice of one option eliminates the choice of another option since we cannot have everything we want). Those immersed in ideological certainty refuse to acknowledge this ambiguity; see J. Golden and G. Johnston, "Problems of Distortion in Doctor-Patient Communications," Psychiatry in Medicine 1 (1979), 127-149. There is also the possibility that "experts" will disagree; see Allan Mazur, "Disputes Between Experts," Minerva 11 (1973), 243-262.
more subtle techniques such as withholding information to confuse or control.\textsuperscript{73}

Trust also presupposes that the action and, hence, the risks are avoidable. In the case of illness or accident, the person is thrown into a situation in which he or she may have little or no choice: "I have to trust this doctor, I have no choice." With no choice, we cannot invoke trust to explain our behavior. Whether or not a relationship is seen to be avoidable is often highly subjective, and presumably varies with the structure of institutions and their social power. The medical institution encourages patients to trust the individual doctor and doctors at large. It does not encourage second opinions or advertising. It accepts a "holistic" or "folk" approach to health care even less.

Finally, under the biomedical model's influence and the general acceptance of the scientific province, social classification shifts from stratification to functional differentiation. People no longer see themselves placed in a fixed social setting. They see themselves as having access to multiple functional sub-systems upon which they simultaneously depend. Essential structures and territorially bounded cultural entities are largely displaced by time-limited entities such as fashion and style. As we have seen, scientific activity encourages functional differentiation. Scientists also surprise the public with new discoveries and new theories as a matter of

routine. These new conditions and relationships, of opportunity and dependence, of openness and lack of integration, have an effect on the structures of confidence and trust. Trust remains vital in interpersonal relations, but particularly in functional systems like economics, politics, or health care, trust is no longer taken for granted as a matter of course.\textsuperscript{74} These systems require confidence but not trust.

The promise of science and technology to narrow the gap between unlimited demand and scarce resources has been unfulfilled. It is difficult to accept the idea of progress in medical matters as an optional goal and not an unconditional commitment. If everything cannot be done for everyone, we must decide who can do what for whom. Decision-making, acting responsibly in the present, is necessary, but there is no knowledge beyond the moment by which we can guarantee the outcome in advance. Every decision is based on past knowledge, a perception of present needs, and is made with an eye to the future. Yet every decision remains inexact and its outcome

\textsuperscript{74}Luhman, in Gambetta, p.104. The virtue of trust has not vanished from the health care relationship. In individual cases, the expectation of trust between doctor and patient does occur. It may be possible to have trust on the micro-level and protect systems against loss of confidence on the macro-level. I am arguing that the expectation of trust is no longer unquestioned on the micro-level.
ambiguous.\textsuperscript{75} Thus, scientific medicine is a human activity no more absolute or relative than any other.

\textbf{The Climate of Distrust in the Physician-Patient Relationship}

The medical profession as a social institution is involved in the interplay of forces of social power and control. There are different types of knowledge and education, professional organizations with privileged access to political decisions, changing structure of markets as well as institutional power relationships in different parts of a society's division of labor. The value patterns which underlie these components of everyday reality shift and change over time. A profession's control of the knowledge necessary for its work depends on these value changes. In light of this situational fluidity, physicians retain control by clinging to expertise.\textsuperscript{76} Slowly, as medicine developed into an institutionalized profession, trust has become more "controlled," even as it is taken for granted as a fundamental component of health care. The fiduciary element remains a focal point within the physician-patient relationship, but the nature and understanding of trust has

\textsuperscript{75}Childress, p. 116. Also see the discussion on subjectivity and ambiguity in R. Morgan and M. Pye, eds., \textit{Ernst Troeltsch: Writings in Theology and Religion} (Atlanta: John Knox Press, 1977), p. 160. It must be acknowledged that science can be a powerful agent for questioning the taken-for-granted assumptions that nurture it; Stephen Jay Gould, \textit{The Mismeasure of Man} (New York: W. W. Norton, 1981), p. 21. The natural science of the 19th century grew out of cultural assumptions that nurtured Darwin and Freud, yet both of these "scientists" presented revolutionary challenges to their culture.

\textsuperscript{76}D. Rueschemeyer, "Professional Autonomy and the Social Control of Expertise," in Gambetta, p. 55.
been revised. While it retains its importance as a moral virtue, the "power" of trust shifts from an enlivening to a brokered condition in the social exchange.

Trust as fiduciary commitment moves beyond technical competence to the moral dimension of personal relations. The consequence of all physical or psychological trauma is the emergence of a sense of deep personal vulnerability. The threat of random dangers to the everyday world's natural attitude can be overwhelming. Ordinarily, we suspend an acknowledgment of these fears because it is improbable that they will be realized. As a result, humans take a certain level of security for granted. Generally, we believe that illness or accident, even death, happens to others. This ability to deny what might actually occur at any moment is part of what we call "mental health." In any acutely traumatic situation, a sense of order is disrupted and one's ordinary ability to deny one's vulnerability is lost. The possibility of loss, and recovery, shapes the personal relations between doctor and patient, and introduces a moral dimension to health care.

However, the physician's knowledge and power is relatively greater than the patient's and deepens the patient's vulnerability. Technical performance can be monitored insofar as it is based on shared knowledge and expertise, but when someone in a social relationship cannot comprehend that expertise, the performance of the "expert" can be controlled by trust. Therefore, society seeks to instill a moral sense of fiduciary responsibility in those who control special knowledge and skill. A fiduciary responsibility is placed on the holder and user of special knowledge and skill. Trust of this

77Apfel and Fisher, pp. 61-62.
kind becomes a social mechanism that makes possible the effective and just use of the power that expertise gives. It can forestall abuses of that power. However, trust as fiduciary responsibility is never wholly effective as a control mechanism and requires complements such as legislative measures, informal and formal peer regulation, professional education, and judicial regulation.\textsuperscript{78}

A decline in trust is not absolute but relative to changing expectations. It may be that the expectations leading the public to grant trust to the medical profession are changing. Such a shift in perception or expectation is not unusual. A given group's knowledge, self-control, or responsibility may be increasing or decreasing over time, making that group more or less professional.\textsuperscript{79} In the case of medicine, the growth of scientific medicine,


\textsuperscript{79}Barber, p. 136. The individual fantasies of patients and doctors about sickness and health, the relationship between doctor and patient, and the willingness to bend or suspend rational judgment have remained constant over time, but the scale and structure of medicine and science have changed radically in this century. Science has become an industry. The scientific research establishment is big business. The social forces unleashed by the size of these organizations and the ramifications of the treatments they develop are often beyond the power of individual doctors to control. Patients look to their doctor to be in control, but the tremendous growth in medicine may place matters beyond his or her control. For instance, DES was one treatment that seemed within the control of the individual doctor-patient relationship. It simultaneously connected the doctor to the frontier of endocrinological research. When the adverse side effects of the drug were clear, patients were left doubting in anger their physicians competency. Doctors, too, felt betrayed by the science they had supported; Apfel and Fisher, p. 38.
grounded in the biomedical model of illness, has created new expectations of physicians. At first, the expectation suggested that a scientific basis for medicine would lead to more knowledge, more skill, and more technological prowess. This increase would lead, in turn, to better outcomes in health care situations.

However, the increased expectations have not been met. As the medical profession has become more powerful in terms of formal knowledge and technical expertise, the public fears that the fiduciary commitment that characterizes the medical profession’s claim to “status” is eroding. It is one thing to trust physicians’ promise to diagnose, treat, and not to make matters worse unnecessarily. It is another to trust them to know what is beneficial to their patient, in the many senses of this word, when choices are available which can make matters both better and worse. Answers that satisfy everyone’s varied concerns cannot be reached on the basis of medical judgment alone. Science increases options, but each option entails its own significant benefit or risk. The public may seek to insure its own protection

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80 The failure of scientific medicine has been in the increased expectations or promises that have not been fulfilled; see Deborah J. Cotton, “The Impact of AIDS on the Medical Care System,” Journal of the American Medical Association 260 (July 22/29, 1988), 519-523.

81 Katz argues that, in fact, the original Greek version of “primum non nocere” did not command (as did the Latin adaptation), “above all, do no harm.” Rather, he quotes Sandulescu, “in the diseases we must seek two facts: to be useful or not to damage;” see “Primum Non Nocere: Philological Commentaries on a Medical Aphorism,” 13 Acta Antiqua Hung Tomus 359 (1965); Katz, p. 94. When a cure can be expected, the Greek version can be easily followed. Problems arise when treatment cannot promise cure but often only control disease (e.g., breast cancer). All treatments can inflict damage either through side effects or iatrogenic effects.
by limiting professional autonomy and power by means of the social mechanism of distrust.

There have always been internal and external checks and balances which defined the limits of the profession's license to practice its art. Generally, however, the medical profession has enjoyed the autonomy to shape both its self-perception and its task in society. Freidson describes the profession as an occupational organization which creates and controls the substance of its own work by virtue of the authoritarian position it has developed.\(^2\) As the one who controls medical knowledge and possesses the training and skills to put that knowledge into "practice," the physician traditionally has been granted the authority and responsibility to serve as decision-maker in medical matters.

As a result, we expect more from doctors because we perceive their knowledge as more extensive than our own. Great weight is given to technically competent performance.\(^3\) However, because their knowledge is at once more complete yet never complete, medical practice is "tragic" in that its promise is never fulfilled. Our disappointment in the implicit promises of medical science is proportional. Thus, more stress on fiduciary responsibility

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\(^3\)Barber, p. 138. Since the public's ability to evaluate the performance of professionals is limited, "technically competent performance" is defined in terms of professional standards. "Professional standards" also serve to set guidelines for members of the profession.
becomes part of the social control mechanism (although doctors resent this as an imposition on their autonomy and authority).

I have argued that our perception of social reality is made up of a taken-for-granted perception that the world is as it appears. We "trust" our perceptions of the world, which are conditioned by the time and place in which we live. Occasionally we are "shocked" to discover that our assumptions about reality are artificial. Once shocked, people cannot live mistrusting the "reality" on which they base their interpretations of experience. Human beings are driven to restore an accent of reality to their world, one which integrates the new information into a satisfactory point of view (satisfactory in that it allows the person to "trust" or take the world for granted again).

Medicine as a profession is a combination of technical expertise and an ethic of service, and as such it receives a special dispensation from society: the physician is given a monopoly of power and authority in health care. As this dispensation acts to the advantage or benefit of society (the world of daily life), society trusts the ethics of medicine. The privileges of professional autonomy are very real. In return for technical knowledge, skill, and dedication to service, the profession asserts extensive jurisdiction on standards of training, credentialing, and conduct. In effect, he or she becomes a self-regulating "gatekeeper" to the goods and services represented by health care.

Through the demands of licensing, credentialing, legislation, litigation, and the market place, medicine acknowledges its place in the overarching reality of the world of daily life. To this extent, the physician is not a fully independent functionary. As a member of a profession, the doctor occupies a
position in the field of health care. This position is a construct of typicality from which he or she receives meaning. The profession has a "past" and a "future" to which the doctor owes consideration. In addition, the physician is a member of a profession which occupies a place in a social matrix with other provinces of meaning in the world of everyday work. It is in relation to these provinces that the work of the doctor takes on meaning.

Implicit in this social arrangement between the medical profession and the public is that professional self-regulation should be advantageous to society. When this advantage is threatened, society may withdraw privileges of professional autonomy and rights to special treatment in a drive to ensure its own protection. In this sense, trust is a form of social control. When society mistrusts the profession, it will exercise other forms of control. The climate of suspicion acts as such a form of control.

84 Jesse Pitts, "Social Control: The Concept," in David Sills, ed., International Encyclopedia of the Social Sciences 14 (New York: Free Press, 1968), 381-396; and Judith Swazey and Stephen Scher, Social Controls and the Medical Profession (Boston: Oelgeschlager, Gunn, and Hain, 1985). Distrust and suspicion do serve an important function in public policy and practical social policy. The public and the government want to base attitudes and policy on the increasing or decreasing trustworthiness of the profession; see Barber, pp. 21f., 136. If the medical profession is moving from its fiduciary commitments, and in the light of a decline in the public bestowal of trust, more pressure for alternative social control will develop. Doctors could be licensed as "trades," subject to Federal Trade Commission regulations; they would become "technicians."
Public attitudes towards the medical profession have always been ambivalent. This ambivalence is both sociological and psychological. It is caused by the structured expectations doctor and patient have of each other, as well as by physician deviance from expectations or malpractice. Distrust according to trait theory of professions is caused by an individual’s failure to embody trait or the failure of a profession to inculcate traits. According to the functional theory, distrust results from a professional’s temptation to pursue self-interest. The problems can be very subtle. In the name of acting in the patient’s best interests, a doctor may act to preserve the profession’s authority. Yet this action can represent self-interest in that it serves to maintain the physician’s own power (in an act of paternalism). Professional altruism, so powerfully influenced by an ethical obligation to benefit the patient (an obligation that doctors and not necessarily patients have imposed on themselves), can cruelly deceive both the patient and the physician.

85Fox, p. 515. Also, see Parsons’ discussion of “persistent ambivalence” in public attitudes towards the professions; Talcott Parsons, “Research with Human Subjects and the Professional Complex,” Daedalus 98 (Spring, 1969), 325-360.


87Katz, p. 97.
As a result of the social organization of medicine, the profession guards its independence and autonomy against what it terms "lay control." As the profession becomes specialized, as the scientific method is used to generate powerful knowledge and expertise, and as third party payers emerge, public's uneasy ambivalence finds new strength in a climate of suspicion. The profession naturally acts to reinforce its authority and maintain its control by emphasizing its area of primary strength -- expert knowledge. This polarization places more strain on the correlative fiduciary aspect of relationship, and leads to a climate of suspicion in which the assumption that the medical profession is acting for the best interests of clients is undermined. An economy of trust is established in which trust becomes a commodity to be bartered.

Summary

The breakdown of the trusting therapeutic relationship has led to an attitude of dis-ease between the physician and the public (represented by the patient). Not all patients distrust all doctors, not all doctors distrust and seek to control all patients. However, relations between people and the professions are under review. The accent of reality that is beginning to shape the expectations of the participants in the health care relationship is characterized by this suspicion. More specifically, trust in this climate of suspicion has become a mechanism used by the profession to acknowledge

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public concerns while maintaining the profession's control of its work. Trust in this climate becomes an "illusion" with no substance.

It is not coincidental that as the scientific biomedical model has led to an increase in expertise and technology, there has been a correlative development of public concern with health care (the development of bioethics as a discipline reflects this concern). For instance, in recent years medicine has been criticized for de-emphasizing the patient as person.\textsuperscript{89} While advances in medical knowledge and technology result in significant gains with regard to treatment, patients feel alienated from their physicians. Much effort has been made to make medicine more "humanistic."\textsuperscript{90} While fewer practicing physicians find the biomedical model satisfactory in caring

\textsuperscript{89}Paul Ramsey, \textit{The Patient as Person} (New Haven: Yale University Press, 1970); John Gorden Freyman, \textit{The American Health Care System: Its Genesis and Trajectory} (New York: Medcom, 1974). Also, see Benedict M. Ashley and Kevin D. O'Rourke, \textit{Health Care Ethics} (St. Louis, MO.: The Catholic Hospital Association, 1978), pp. 88–95. William J. Goode argues that the medical profession is a "person profession" which does not produce goods, but provides service to people in crisis; "The Theoretical Limits of Professionalization," in \textit{The Semi-professions and Their Organizations}, ed. Amitai Etzioni (New York: The Free Press, 1969), pp. 266–313. Ivan Illich believes that modern medicine no longer concentrates on a personal dimension but on productivity; \textit{Medical Nemesis}. Freidson feels that the change to depersonalization has adversely affected physicians as they lose their traditional identity; \textit{Profession of Medicine}.

\textsuperscript{90}M. A. Schwartz and O. Wiggins, "Science, Humanism, and the Nature of Medical Practice: A Phenomenological View," \textit{Perspectives in Biology and Medicine} 28 (1985), 331–361. Toombs argues that such an enterprise can only fail if illness is conceptualized according to the anatomical/pathological model as an objective, abstract entity, in some way separate from the one who is ill; Toombs, p. 235; also see E. J. Cassel, "Disease as an 'It': Concepts of Disease Revealed by Presentation of Symptoms," \textit{Social Science and Medicine} 10 (1976), 143–146; David C. Thomassma, "The Basis of Medicine and Religion: Respect for Persons," \textit{Linacre Quarterly} 47 (1980), 142-150.
for patients, much of the recent literature in bioethics continues to argue for physicians to develop a "human vision," as opposed to a "medical vision," to better care for the patient. The medical profession has given attention to regaining the confidence and trust of the public in recent years by acknowledging the public's concerns about cost and control of health care, humanistic medicine, and the rights of patients. However, the biomedical model of medicine remains dominant and determines the foundation of the medical province of meaning.

The physician cannot escape a "medical" view of himself and his relationship with his patient due to a particular eidetic interpretation of the phenomenological boundaries (the horizon of meaning) of the medical profession. This view serves to characterize the meaning of "work" and expectations of trust for the doctor, even as it serves to separate the phenomenological "reality" of the physician from the experience of the patient. While the two social roles are correlative, they are phenomenologically distinct in the way they conceptualize and "trust" their experience and each other. A phenomenological "shock" occurs when expectations are contradicted, when what was trusted or taken-for-granted is called into question. Distrust is a method used to restore a sense of control in the interaction. If the challenge to a horizon of meaning remains unresolved, this distrust becomes destructive of an understanding and

91 Oliver Sachs discusses "human vision" as directed at the person who is ill and "medical vision" as directed at the clinical data of illness; The Man Who Mistook His Wife for a Hat and Other Clinical Tales (New York: Summit Books, 1985). Also, Schwartz and Wiggins, pp. 331-334; R. J. Baron, "An Introduction to Medical Phenomenology: I Can't Hear You While I'm Listening," Annals of Internal Medicine 103 (1985), 606-611.
acceptance of the other. In a self-protective posture, reform of the
relationship becomes shallow and illusory.
Chapter Four

Trust-as-Control in a Theological Perspective

Introduction

An eposche which builds upon the sociological and phenomenological argument in chapters two and three reveals the distrust that fosters an inauthentic "giving and receiving" of trust in relationships, even in the relationship between the human and God.¹ Such giving breeds suspicion, resentment, and shame within the receiver, even as it demeans the giver. It is produced by the desire to escape dependency, yet serves to perpetuate that condition. Physicians profess to work for the benefit of the patient. However, by doing so, they also work for their own benefit. Without adequately acknowledging this self-interest, which grows out of their mutual dependency, seeds of alienation and estrangement are carried within the medical relationship.

¹Alan Keith-Lucas has written on the dynamics of giving and taking help, but his work does not deal directly with the peculiar situation of a condition of "dis-ease" in the physician's relationship with others. I will draw upon some of his ideas, but recast them from social work to a theological perspective; see Alan Keith-Lucas, Giving and Taking Help (Chapel Hill: The University of North Carolina Press, 1972). More helpful from a theological point of view is Alastair Campbell, Professional Care: Its Meaning and Practice (Philadelphia: Fortress Press, 1984) and Moderated Love: A Theology of Professional Care (London: SPCK, 1984). Campbell exhorts us to resist making professionals into cult heroes and paradigms of loving concern, since this leads to the elevation of doctors as "gods." Such an elevation obscures the humanity and fallibility of the professional. Also helpful is Richard Titmus, The Gift Relationship: From Human Blood to Social Policy (New York: Pantheon, 1971). Also, see David Michael Levin, The Body's Recollection of Being (Boston: Routledge & Kegan Paul, 1985).
In the shock accompanying illness and the recognition of dependency, the loss of the epoque of well-being threatens one's self-identity and control and disrupts previously taken-for-granted relationships. The phenomenological "breaching" of the natural attitude that illness provokes suddenly makes one aware of experiencing "himself" or "herself" as dependent upon others. In fact, at a time when a person's "self" becomes of paramount concern, he or she am aware of the fragility of this "self." The habitual structuring of one's everyday experiences are revealed as constructed or fabricated. The patient presents himself or herself for help in a uniquely vulnerable and dependent condition, and is forced to trust that the physician, often a total stranger, knows what to do and will act in the patient's best interests.

However, the physicians' and patients' horizons of meaning are seriously out of joint. People have increasing difficulty determining the relevancy of medicine's approach to their experience of illness. The interruption of illness causes the person to perceive that he or she is both subject and object in the world, a threatened embodied self. In the medical province, armed with medical knowledge, the physician may slip into perceiving the patient as a "body" over and against the doctor's self. At one time, this relation was acceptable to the public. However, Leon Eisenberg claims that "present-day disenchantment with physicians, at a time when they can do more than ever in history to halt and repair the ravages of serious illness, probably reflects the perception by people that they are not

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being cared for." The habits of mind which medicine fosters in many physicians seem disconnected from the "controlling presence" that the experience of illness represents to the patient. A part of the physician's task in treating patients is to bring them to alter their perceptions of their life-world, to experience their lives in terms the doctor's understanding of the patient's symptoms. This alteration in perception allows the patient to place the experience into a meaningful perspective based on a common frame of reference. However, when either party becomes a controlling presence, the common universe between them is fragmented. The center of meaning around which the medical encounter is formed is threatened.

In the Christian religious tradition, the image of the transcendent, creator God has provided a central focus for a sense of meaning and reality. It was assumed that God or the divine exists or has reality "out there," i.e., as distinct from and independent of human nature and our way of thinking.


4I recognize that ordinarily all social relationships involve an exchange of power and control. Even in a mutually balanced interaction, from time to time each party has a controlling influence in the "give and take" of relationship. By "controlling presence" I mean to imply a permanent influence sought or achieved by one member in which the other is reduced to an ontologically diminished status.

5There are multiple realities within any community. Within the Christian tradition, for example, there have been many interpretations of the nature of deity, each of which provided a center of meaning around which a church, sect, or denomination could take its identity. While two groups might define themselves over and against the particular interpretation of the other, the common feature was attention to deity and some allegiance to the community of God.
about God. In the postmodern age, I will argue, the relevancy of God to human life is questioned by many. Once the acceptance of the God-as-center is bracketed, the human community is thrown upon its own resources for identity and coherence. The effort to replace theology with anthropology has given rise to humanistic atheism. In the postmodern age, such atheism also has proven unable to provide a depth of meaning by providing people with a sense of unity and community that transcends the perception of finitude. We are left with a culture of criticism in which nothing is sacred, and one is left standing on the abyss of nihilism.\(^6\)

In a culture flavored by nihilism, in which the ability of individuals to suspend disbelief in such a deity is losing its resiliency, the person confronts without mediation the riskiness of relationship, the perception of the precariousness of individual and social identity and security. In an attempt to guarantee self-identity, one is tempted to restore a sense of self-control and autonomy by protecting the self from riskiness. However, while this movement of self-preservation is natural, it is represents an attempt to eliminate what is inescapably present -- the risk that accompanies the human need for relationship.

In the climate of suspicion created by the desire to escape risk and neediness, both parties in the health care relationship react from within a

particular horizon of meaning or accent of reality which is increasingly characterized by self-protectiveness and defensiveness. The danger of such a climate to social relationship lies in a tendency towards skepticism or the use of distrust as a means for social control of others. In this chapter, a theological analysis will highlight the serious nature, and inevitable failure, if physicians use trust-as-control to dominate others.

The Postmodern Breakdown of Faith in a Transcendent God

The Enlightenment represents a cultural-historical development of this-worldly values, methods of inquiry, critiques of traditional authorities, and criteria for truth which claimed to cut through the conflicts caused by the ambiguities of historical religion. This reaction against authoritarian religion sparked an optimistic belief that humans themselves are able to provide for the needs of the human spirit in an atmosphere of freedom and reason. Moreover, this spirit brought changes in ethical and social theory, characterized by an emphasis on humanitarianism, individual rights, and an appreciation for the critical method of inquiry. It resulted in an appreciation of the role played by social interaction in structuring cultural meaning and values.

The application of the critical method to the study of human existence has resulted in the development of the social sciences. Social scientists

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7The patient who reacts to the need for additional medical tests by announcing that, "All you doctors are alike. All you want is more money," may be attempting to use distrust to gain a measure of control over the situation. Such an attitude seeks to manipulate the doctor into some confirmation that he or she is trustworthy -- that he is not like "other" doctors. That manipulation can produce feelings of anger, resentment, and shame in the physician.
maintain that the social construction of reality is played out within the
world-field of objects and persons external to the individual's consciousness,
affecting his or her way of thinking and acting in the world. This
relationship between a "produced" society and the individual producers of
society is reciprocal: They act upon each other. For sociologists and other
social scientists, this interaction is a given aspect within existence. Therefore,
meaningful patterns of life are not derived simply through conceptual
thinking. Instead, people become familiar with the world by living in it,
encountering and struggling with other persons and objects. It is through
this active participation in the world that conceptual thinking and patterns
of living are developed. These patterns are then internalized and come to
affect the activity within the world. Social scientists conclude that the
embodied self does not live in isolation, but within an objective world and an
interpersonal matrix. In a sense, everything we know of the world is
received from our social milieu. All is presented to us through the social
makeup of the everyday life.

In sociological theory, morality as a sense of value and meaningful
existence, and ethics as a means for evaluating behavior within morality,
develop over time within the reciprocal relationship of a "produced" society
with its members. Ethical thinking helps shape and maintain the ties that
bind individuals to each other and to the community. An individual or
group's behavior and choices regarding appropriate behavior arise from the
patterns of life deemed meaningful by a community. As long as these actions

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8See the discussion of "meaning" in the context of human interaction and
social experience in Alfred Schutz, Collected Papers II (The Hague: Martinus
can be assigned meaning, and, therefore, made acceptable within the limits of such a "reality," some sense of harmony can be maintained. No appeal to an authority of normative behavior outside of the system is considered.

This idea of a socially constructed reality is applied to religion. In terms of the sociology of knowledge, religious concepts are externalized or projected, given a facticity, and internalized as part of the ecclesiastical tradition of the religion and as part of the ongoing history of the society. These concepts come to act upon a people by establishing moral and ethical norms and belief systems. In a pluralistic culture in which religions must share a place with other provinces of meaning, religious concepts, beliefs, and values are bestowed with meaning in the world of daily life.

In the post-Enlightenment criticism of theism, God has been characterized as essentially transcendent, yet revealed in the objects of the world. Conceptualized as omnipotent, omniscient, and omnipresent, God is the Unmoved Mover who is the origin of all motion and the source of all rest. The God who is alone God is "an identity which is only itself."9 The deity is fully and completely self-enclosed and self-present. This ultimate subjectivity of God does not establish a continuum between divinity and

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humanity. As the full realization and original ground of selfhood, God is wholly other, is absolute "alterity."\(^{10}\)

The conceptualization of God as "other" reflects a polarity that is the basis for the theistic model carried within the Western theological tradition. Though consistently monotheistic, Christian theology operates with binary terms. Whether speaking of God and world, infinite and finite, life and death, giving and receiving, or trust and distrust, these opposites are not regarded as equivalent. Invariably one term is given an ontologically privileged position through the reduction of its relative (e.g., "It is better to give than to receive"). The resulting economy of privilege sustains an asymmetrical hierarchy in which one term rules the other throughout the theological and axiological domains.\(^{11}\) Such a dyadic foundation, in which each term has ontologic value of a primary and secondary nature, extends to the domain of health care. The conception of relationship places the terms "physician and patient" and "health and illness" in a seemingly exclusive and evident opposition. The first term in each pair obtains a primary position in the ontological economy of privilege. It is this economy of relationship, both in its social and conceptual ramifications, that has led to the cultural climate of suspicion which undergirds the particular concerns discussed in this dissertation.

\(^{10}\)Mark Taylor, *Erring: A Post-Modern A/theology* (Chicago: University of Chicago Press, 1984), p. 23. This God rules and is ruled by the nondialectical logic of simple negation: God is "not this"; God is "not that." Norman O. Brown describes this logic as one of repression since no positive statement is valid; *Life Against Death: The Psychoanalytic Meaning of History* (New York: Random House, 1959), p. 161.

\(^{11}\)Ibid., pp. 8-9.
The spirit of the secular age has been marked by an emphasis on the world as shaped and structured by human reason and will. However, in the midst of the gradual secularization of Western society, it also is becoming clear that the way in which we view the world and organize a meaningful existence depends upon the model of meaning and structure of reality to which we subscribe (in which we have faith). There are many models available in the world, each claiming to represent reality most adequately by defining experience in the most meaningful way. Whether we examine a particular religious, scientific, political, psychological, or economic model or paradigm, each represents a "reality" according to its own terms and truth claims. Any one can provide norms for behavior which take on a particular meaning and value consistent with the parameters of the model.

While a model may be consistently meaningful within itself, thereby offering some means of identifying "norms" for behavior, it cannot extend its view of reality beyond its own parameters. It exists in a world made up of multiple paradigms. Although a person may be able to ignore these

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13A Marxist or Freudian can have complete "faith" in his or her particular means of ordering reality, yet while consistent within its own parameters, these "orders" become relative to each other as finite provinces of meaning within a culture made up of multiple levels of reality; Alfred Schutz, *Collected Papers* 1 (The Hague: Martinus Nijhoff, 1962), pp. 229-231.

competing claims for a time, finally, inasmuch as these provinces are finite, anomalies will appear to challenge the province’s accent of meaning. As a result, “...the spirit of the typical “modern” man is relativistic and skeptical.... What do arguments prove, if an opposite theory can be based equally logically upon an impregnable principle?”15 If the person is to possess a grounds of authority for lived experience in a world in which various models compete with one another, some principle must be found which can transcend the truth-claims of competing models and offer a means for resolving relativistic interpretations of “good,” even “normal” behavior. The concern with moral relativism, or the inability to determine a ranking of moral principles and theories, reflects this uneasiness.

The problem is more radical. Phenomenologically, “habits of mind” constitute experience -- construct it -- in ways that are not quite captured by concepts like models, paradigms, or world views. Because the notion of paradigm offers a convenient way to talk about how we orient ourselves in relation to the world, the term has become central in descriptions of professional practice. Paradigms, however, result from habits of mind -- of observation, of selection, and of interpretation -- which are the bedrock of a person’s “approach to the world.” Medical paradigms and models represent orienting world views which compose a profession’s culture, but these are themselves constituted by spontaneous and taken-for-granted habits of mind.16


16Kestenbaum, p. 8.
Prior experience and the meanings retained or funded by it affect present experience, often in subtle as well as determinate ways. Through our habits of mind, meanings are present, but not visible in a situation; we "live" them before we "know" them. They are of "second nature" to us. The invisibility of this second nature, its naturalness and spontaneity, accounts for our ability to "make sense" of reality.\textsuperscript{17} When habits of mind are called into question, a person's attitudes towards everyday life, his or her understanding of the past and present, and his expectations for the future, suddenly are adrift.

There is in the postmodern world presently a crisis of trust. The theistic habit of mind which determines Christian observations, selections, and interpretations of reality is seen as incommensurate by other habits of mind in a pluralistic culture. However, the "unambiguous" status of science and its praxis was supposed to eliminate metaphysical and epistemological confusions and ambiguities attributed to religious thought. Historical, sociological, psychological, and phenomenological critiques of religious authority have produced religious, ethical, and cultural pluralism, and instead of eliminating have created new metaphysical and epistemological interpretations. As a result, western culture is passing through the culture of

\textsuperscript{17}Ibid., p. 7.
criticism into a postmodern period in which conceptions of science and religion are undergoing criticism. 18

The effort to establish certainty through the Cartesian method of doubt and the scientific search for an objective basis for confident knowledge as a basis for action in the world leads to "superficial" knowledge at the cost of a depth of meaning. It was believed that the proper formulation of method would uncover the limits of natural law and reveal the inner workings of creation. Such a viewpoint presumes that the world of facts, and often the world of values, has a unique pattern of rational coherence. 19 The emphasis on knowing thoroughly, on seeing all sides, represents the desire for fully objective knowledge (knowledge of the "ding an sich") -- a vestige of Descartes' wish for certainty and the Enlightenment confidence in universal reason. However, the scientific method, which has been employed in this drive for a universally common perspective, is unable to deliver the goods. With the movement from skepticism to nihilism, the

18For a critique of the theistic conception of God, see Altizer, The Self-Embodiment of God; and The Descent into Hell: A Study of the Radical Reversal of the Christian Consciousness (New York: Seabury Press, 1979). On the other hand, Langdon Gilkey argues that the secular age (the postmodern world) is a "time of trouble" due to the shrinkage of the world-dominant power of the West, a decline in the pull of Western ideas, a science and technology that raises problems even as they solve others, and a decline in the ideologies of progress and Marxist social vision. This reversal in secular fortune Gilkey sees as an historically extended phenomenon which arises out of the past and represents the challenge of the future to theology; Langdon Gilkey, "Theological Frontiers: Implications for Bioethics," in Earl E. Shelp, ed., Theology and Bioethics (Dordrecht: D. Reidel, 1985), pp. 115-134.

19Engelhart, p. 19.
question is no longer what can we know, but can we know, or depend upon, anything at all?

Thus, the late 20th century is a time of growing distrust, not only in religious belief, but in the belief structure of science and humanistic culture. For instance, in the secularized natural attitude, science is believed to need no external moral guidelines. However, the guidelines of science have proven inadequate to secure deeper human values. While science and technology have become indispensable to our lives, inasmuch as agriculture, industry, health care, etc., are dependent upon them, the vulnerability of culture is revealed. We are experiencing the shock that occurs when confidence in a preceeding ethos, such as the ideology of progress, is shaken. A yearning for reintegration of meaning and value to set the world right and reduce anxieties leads to the recognition that the scientific accent of meaning is only one aspect of the world of everyday life. This perception reflects a criticism or epoche applied to secular culture’s accent of meaning. It opens the way for a return to a theological analysis of the nature of dependency and the problem of an economy of domination in relationships. Issues of domination and exploitation arise in human life as we attempt to equalize the unequal by erasing the difference of that which is other -- including the other—God.20

Theological Roots of Trust-as-Control

One theological tradition within early Christianity claimed that Jesus suffered in his "human" aspect, but that this spirit was distinct from the "divine nature" in him. Accordingly, the suffering Jesus was not God, not

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20Taylor, p. 23.
even a symbol of the nature of God, since the divine nature excludes all
suffering. Arius argued that God is a selfless divinity, above all needs. The
only response to the perfection and absolute will of this God was
unconditional obedience in a life of faith. This claim was based on the
assumption that God neither needed nor sought the mutual good of
fellowship with humanity, yet choose to relate by the gift of grace in Jesus.
God retained the privilege and the power of the "free" gift of relationship.
The ultimate inspiration for the idealization of selfless giving was this vision
of the divine as pure self-giving devoid of all self-concern. Following this
tradition, the tradition of "imitatio Dei" becomes one of self-abnegation, and

21Classical theism denied the relativity and temporality of God. However, the
tradition held that Jesus was both suffering man and God. The
Patrificationists drew the conclusion that God must suffer. The orthodox
reply to this position was that only the manhood in Jesus included suffering,
not the divine nature. The two natures were really distinct, even though of
one person. According to orthodoxy, Jesus as suffering was not God; Charles
Hartshorne and W. L. Reese, eds., Philosophers Speak of God (Chicago:
University of Chicago Press, 1953), pp. 152-153. The two authors object to
this assertion, arguing that it is paradoxical for God to be all-inclusive, yet
exclusive of suffering. To avoid patrificationism, they see Jesus as a loving
and altruistically suffering human being who is not God, but a supreme
symbol of deity, at the center of human suffering. This suggests that God is a
being with absolute nonimmunity (not absolute immunity) to suffering; pp.
162-163. See Stanley Hauerwas, Suffering Presence: Theological Reflections
on Medicine, the Mentally Ill, and the Church (Notre Dame: University of

22For an excellent review of the theological issues at stake in the dispute
between Arius and Athanasius, see Arthur C. McGill, Suffering: A Test of
Theological Method (Philadelphia: The Westminster Press, 1982). Also, see
Stephen G. Post, "The Inadequacy of Selflessness: God's Suffering and the
Theory of Love," Journal of the American Academy of Religion 56 (Summer,
the domination of mutuality and reciprocity between the human and the divine.

Although soundly reputed by Athanasius and his followers, the Arian view of God as wholly self-contained lingers as a counterforce in Christian theology which has surfaced in the modern period. The claim that the transcendent God of Christianity is experienced as domineering rather than life-giving to human individuals and community is disturbing. Generally, the orthodox tradition within the religion perpetuates the priority of the divine center over the individual human. Relations between individuals in community are expected to model the relationship between the divine center and the individual. In the classical theological tradition, knowledge of self is mediated by knowledge of God, and humans are expected to imitate God in their dealings with others.

However, in the postmodern world, attempts to bolster the hierarchical relation of opposites that sustains the theological economy of privilege fail to fully satisfy. As long as the assumption of hierarchy is made, people are left with shame at their stubborn selfishness and inability to match the idealization of selfless giving. In the attempt to bracket

23McGill, pp. 34-52.

24Karl Barth's classic work, Church Dogmatics II (Edinburgh: Clark, 1975), p. 174, appears to maintain the absolute gulf between God and mankind in terms of their respective "knowability." As we shall see in chapter five, his concept of God risks being misunderstood. Of course, attempts to eliminate the economy of privilege are equally unsatisfactory. The "search for the historical Jesus" represents the effort to find a more reciprocal relationship between the divine and the human (more convenient, Barth might say). See, for instance, Adolf Harnack, What is Christianity? (Gloucester, MA.: Peter Smith, 1978).
discomfort and doubt, people are driven to seek self-sufficiency or self-annihilation.

The depths and tenacity in the postmodern world of the hermeneutics of suspicion must be appreciated. The denial of God as central to human life and the elevation of humankind to centrality throws individuals into confrontation with other selves, and finally with the otherness within themselves. At the moment when the phenomenological epoch is bracketed, the self confronts the other within and without, and self-identity is disrupted. God and self become master and slave, engaged in a life-and-death struggle that is inspired by the shock that grows out of a direct encounter of the other as "other."

The Christian theological tradition maintains that humankind is created in the image of God, and, therefore, is bound by its relationship with God and each other. If God and mankind image each other, as if in a mirror, the self sees itself reflected in the other. However, the encounter with the other as "other" leads to the encounter with the "self" as other in the reciprocity of perspectives. Facing the all-powerful master, the self realizes that it has lost itself, for it finds itself as an "other" being. By forcing the self outside of itself, God discloses the subject's estrangement and self-alienation. In the Augustinian tradition, this disruption or confrontation is the necessary first step to reconciliation with God in faith. However, in the

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25 Postmodernity recognizes the dependence of all truth claims on the vested interest of the claimant, thus undermining any consensus of understanding; see David Klemm, The Interpretation of Existence (Atlanta: Scholars Press, 1986).

26 Taylor, p. 23.
post-modern world characterized by a climate of suspicion, awareness of their dependency drives people to seek self-possession through the domination of others.

Dependency and Domination

I have argued that social existence involves the gift of life, of meaning, and of place in the world. A person born into an ongoing tradition is given an identity and a means for making sense of reality. It is crucial to note that giving represents only one-half of a person’s relationship to the everyday world. Receiving is completed by the giving one returns to the world. It is through this exchange that people participate in “reality.” The natural attitude of the world of daily life into which they are born represents (or gives) a sense of reality to them, and they in turn re-presents (or give back) themselves to reality. Therefore, persons participate in reality by giving and receiving through combinations of relationships.27

Ordinarily, these combinations occur in a taken-for-granted fashion as the person lives in the world assuming that the conditions of his or her life are as they should be. However, when the natural attitude is disrupted, the person becomes aware that his or her life could be other than it is. The person becomes aware that he or she is incomplete, dependent upon others for the conditions that make up his or her “life.”

27 Gibson Winter, Elements for a Social Ethic: Scientific and Ethical Perspectives on Social Process (New York: Macmillan, 1966), p. 255. One of the insights of the social scientific perspective is the “image of man as made by history and as maker of history.”
In any relationship within the everyday world, giving and receiving are involved. Furthermore, receiving depends upon the nature of the giving. Ideally, receiving from the world (and from others who are a part of it) should not become a means for alienation and anxiety. Unfortunately, in the world of daily life in which people struggle, compete, choose, demand, punish, and reward, rarely are gifts exchanged freely. As people begin to suspect the depths of their dependency, they become possessive of their identities, suspicious of the other, and threatened by that which is outside of themselves. The presence of "otherness" creates anxiety, and seems to produce a defensive withdrawal from the other in order to protect and preserve the self.28

Dependency causes people to guard themselves jealously. They become suspicious of gifts and resist receiving a gift with gratitude because they fear becoming obligated (in debt) to the giver.29 Consequently, people cannot receive easily and cannot give easily in return. Gifts become commodities which have a price, and which are returned in a similar fashion. Neediness and dependency are perceived as weaknesses which people are

28Ibid., pp. 228-229.

29See the discussion in P. F. Camenisch, "Gift and Gratitude in Ethics," Journal of Religious Education 9 (Spring, 1981), 1-34.
afraid to reveal, yet these conditions lie at the very root of individual and social existence.  

In this condition of dependency, people tend to objectify the other, reducing his or her gifts, and therefore, his or her self, to the status of "objects." Domination and exploitation become motivating forces in human interaction as people attempt to mask their dependency from others and from the self. Through a person's fear at being vulnerable, he or she renders himself or herself unable to accept life and relationship as a gift, freely given and freely received. Consequently, he or she cannot live his or her life with gratitude, and feels threatened by the need for relationship.

The natural attitude within which people ordinarily encounter their world carries with it a sense of "real estate." Unlike possessions, which are removable, able to be made absent when the tax assessor arrives, "real" estate is defined as that "property" which is fixed in place. Property, therefore, becomes what is fully present. The economy of domination is tied to this logic of property in Western metaphysics. Confronted by a god who is absolutely beyond their control, people seek to imitate aseity, and thereby gain control over their perceived creatureliness. However, this control becomes self-directed as the person seeks to aquire and retain some "fixed" meaning in life. This drive towards domination is based on the principle of

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Dependency and neediness, which arises from it, are fundamental components of human existence and cannot be denied. It is from this common condition that structures of meaning derive: "We are related to one another -- existent being to existent being; value (positive or negative) is present in the fulfilling or crippling relations of being to being"; H. Richard Niebuhr, Radical Monotheism and Western Culture (New York: Harper and Row, 1960), p. 107. It also is from this common condition that interdependence and mutuality derive their importance in relationship.
ownership which, in turn, is based in the acquisitive logic of need. Too easily, this drive seizes upon one’s body and sense of self as a possession to be protected. One’s “well-being” similarly can become well guarded.

A sense of physical well-being and personal integrity allows a person to “work” in the world in existential and ontological peace of mind. Illness is an interruption, a bracketing of a person’s sense of embodied wholeness. Illness names that experience in which our everyday, embodied capacities fail us. It obstructs our ordinary access to the world and presents the body as a signifier for the way in which we are limited and dependent beings:

"Illness erodes the image we have constructed over the years, often painfully, of ourselves and our world. That image is our personal effort to harmonize our deficiencies and our strong points. It is our personal definition of our situation in respect to others and the world, our unique relationship to work, play, or salvation, laboriously


32By describing this sense of well-being and personal integrity, and by calling illness an “interruption” of this sense, I am not endorsing the World Health Organization’s definition of health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” If this definition is accepted, it becomes virtually impossible for physicians, or anyone, to fulfill its implicit demand. However, for some authors, “holistic” concepts of health appear to be less misleading and more effective than biomedical concepts. For the WHO definition of health, see Tom L. Beauchamp and Leroy Walters, eds., Contemporary Issues in Bioethics (Belmont, CA.: Wadsworth, 1982), 48. See the discussion of concepts of health in Daniel Callahan, “The WHO Definition of Health,” and Sally Guttmacher, "Whole in Body, Mind, and Spirit: Holistic Health and the Limits of Medicine," ibid., pp. 49-53, and pp. 54-58.
fabricated and balanced against the changing exigencies of life. Illness threatens this carefully wrought self-image.\textsuperscript{33}

Pellegrino quotes Ortega y Gasset in claiming that each person fashions existence out of the circumstances in which he or she finds himself or herself. Each person confronts the realities of his or her unique situation and humanizes it, attaining an equilibrium with it. "In short, the reabsorption of circumstance is the concrete destiny of man."\textsuperscript{34} Illness moves us toward the absorption of a person by circumstances. Illness fragments our constructed world by bracketing the natural attitude that enables us to organize and "live with" circumstances and exigencies of human existence. It is this fractured condition that the medical relationship works to "heal" by a mutual effort with the patient to find a new balance, to restore a balance or an integration of the changed circumstances which enables the person to recover some sense of his or her personal project.\textsuperscript{35}

However, in the movement toward the absorption of the person by changing and threatening circumstances of illness, a person's self-control is disrupted. The person is made vulnerable in relations with others. The power differential between the physician and the patient is, in effect, an economy of domination which results in a focus on utility and consumerism in the health care relationship. According to the principle of ownership, the

\textsuperscript{33}Edmund Pellegrino, "Being Ill and Being Healed," in Kestenbaum, pp. 158-159.

\textsuperscript{34}Jose Ortea y Gasset, Meditations on Quixote, trans. by Evelyn Rugg and Diego Marin (New York: Norton, 1963), p. 45, quoted in Pellegrino, ibid., p. 159. Also, see Kestenbaum, p. 76.

\textsuperscript{35}Pellegrino, ibid.
doctor "owns" or possesses his or her knowledge and skills, the patient "owns" or possesses his or her body; each possesses certain proprietary rights. Health care becomes a bartering battleground in which goods and services are exchanged in an economic process of giving and receiving cure and care. In recent years, there have been controversies regarding a person's right to buy and sell human organs (does one possess ownership of his or her body and have the right to sell pieces of it), surrogate mothering, and physician investment in laboratories and testing facilities (after all, their knowledge is their possession and can be utilized for additional profit). Participants struggle to acquire and accumulate power to minimize what they give and maximize what they receive. However, dependency and neediness remain and cannot be eliminated. These two conditions may be ameliorated, but they cannot be controlled.

The modern struggle for autonomous existence free from the domineering presence of a transcendent god finds expression in a drive for "health" and "life" as commodities for self-possession. The demand that there be equality in all respects between the physician and the patient, or that everything be done for a patient, is a reflection of this struggle. However, the effort to possess the other represents an indirect attempt to possess one's own self. The attempt is doomed because it carries within it the seeds of its own destruction. The effort to possess total and complete presence, without loss, without need, results in death. Although we strive to possess ourselves as property, it is not the presence of self that we can control. It is the

recognition of an absence of possession and control that gives complete meaning to the self.

Shame and Resentment

In the absence of self-control, with the recognition of dependency as incompleteness, a person often feels guilt or shame in relations with others. People who feel guilty invoke the concept of right and wrong and expect their victims to be resentful. "Guilt" is relieved by reparation and forgiveness that permits reconciliation.37 Although guilt is the result of injuring or violating the good in another through the denial of need, at least to feel guilty is to be still willing to live in relationship. The person is willing to receive, although he or she might violate the gift and feel guilty. The word "shame" denotes a feeling or emotion that a person experiences after wrong or bad actions. According to John Rawls, shame is a feeling that a person has when experiencing damage to his or her self-esteem.38 People who are ashamed appeal to an ideal of which they have fallen short. In a discussion of the use of trust-as-control, shame is the more troubling concept.

Shame results when alienation has reached the point that the person feels deficient in his or her "self." Every encounter threatens to remind the person of this deficiency and reveal it to others. To mask this feeling, people may react in a variety of ways. First, those who are ashamed strive to become selflessly involved or preoccupied with the world in order to deny


their violated sense of self. Second, people strive to destroy the goodness which forces them to confront the inadequacies within themselves by turning outward to dominate the world around them.\textsuperscript{39}

If either of these approaches is taken, people engage in a dynamic of giving and receiving twisted into a self-centered giving and shameful receiving. If the giving that occurs in relationship is of a type to evoke shame and humiliation, the interaction will be received with resentment. Shame fires the desire to gain control over the oppressor and become masters ourselves. It gives impetus to the drive for autonomy and independent selfhood as the means to relieve the subject’s estrangement and humiliation at being deficient and needy.\textsuperscript{40}

The possibility of shame and resentment in the doctor-patient relationship is a seldom discussed topic. Any illness can be shame-producing for the patient and the physician.\textsuperscript{41} Illness may bring on feelings of helplessness, create changes in one’s mental status, and may produce physiological symptoms that are distasteful or offensive to the patient and

\textsuperscript{39}The humanistic tradition has never realized the deep rooted need within people to destroy. Attempts to establish “good” within the world can release tremendous destructive tendencies.

\textsuperscript{40}See Paolo Freire, \textit{A Pedagogy of the Oppressed} (New York: Herder and Herder, 1971). The roots of the struggle between deontological and consequentialist ethicists over which theory will provide maximum individual freedom lie in the drive to relieve human estrangement. Also, see the discussion of the adverse influence of atomistic individualism on a sense of commitment, in Robert Bellah, et al., \textit{Habits of the Heart: Individualism and Commitment in American Life} (Berkeley, CA.: University of California Press, 1985).

\textsuperscript{41}See A. Lazare, "Shame and Humiliation in the Medical Encounter," \textit{Archives of Internal Medicine} 147 (1987), 1653-1658.
others. The person is aware that he or she is "set aside" from the "healthy" condition that now belongs to others. These perceptions can lead to feelings of shame and humiliation. The physician, too, may feel ashamed and humiliated if there is a diagnosis failure, a poorly performed procedure, if the patient or family is disrespectful, or if the physician identifies psychologically with the patient’s condition (i.e., a rapidly deteriorating dementia and the patient’s resulting loss of capacities). In the condition of shame and humiliation, the person will acquiesce to or resent the one whose presence evokes the feeling.42

As we have seen, in relation to illness, both physician and patient become aware of "otherness," either in awareness of their own embodied being or in awareness of their dependency on others. The person struggles to eliminate this awareness in two seemingly contradictory ways. On the one hand, the subject is attracted to the other and seeks identification and/or incorporation with him or her. For instance, someone who is ill may identify with the physician and follow his or her orders with slavish devotion. Also, physicians can identify so closely with their patients that their work becomes centered around the person's condition. On the other hand, the person is repulsed by what the other represents and attempts to negate or exclude the difference.43 The patient may reject the help which the physician represents in an attempt to maintain a sense of control. The physician who sees too much of himself or herself in the patient may adopt a


43 Taylor, p. 29.
distant attitude. In either effort, the other is converted into a means for self-control.

According to the profession's code of ethics, which represents the profession's accent of meaning, a physician's commitment to fiduciary service is depicted as selfless service or giving for the sake of the patient. This commitment can become distorted under the conditions of shame or resentment. The other in the relation, the patient, is expected to respond by receiving this gift gratefully. The patient should trust the doctor since the doctor gives of himself or herself for the benefit of the patient. Compliance and gratitude become the "payment" for this gift. Of course, the physician controls this economy of exchange.

In the effort to dominate the uncertainties and the involvement with otherness that medical care unavoidably represents, the physician seeks a means for self-expression which at the same time shields him or her from the shock of confrontation. This attitude of selfless giving leads to the conceit of philanthropy in which one gives to make his or her superiority apparent. Such philanthropic giving also serves to make the giver feel good in his or her superiority. Giving becomes a means to deny both neediness and the shame that accompanies the denial of personal dependency.

The exchange of gifts becomes a struggle for mastery that joins affirmation with negation. The self affirms itself by negating the other, in the extreme by reducing the other to negative terms. Consequently, the subject embodies a form of negation in which identity attempts to secure itself by excluding difference. This movement reflects allegiance to the

noncontradictory logic of identity by marking the boundary of identification in an absolute manner. The subject tries to master alterity by negating the other and enclosing the self within the secure "solitude of solidity and self-identity."\textsuperscript{45} In this way, the presence of the other threatens to introduce an awareness of a void, a need, in the subject. What develops in the relationship between physician and patient is a hierarchical relation of opposites in which giving and receiving becomes a battle for control, a battle to fill the void of incompleteness which the perception of otherness makes one aware.

Whether this dynamic of giving and receiving occurs in the divine-human relations or the medical relationship, it evokes resentment.\textsuperscript{46} The effort to secure a self-contained self-identity by controlling relations with the other is a defensive one which grows from the underlying condition of dependency. In the hierarchical relation of opposites, this effort seeks a triumphant affirmation of the self, but produces instead a reaction that negates what is outside, or other than, what is different, what exposes the incompleteness of the self.\textsuperscript{47} Rebellion against God reveals a deep resentment that sustains the disparity of power and control. Although the human is estranged from God, this estrangement is a form of relationship. On the psychological level, resentment is an ambivalent sentiment, combining affirmation and negation, acceptance and denial. It is never simply hostile


for it carries within itself latent admiration of, and attraction for, the other against whom the one, nonetheless, reacts negatively. The person's admiration is both hidden and revealed in the hostility.

Thus, resentment harbors envy, the counterpart of shame. This envy finds expression in a drive to transform the shame of being found inferior and being made to feel powerless into selflessness and service. The source of a patient's discontent is never simply the condition of bondage to the physician's power and authority. Although the patient is made aware of and may be distressed by the subservience of the "sick role," he or she yearns to possess the mastery of knowledge and position, the physician's power and authority. The patient resents and envies the "health" of the physician who goes home from the hospital at night, and whose "presence" in the patient's vulnerable situation commands obedience.

The physician resents the patient who in illness represents a threat to his or her power and authority -- the patient may not recover. At the same time, the physician also can envy the patient's vulnerability. Although the patient has much at stake, he or she does not have to confront the physician's struggles with uncertainty, with the anxiety of the faulty diagnosis or procedure, or with the shame and humiliation that can accompany the "loss" of a patient.

According to the professional ideal, maintained by the expectations of the public, of self-sacrifice and altruistic service, the physician should

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\(^{48}\)Freire discusses the desire of the oppressed workers to reverse their positions and dominate their oppressors. However, as he points out, this reversal only perpetuates the economy of domination; Pedagogy of the Oppressed.
participate in the "religion of self-annihilation."\textsuperscript{49} The physician's exercise of expert knowledge and authority simultaneously manifests his or her own strength and discloses the weakness that seems to define the patient. However, the doctor who works to withhold or overcome feelings of anxiety and emptiness by serving the needs of others is hiding feelings of resentment, envy, and shame. In the objectification of the other through self-centered giving and receiving of relationship, this effort at domination leads to a true self-annihilation.

The dynamic of shame and resentment fostered by inauthentic giving and receiving has another dimension. Demands for patient autonomy and reciprocity represent not only an attempt to share the professional's role as decision-maker, but also represent an attempt to usurp his or her power. As a professional, the doctor naturally wants to retain control of his or her work. As we have seen, such control is what provides the doctor with a sense of meaning and identity. By achieving a measure of equality in the "work" of health care, the patient hopes to be able to overcome the lack, close the gap, or fill the need which disrupts and unsettles the sense of self.\textsuperscript{50} Therefore, the struggle for patient rights, the stress on autonomy in bioethics may represent the attempt to fill a lack of wholeness, to "possess" health by denying or negating the finitude and dependency of which illness makes people aware. However, since finitude and dependency are always present,


\textsuperscript{50}Taylor, p. 27.
the struggle to fulfill the void and negate the need fails. It becomes a recurrent struggle which forms the ground for a climate of suspicion and erodes the fabric of trust between patient and physician.

As consequence, the individual's struggle for wholeness as self-possession presently marks the relation between physician and patient. Both parties are dependent upon each other, and both react to needs by developing strategies for self-preservation through self-completion. The physician seeks the knowledge to overcome illness, thereby restoring wholeness to the other (and thus, to himself or herself). The patient seeks to control neediness by cooperation, denial, or aggressively demanding his or her rights. However, either person's strategy is only an effort to negate the correlate in the pair of opposites. The doctor's authority and the patient's demands, for instance, are reflexively derived from a negativity; that is, from the fear of death. It is hard to focus inwardly on one's own condition of dependency. In the effort to overcome or deny the neediness which dependency creates, the easy target is the other in the relation. Trust in relationship is undermined in the drive for control.

Phenomenologically, "world" represents that concept without which we cannot do, for it gives to experience the fundamental order, unity, and meaning apart from which it would not be coherent enough to be experienced at all. The concept of God as the source and author of the world provides the first reference point of meaning and structure. The theological claim that "God created the world" means that the world gains its being and its fundamental forms of order from a source outside of or beyond itself. Thus, theologically, the deepest roots of the order within which life must be lived are not immanent in the world itself, but have been given to it from
without God becomes radically "other" as humans become created beings, wholly dependent upon the other for life, order, and meaning in existence.

Ironically, the struggle in which the subject attempts to assert itself by negating the other and securing identity by excluding difference inverts itself. It becomes an act of identification with and incorporation of the other. This movement is a reflection of Feuerbach's contribution to anthropological atheism. His inversion of the divine-human relationship can be applied to the one between physician and patient. The physician is the person to whom is assigned primary responsibility for defining, controlling, and caring for illnesses and those who suffer from them. Over time, this function shapes in an increasingly complex way the definitions and social roles which are associated with health care. Through the process of externalization, the public gives up powers to the medical profession in return for care and beneficence. This "gift" to the profession becomes objectified as health care and is returned to the public in the profession's fiduciary commitment. In the drive for patient power which has characterized health care in recent decades, the "inverted relationship" is inverted to gain what the patient desires: The attributes of the physician are transferred to the patient. Many within the profession naturally resist and resent this inversion, claiming that it weakens their ability (and power) to act in the patient's best interests.

As we have seen, when science and its province of meaning come together with medicine, a search for certainty becomes a necessary


component of the physician's way of knowing. Certainty here is not to be taken only as an addition to knowledge in the sense that it accomplishes the appropriation and the possession of knowledge. Rather, certainty is the authoritative mode of knowledge that is "truth." The scientific interpretation of knowledge becomes associated with truth, with certainty, and in this way makes a claim to power. The physician becomes entrenched within the borders of the scientific province and accent of meaning. The others who would critique his or her "profession" become adversaries out to subvert the value of his work.

As biomedical knowledge has grown, however, the power differential between the physician and patient has gone beyond limits acceptable to the public. The "otherness" represented by the power and authority of the medical professional threatens people, and sparks a desire to assert some control over physicians through distrust, litigation, and legislative constraints. This reversal reveals the slave's struggle against the master to be a struggle for mastery. Also, it shows the thirst for objective, certain, and clear knowledge. If we can know the facts, then we can know certainly; all disputes can be resolved, and chaos controlled. It is well to recognize the value of recent work on patient rights as a reaction to the profession's attempt to ensure control and authority (masked in name of public good). However, if this work merely inverts the power hierarchy, then trust will not be restored.

Instead, the two become locked in a competition that cannot be resolved and which becomes self-defeating. It is important to note that the

physician is bound by this dynamic, too. This perpetual struggle is the reason that the application of moral principles such as autonomy, beneficence, or justice to health care issues does not find universal agreement and acceptance. Each party in the relationship interprets these principles in a different fashion, from within the boundaries of his or her own perspective. Each strives to reinforce the accent of meaning he or she brings to the relationship by excluding the possibility that meaning could be other than it appears to be. In the process of striving for the fully objective ego, however, each adversary denies the mutual bonds which tie them together.

This denial is bound to fail. The self is identified by what "it is not" as much as it is defined by what "it is." The effort to model the self after the "original" author of creation reveals a presupposition underlying the Western ontotheological tradition. The critical thrust of Western philosophy and theology debunks the metaphysical positivism that assumes a "direct relation exists between a sign and a corresponding object 'in reality'," and that this relation is discoverable through proper interpretation. According to this positivism, if we can develop the correct method, we can know a phenomenon completely, beyond subjectivity and relativism.

However, the process of interpretation is one of continual re-creation formed in a tradition of hindsight. Every description of the physician or of the physician-patient relationship is an interpretation, an assessment which is built upon the criticism or destruction of its predecessor. No interpretation is final, and final interpretation is absent. The seeds of a replacement are sown when any "new" interpretation presents itself. In other words,

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interpretation begins as alienated interpretation. Once it becomes a paradigm, taken-for-granted, its destruction is assured. Therefore, there is no use seeking the presence of an original event or "text." What is said, written, or done is important, but what is left unsaid, unwritten, or undone is equally, if not more, important in the potential which it represents.\textsuperscript{55} The meaning or value of an object is always contingent, never present in it. The interpreter's paradoxical task lies in the inability to complete the interpretation which he or she is compelled to make.

To summarize this section on the theological roots of trust-as-control, in an effort to usurp God's primacy, humans have used the social institution of medicine and its social power to make health "present," to deny the irreducible dependency and interdependence that is part of the fabric of human existence. In the binary relationship between creator and creation, the predicate of divinity (wholeness, fully present, fully self-contained) is absent from us. Resentful and ashamed of our deficiency, we attempt to transfer this presence to the human. Our desire for the negation of uncertainty, illness, and death becomes the quest for certainty, health, and life. Such a movement creates and maintains the expectation that health is primary. This desire becomes total and domineering, since it can never be fulfilled. What is more, this quest can end only by a return to the origin of the search: the face of uncertainty and mortality mirrored in the image of a transcendent and absolute other-god. Confronted with this "reality," the self flees again into a quest for fulfillment of need that results in self-denial.

The modern critique of theism transfers the attributes of God to humankind. Humanistic atheism then expresses a psychology of mastery in which self-assertion is a function of the attempt to negate the other in whose face the self sees itself reflected. This struggle for domination embodies the interrelated principles of utility and consumption which lie at the heart of technological consciousness. The psychology of mastery and the economy of domination represent efforts to deny death which can only end in narcissism and nihilism. This manner of self-assertion (or humanization) is finally self-defeating. The effort to master the self by mastering others (through the control of profession, the control of work, and technological control of the "world") theologically represents the attempt to dominate and subvert (the false) God.

In a manner similar to other struggles for mastery, this drive to master alienated existence finally subverts itself. "The goal of this search is salvation - a cure that is supposed to bring health (salus) by closing the wound within. The search inevitably fails." Contrary to expectation, the repressive quest for domination and presence ends by disclosing the irreducibility of absence and the inevitability of death. Illness (as the

\[56\text{Taylor, pp. 13-14.}\]

\[57\text{The hospital is a literal representation of the progressive humanization of the world. It is an effort to master "health (and) care" by organizing, building, and operating an environment conducive to the cure, control, or domination of illness and trauma. And yet, what could be more sterile than a hospital? Life in the hospital is the way in which many people have experienced most directly what it means to live without God in the world. See Charles E. Rosenberg, }\] The Care of Strangers: The Rise of America's Hospital System (New York: Basic Books, 1987).

\[58\text{Taylor, p. 71.}\]
absence of health) may be more important than ordinarily admitted in the
philosophy or theology of medicine. The perception of mortality and the
need for relationship is the void made present by illness; it is the wound that
illness reveals. The effort to treat the illness can never resolve the
dependency characterizing the human condition. The more we try, the more
we exacerbate it.

Trust is never wholly or finally realized in social relationship.
Maintaining its presence is a reciprocal and an endless task for the
concerned parties. However, when trust is used as control, a self-assertive,
atomistic individualism develops that is insufficient to maintain one's self in
the face of an opaque destiny and visible sources of danger. A doctor who
uses the illusion of trust sees himself or herself as acting autonomously; the
patient who adopts this posture makes a similar claim. Both are working at
cross purposes.

Trust requires another type of self-reference. It depends on risk. Risks
emerge as components of decision and action. They do not exist by
themselves. It is the internal calculation of external conditions which create
risks. Trust is based on the circular relationship between risk and action,
both being complementary requirements. Action is related to a particular
risk as an external (or future) possibility, although risk at the same time is
inherent in action and exists only if the actor chooses to trust.

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59 Luhman, p. 100.

60 Ibid.
In human interactions, consciousness is oriented to the appearance of an "other" in a field of awareness. The other is one who, like me, occupies a center of orientation to the world and its meanings. As a valuing being, the other presents himself or herself as a privileged locus of value, one not to be violated or simply used. In this way, the other sets limits to morally permissible projects. The other sets claims on me for loyalty and service. These claims have their basis in the distinctive being of the other as a center of valuation toward the world.\textsuperscript{61} Once a taken-for-granted accent is "shocked," if the other's claim is clarified, trust becomes possible. Trust, then, offers a means to transcend borders of multiple provinces of meaning, principally the two horizons of the physician and patient. The possibility of trust emerges when taken-for-granted certainty is removed in the shock of encountering the "other."

\textbf{Summary}

Much recent criticism of doctors' ethics originates outside the profession's ranks, and is directed at controlling or delimiting the physician's power in an age of high technology, expert knowledge, and the fear that physicians may trade upon their fiduciary reputation. If we accept the premise that such criticism reflects the public's use of distrust as a mechanism for the social control of a powerful profession, I argue that the members of the profession use trust in a similar fashion. Claiming to act for the benefit of their patients, physicians use the illusion of trust as a form of control to preserve their power. Even with the best of intentions, the effort

to maximize the efficacy of professional practice easily is transformed into domination and control in the medical relationship.

A theological analysis highlights the use of trust-as-control by humans in relationship. A theological discussion begins with the declaration that separation from God creates the basic human condition of dependency from which the awareness of incompleteness and neediness flows. By bracketing the traditional theological model of the transcendent, wholly other God, the dilemma of relationship in the post-modern world is revealed. In a culture of criticism, the recognition of multiple levels of reality raises the conflict of relativism and pluralism. The perception of multiple competing groups also creates an internal awareness of the self-as-other.62

A crisis of authority at all levels of social life is the result. Faced with the inescapable condition of dependency, people seek meaning in their existence which is dependable, which they can take for granted. The difficulty of bracketing the shocks to the natural attitude that exist in a pluralistic world undermine people's certain confidence in values. We may deny the conditions of uncertainty and neediness because they makes us uncomfortable. To deny our uneasiness, we focus on and demand what we desire because this demand implies more control in the face of our basic dependency. However, this desire for control is itself a reflection of dependency. It is a more aggressive, self-directed effort to cover up

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62 "Otherness has entered, and it is no longer outside us among the 'others.' The most radical otherness is within"; David Tracy, Plurality and Ambiguity: Hermeneutics, Religion, and Hope (San Francisco: Harper and Row, 1987), p. 78.
neediness, but the satisfaction of what we want or desire cannot be satisfied. Dependency cannot be eliminated from our lives.

In the effort to eliminate the neediness flowing from the human condition of dependency, both physician and patient retreat from authentic presence in the health care relationship so that the other can fill the gap -- and prove his or her trustworthiness. However, this movement creates a giving and receiving which is self-directed and intended to control the presence of the other. The struggle for control affects the fiduciary component of the postmodern health care relationship. Instead of giving (and receiving) trust offered by the other's presence, thereby accepting responsibility for one's actions and responding to the other's actions, each party struggles to eliminate risk by controlling the other who has become a threat to the self's image.

A recurring theme in Western theology is the effort of humans to achieve a position of dominance in relations with others. This effort appears to grow out of the conviction that mastery results from the ability to secure presence and establish identity by overcoming absence and repressing difference. Similarly, in matters of health care, given the inevitable diversity of individual experiences and religious and moral conscience, conformity to a single moral norm cannot be attained without the threat of,

63The desire to eliminate otherness or difference becomes a drive marked by total absorption and control. It is in the nature of theocracy, for instance, that it must be willing to persecute in order to maintain its vision of a divinely ordained civic order and its claim to a divinely ordained truth that undergirds that order. The human tendency towards ideological totalitarianism reflects the desire to master the complexities of existence by dominating the other.
or the fact of, the repression and persecution endemic to paternalism and coercion.\textsuperscript{64} The struggle for mastery, however, is always self-defeating. For theists or atheists, the result is shock of confrontation with otherness that can no longer be bracketed. We are driven to minimize through domination or submission the risk of relationship. More basically, this drive is based on the denial of the human need for relationship and human interdependence. Theological analysis of the drive for domination offers a counterpoint and a new possibility for relationship.

A discussion of the essential role of trust in the medical relationship develops the thesis that the relationship must be fluid and historical, acknowledging the social nature of human existence.\textsuperscript{65} The concept of God as unmoved mover distances the deity from humanity. If God is envisioned as a "presence" whose divine life is enriched by relationship with humans, interdependence becomes the basis for relationship.


Chapter Five

Trust-as-Faith: Giving and Receiving in Dependency

Introduction

In the previous chapter, I argued that the economy of domination that uses trust-as-control is caused by the denial of mutual dependency. The growth of the scientific structure in medicine reflects a desire to minimize uncertainty and to control the limits of medical work. This desire has shaped the profession's sense of its identity, the value of its work, and consequently, the nature of its relations with the public. While this orientation has produced great advances in medical authority, it also structures relations among people in particular ways. Interactions become more objectified, more routinized. This structure has created a "distance" between the vulnerable patient and the powerful physician. Perhaps because of this distance, people have accepted the arrangement in return for medicine's promise of help in times of need. The public, and the physician, believes that the fiduciary component of the profession's identity places the patient's interests above the physician's own self-interest. In terms of this relationship, both parties are committed to a fiduciary relationship.

The promise of biomedical science to overcome illness and disease is proving premature. The investment of huge sums of money and concentrated efforts have led to enhanced knowledge, some undeniable successes in treatment, and technological advances. However, the continual presence of illness and uncertainty beyond the ability of physicians to control reveals the fact of human limitations. As people become ill, their human condition of dependency and vulnerability is laid bare. People facing the interruption of illness want some sense of control in their lives. The
physician wants to control and minimize uncertainty and contingency in his or her work. Trust-as-control provides a form of satisfaction for each.

Trust-as-control may enable some measure of interaction. It establishes the physician's "authority" in medical matters. It may support a person's confidence in physicians' skill and knowledge, and it may provide a sense of self-confidence to physicians. However, this approach to relationship represents a negative movement. It will not foster a depth of trust between the parties in the medical relationship, i.e., that each is working to mutually enhance the efforts of the other. With trust-as-control each person will hold back full commitment and approach the relationship with caution and reservation. Trust-as-control has moral, social, medical, and theological repercussions. It adds fuel to the feeling of moral impasse in matters of medical ethics. Socially, it reveals the presence of interest groups. Medically, it fosters the practice of defensive medicine. Also, from a theological perspective, it does damage to the community of interdependent people by fragmenting a focus on mutual enhancement.

In chapter five, the theological discussion seeks a constructive way out of this impasse by showing that trust-as-faith suggests a reorientation of the uneasy and precarious balance of power I have described. I discuss the manner in which faith-as-trust opens a depth of meaning transforming the economy of domination into a free exchange of dependency. In discussing the Christian view of faith as a gift of God and faith as the human response

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1 See Hauerwas' critique of a medical authority which proclaims certainty and control in Stanley Hauerwas, Suffering Presence: Theological Reflections on Medicine, the Mentally Ill, and the Church (Notre Dame: University of Notre Dame Press, 1986), pp. 39-62.
to that gift, I concentrate on the following points: faith (fides) is given by God
to restore the proper relationship between God and the world. Faith (fiducia)
is the response to this gift. In this giving and receiving of faith, there is a
transformation from an alienated existence to one of faith-ful trust. The
"contextual" nature of trust for those involved in medicine is compatible with
these theological concerns.

There has been a shift from theologies of medicine to a focus on
medical theologies. Before the last two decades, the preponderance of writers
on Christian theology and biomedical issues assumed that the question was:
What does Christianity (the Bible, the tradition, and the church's
ecclesiastical authority) have to say about the ethical issues raised by
medicine? Now the question has become: What does the phenomenological
experience of human health and illness have to say about perceptions of
faith -- of the experience of God and of interpretations of Scripture and
tradition? In part, this movement is a recovery of 19th century liberal
theology's emphasis on experience as important theological data -- that
insight into the ways of God can be gained in dialogical human relationships.²

The experience of otherness (the awareness that things can be other than
previously assumed, that the "self" is not necessarily privileged), especially
in the interruption represented by illness, is very uncomfortable.

Theologically, faith as fiducia, or trustful response, becomes the basis of the

²James Nelson uses the term "dialogical" in his article, "Reuniting Sexuality
Suchman expresses these concerns in terms of "connexional" relations; see A.
L. Suchman, et al., "What Makes the Doctor-Patient Relationship Therapeutic?
Exploring the Connexional Dimension of Medical Care," Annals of Internal
Medicine 108 (June, 1988), 125-130.
fiduciary component of social relationship. It brackets the distrust and alienation from otherness characterizing postmodern experience. However, otherness cannot be eliminated. Therefore, a medical theology begins with a recognition of the necessity of trust "in spite of" the irreducibility of human dependency.

Therefore, this chapter will begin with the description of a theology of dependency based on the human condition of incompleteness. Dependency is an inescapable part of human life in that people rely on others, on their community, their culture for meaningful existence. People may act upon these meaning structures, but their actions themselves are interpreted according to the present form of meaning. Thus, people are not self-sufficient, complete beings. Each person receives his or her life from beyond himself or herself. In theological language, "to rely upon others, and ultimately to rely on God is to experience the limits of self-sufficiency, and thus to recognize the finitude of oneself, others, and all that is."³ However, the drive to dominate and deny dependency causes people to seek independence and self-sufficiency. The inability to overcome this condition reflects the "fallen" condition of human existence.

Traditionally, within Christian theology the incompleteness of humanity finds completion in reliance upon and faithful relationship with God. However, this completion does not eliminate dependency. Illness, for instance, is a time when we are compelled by necessity to realize that our lives are not our own. One's embodied existence, no matter what shape, which was taken for granted before and the expectations for the

continuation of that reality are called into question. The condition of illness represents a situation in which one’s ordinary experience of everyday reality is bracketed.

The problems of dependency in the context of medicine are moral ones. In illness, the patient is immediately aware of his or her vulnerability, and clings to the hope that the physician is trustworthy. At the same time, the physician’s knowledge and power represent the threat of domination and control. I want to examine, with a theological accent of meaning, the moral implications of dependency. Illness as a representation of dependency is an experience which calls into question our everyday ideas, expectations, and values. Theology works to place these concerns into another context, the locus of which is beyond human control. A second reason for theological reflection is that, other than existentialism, most secular philosophies do not begin with human frailty. They build on the strengths of human reason without appeal to God, or upon our mastery of nature, to the neglect of human weakness. Theology looks squarely at the depths of being human, dependency and all. Thus, in chapter four, I offered a theological examination of dependency and the use of trust-as-control. In this chapter, I discuss the theological implications of dependency for the attitudes and dispositions with which physicians’ relate in a fiduciary fashion with patients.

Towards a Theology of Trustful Dependence

Certainly, medical treatment depends upon a certain cooperation and mutual understanding between patient and physician. This is not possible unless they share a set of common presumptions about the nature of illness,
the treatment, and the roles that patient and doctor are to play. When interpretive schemas diverge too far, the therapeutic alliance breaks down. The use of trust-as-control to insure cooperation represents the denial of multiple provinces and exacerbates the differences in horizons between patient and physician. In this section, I will develop an interpretive schema with which physicians can review the work of their profession. This schema is based on a theology of dependence and is fundamental for a medically oriented theological ethics.

Phenomenological sociology builds upon an understanding of the constitution of meaning in the solitary ego, moves to an exploration of conditions that account for interpersonally shared meaning, and ends with a study of the phenomena of objective culture, such as the fiduciary component of professional experience. Although these meaning structures have their locus in consciousness, and are in this sense "subjective objects," they are phenomenally outside the perceiving subject and are confronted by him or her. Thus, the physician is familiar with the world of experience and confident that he or she understands its boundaries. However, what is "real" in the physician's horizon is to others altogether different. When the physician's accent of meaning is bracketed, and multiple realities are revealed, the physician's familiarity and confidence in his or her reality are called into question. One's trust in his or her perceptions of reality, and in

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others, becomes a concern. At the same time, the dependency of people upon each other is revealed.

A medical theology based upon recognition of dependency begins with the perception of the social basis of human existence. Even where people are autonomous, some sort of outside assistance makes that independent life possible. An individual from birth is supported by family, society, culture -- his or her life is given meaning from the social matrix into which he is born and in which he grows up. His understanding of life, his values are gained from interaction with others within an environment that existed before his birth. Choices involve weighing decisions between alternatives, the existence of which are present because of social structures of meaning.

I want to examine one aspect of human dependency: its implications for physicians' expectations of their work with others. Familiarity, confidence, and trust are different modes of asserting expectations -- they represent different types of self-assurance.\(^6\) Confidence and trust have been discussed. Familiarity draws a distinction between familiar and unfamiliar fields and places a priority on the familiar. The unfamiliar remains opaque. Ordinarily, there is no need for conscious self-reflection on this distinction: One is familiar, not unfamiliar, with oneself. However, illness represents a

\(^6\)Belonging to the same family of self-assurances, familiarity, confidence, and trust seem to depend on each other and are capable of replacing each other to some extent; Niklas Luhman, "Familiarity, Confidence, and Trust: Problems and Alternatives," in Diego Gambetta, Trust: Making and Breaking Cooperative Relationships (New York: Basil Blackwell, 1988), pp. 94-108.
moment in which a person becomes aware of the intersection between the "unfamiliar" and the "familiar." 7

Familiarity is an unavoidable fact of life. As we have seen, trust is a solution for problems of risk. However, as Luhman points out, trust has to be achieved in a familiar world, and changes occur in familiar features of the world which will have an impact on the possibility of developing trust in human relations. 8 Phenomenologically, illness transforms the taken-for-granted world of everyday life into one unfamiliar in its dimensions. Human society has developed meaning structures and symbols to make this unfamiliar interruption familiar. However, there remains something irreducible about the experience of infirmity.

Typically, physicians and patients seek a familiar set of relations because they have confidence in the symbols which orient them to the familiar roles of the medical relationship -- they seek a way never to leave the familiar world. During the transition from the unfamiliar to the familiar, during the shock which accompanies illness, they seek to maximize their position of power. On one level of meaning, the experience of illness is controlled by a complex process of domestication. At the same time, there is something about illness that cannot be domesticated or eliminated: the recognition of dependency and vulnerability.

7Ordinarily, the difference between the familiar and the unfamiliar is mediated by symbols, which serve to bring the unfamiliar into the familiar while retaining something of its power. Luhman discusses the role of symbols in mediating the movement of the unfamiliar into the familiar; ibid.

8Ibid., p. 95.
During moments of disruption, a person perceives the risk inherent in social interaction -- the riskier the moment, the closer to an acknowledgment of dependency, to awareness of the "thrownness" of existence described by Heidegger. Threatened by that which is beyond human control (the givenness in the social and physical world), to deny the risk to the self of one's dependence on anyone and anything beyond the self, the person become possessive of his or her identity and suspicious of others. This possessiveness disrupts the free and open exchange of relationship -- in a sense, people clutch their dependency to themselves. Rather than accept the human condition itself as a gift, people attempt to eliminate their dependency and neediness. Therefore, they cannot give easily and cannot receive easily in turn. Gifts such as trust are transformed into commodities to be bartered. Dependency and the feelings of neediness it fosters come to be perceived as weaknesses which people are afraid to reveal, yet these conditions lie at the root of existence. The effort to deny dependency can lead to the false expectation that the needs of everyone can be eliminated. This egotistical view of the ideal of service is a distortion of the giving and receiving relationship, and becomes the conceit of philanthropy when it is

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assumed that the (person's) commitment to his or her fellow human is a gratuitous, rather than a responsive or reciprocal, act.\textsuperscript{11}

The drive to eliminate dependency provides the conditions for the "sin" of pride.\textsuperscript{12} In the condition of estrangement from God, the gifts of the other (which includes the gift of his or her needs) are reduced to "objects." In doing so, people refuse to acknowledge and express their own vulnerabilities and dependency; they objectify themselves in turn. Domination and exploitation become motivating forces in social interaction as people attempt to mask their neediness and dependency from others and from themselves. As a result, they are unable to accept life as a gift and cannot return the gift to the world with authentic gratitude.

All people are dependent in some way. Aware of their finitude, they feel a need for a long and healthy life. Aware of their individuality and sense of self, they feel the need for social relationships. One of the great human fears is suffering alone, of being abandoned by others in moments of need.

\textsuperscript{11}William May, "Code and Covenant or Philanthropy and Contract?" in Stanley Joel Reiser, et al., eds, \textit{Ethics in Medicine} (Cambridge: MIT Press, 1979), p. 70. The biomedical model fosters such an effort to deny the existential condition of neediness insomuch as it stresses "curing." We must accept, as Hauerwas argues, that medicine is a tragic profession since it deals with the conditions of life which cannot be eliminated; "Medicine as a Tragic Profession," in \textit{Truthfulness and Tragedy} (Notre Dame: University of Notre Dame Press, 1977), pp. 184-202.

\textsuperscript{12}For a discussion of sin, see the entry in James Childress and John MacQuarrie, eds., \textit{The Westminster Dictionary of Christian Ethics} (Philadelphia: The Westminster Press, 1986), pp. 585-586. I am using the term in the Protestant sense of the actions and moral transgressions which result from a broken relationship with God in mistrust and a lack of faith (p. 585). The sin of pride does not refer to particular acts, but to the condition of estrangement which misleads humans in their exercise of freedom.
In the Christian tradition, the church is to be a people who are faithful to one another by willingness to be present to one another despite human vulnerabilities. Precisely because humans are dependent creatures, there is a trust-as-faith given to and received by others who are willing to be present to another in the midst of their vulnerability, neediness, and incompleteness. This willingness to be present suggests that the appropriate model of medical relationship is trust between mutually dependent parties. Trust-as-faith is the quality of relationship which enables partners to freely give and freely receive in mutually enhancing, enlivening (healthy) ways.

**Fides and Fiducia: The Importance of Trust-as-Faith for the Medical Profession**

Theology starts when faith begins reflecting upon itself. "For theological ethics... the first task in order of importance is to establish convictions about God and God's relations to the world. To make a case for how some things really and ultimately are." This task seeks to show the manner in which faith sheds "new light" on the fullest and most profound dimension of human existence. Driven by a need to deny his or her

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16McCormick, p. 7.
dependency and the awareness of his or her own face in the sick bed, I have argued that the illusion of trust dominates relationship with the person whose presence paradoxically challenges and confirms the physician’s accent of meaning. The task for theological ethics is to reorient this distorted exchange of relationship and to restore the sense of trustworthiness and trustfulness for both the physician and the patient. If a common understanding of the nature of trust is eroding, a theological perspective offers an understanding of human dependency and interconnection which restores the epoche of doubt and despair disrupted by illness.

In the Christian tradition, it is important to remember the sense of alienation from God and self-estrangement which characterizes the sinful nature of the human condition. “Man is sinner,” and sin implies the attempt to be absolutely independent and autonomous. Since, however, a person’s powers and abilities to know beyond the moment are limited, when one makes himself or herself the object of self-consciousness, he or she discovers that the actual self always falls short of the ideal self. As a result, to deny his or her dependency, one is driven to self-aggrandizement and becomes alienated from his or her creator in the drive toward an economy of domination of the other.

Consciousness of this drive becomes a necessary pre-condition for restoration of wholeness. In the postmodern world, in the culture of criticism that is fostering a climate of suspicion between physician and patient, to

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retreat into a protestation of codes and professional ethics creates the illusion of trust. Following the Augustinian view that sin distorts all human faculties, man cannot know the truth about himself and God until his understanding and will have been transformed. The person cannot free himself or herself from bondage to sin, from the drive to domination, by his or her own will. It is only through God's revelation of himself in the Incarnation that people become aware of the depth of sin, and only then does faith become possible as a grateful act of willing response to God's grace-filled gift.\textsuperscript{19}

Faith does not free the person to be free, independent, or completely autonomous. Rather, it frees the person to be free in interdependence, in the recognition of a mutual dependency upon others or God in a relationship that changes over time, and calls faith into question. Consequently, from a theological point of view, the profession cannot control the limits of its work in any final fashion, and the attempt to do so leads only to the illusion of care and concern. The embodied presence of the other person who establishes the limits of the physician's power represents a gift which calls for a response. The danger in the unique social relation which medicine represents is that this exchange of gifts may become distorted if one or the other places himself first in an effort to dominate the relationship. The physician must work to bring out the content of and the confession of mutual dependence and trust, to help the patient restore a frame of reference providing a meaningful existence. Otherwise, medicine becomes another type

of domination in which trust in relationship is a commodity to be bartered between self-interested parties.

This bartering economy which leads to domination is grounded in the anxiety caused by the perception of human finitude. The natural attitude works to bestow upon everyday reality a sense of permanence, of explanation. In the moment of phenomenological disruption, the natural attitude is bracketed and the risk of relationship (the awareness of mutual dependence) is revealed. Trust-as-faith restores the natural attitude in which life, health, and relationship again assume a "reality," and yet no longer are taken for granted. This seeming paradox is due to the hidden, yet revealed nature of God.20

According to this theological perspective, with the acceptance of this gift, freely received in faith, in trusting obedience to what has already been given, humans are free to be in relation to God and others, personally, not as types. At this moment, all of temporal existence and power is called into question and revealed in its true nature: The structures of power formerly taken for granted as complete in themselves are shown to be incomplete, dependent, and truly interdependent. A person is revealed as a creature whose willful pride covers a refusal to recognize dependency and need in the drive for control and domination. This refusal distances him or her from his

20Faith is not directed toward a God who acted or who will act; faith lies in the presence of God-as-Christ in the present. Barth, like Luther, sees Christian faith not primarily as belief in dogma or necessarily fixed and determinable events, but as wholehearted trust in divine grace and love as revealed in Jesus; see H. Richard Niebuhr, Christ and Culture (New York: Harper Torchboks, 1951), ch. 7. Also see Richard J. Mouw, "Biblical Revelation and Medical Decisions," in The Journal of Medicine and Philosophy 4 (1979), 367-382.
or her true self as a creature of God, truly dependent upon others in the world. Society and the human do not stand apart from God and each other, but are fully realized and completed in God and in each other.

These are not relations which humans can create on their own out of their dependency and need. They result from the renunciation of self-determination and self-sufficiency, from the realization that the desire for self-control is illusory. Trust as expectation of the beneficence of others cannot be rooted in self-possession or control, but depends wholly upon a free and mutual exchange of neediness.

The human condition is embodied in lived existence and social reality. The recognition of dependency and the neediness it creates arouses anguish because for much of our lives we ignore the neediness which links us to others. For the physician, particularly, engaged in working with those who are ill, who are suffering, and vulnerable, the medical accent of meaning provides structure which insulates the person from this recognition. Through the clinical perspective, through the organization structure, the dedication to knowledge and expertise, and especially the profession of altruistic service to those in need, the physician seeks to control the uncertainty, the anomie, of illness that threatens the order and meaning that medicine represents. However, relations with the ill are inescapably ambiguous and filled with tension. Through contact with illness, whether directly in a medical encounter or indirectly through research and teaching, the physician represents one side of a relationship whose existence is due to a concrete manifestation of dependency and neediness. By knowing more, by trying one

\footnote{Suchman, et al., pp. 125-130.}
more therapy, eventually by manipulating and controlling people, the physician attempts to convince himself or herself of his or her freedom and mastery of the world, avoiding admitting how much he or she receives from others.

As we see, from the standpoint of Christian faith, this avoidance of dependency is mistaken.22 The natural desire to deny our dependent nature creates an economy of domination which does not eliminate needs but only masks them, leading to further efforts of denial. The recognition of our relativity does not mean we are without an absolute. As Niebuhr writes, "In the presence of their relativities men seem to have three possibilities: they can become nihilists and consistent skeptics who affirm that nothing can be relied upon; or they can flee to the authority of some relative position, affirming that... a value, like that of life for the self, is absolute; or they can accept their relativities with faith in the infinite Absolute to whom all their relative views, values and duties are subject."23 With faith in this Absolute, Drew Christiansen argues, it is possible to let go of a desire for complete self-control, to accept support from others, and to find fulfillment in a community

22"In an ultimate and inescapable way, man even as doer and maker is still receiving and being made." A human being, Rahner writes, "comes to the real truth about himself precisely by the fact that he patiently endures and accepts this knowledge that his own reality is not in his own hands"; Karl Rahner, Foundations of Christian Faith (New York: Seabury, 1978), pp.42-43.

23Niebuhr, p. 238.
of care. Overcoming the economy of domination produced by the use of trust-as-control involves placing one's basic trust in a presence which is beyond one's control.

Being able to rely on the presence of a physician, with the trust that he or she is present for the person's benefit, sustains patients at a time when they are most vulnerable. However, as people who participate in the meaning structures of their profession, physicians have a dual loyalty to their profession and to their patients. Certainly, fidelity to patients rebounds to the benefit of the profession -- it serves to maintain public confidence in the physician. However, loyalty to the institution can become self-interested. If the physician begins to consider the other only in his or her value-relations to himself or herself, the giving and receiving of presence between them will be twisted into trust-as-control. By accepting in trust the gift of the absolute faithfulness and trustworthiness of God, it becomes less difficult to accept dependency and vulnerability. The physician who is able to receive in faith the presence of others can return the gift of presence to others. Paradoxically, from the Christian point of view, recognition in faith of human dependency establishes the person's sufficiency to live in the face of that condition, and frees the person to the satisfaction of faithful giving and receiving. Therefore, May can argue that ethics grounded in the covenantal

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relationship with God enables one to be responsive and requires one to be available to the other above and beyond the measure of self-interest.  

Before beginning the next section, I will pause and summarize the theological discussion. In addressing the question of what theological ethics can offer or contribute to bioethics, I have been focusing on the "something more" which Christianity claims to represent. This something more appears to be the faithful way in which a person can exist in trustful dependency within the relativities of the world. If, with Tillich, the task of theology is to articulate the answer to the questions formulated within culture, perhaps the interdependency we have discussed, the trust-as-faith, represents an answer to concerns with relativism and pluralism in a post-modern situation.

However, taking into account the fact of historical change, and the limitations and relativism it contains, how can the theologian locate any absolute moral norms? How can the theologian establish an appreciation of and interpretation of Christianity and culture which allows for the autonomy of both and yet allows the two to be interdependent, as well? Since the insights of theology, as well as other sciences, change over time, there is a need within theology to move beyond itself, even as it is being developed. The pronouncements of a theology cannot be absolute; theology can function

26Somehow, "covenant ethics shies back from the idealist assumption that professional action is and ought to be wholly gratuitous and from the contractualist assumption that it be carefully governed by quotidian self-interest in every exchange"; William May, "Code and Covenant or Philanthropy and Contract?" in Reiser, et al., pp. 73, 74.
as a form for consistency, but it cannot be final. Thus, the essence of Christianity must be "recreated" in every age.27

Therefore, in developing an argument for the place of theological ethics in biomedical matters, I have argued that the structures of sociality and human intersubjectivity constitute meaning and values for people, a way of seeing the world, which orient them to a lived reality. Unfortunately, as this orientation becomes "taken for granted" and objectively abstracted, we can lose the awareness that values are not isolated or fixed entities, existing outside of encounter with others, but emerge in relations among beings. Value does, then, have objective presence -- it is disclosed, rather than projected, in the encounter of being with being.28

Value emerges in relations among beings, but because it emerges in encounters that transcend limited forms of human need and awareness, it is not "subjective" in a dualistic sense. Dualistically understood, "subjectivity" refers to an enclosure of the self that, by reducing reality to the reality of the self, projects value as its self-centered attentions dictate.29 Trust-as-control is a reflection of this subjectivity.

A Christian theological ethics finds the locus of value in God. However, the God of radical monotheism "shocks" the relation of being and value


because God lies beyond both being and value, and "one cannot say that God has need of any being external to himself."\textsuperscript{30} In the critique of traditional theistic notions of God, separateness, as a quality of divinity, becomes extolled as a virtue in and of itself. In this schema, relation to otherness implies self-deficiency, and fosters the control of otherness for the sake of the separate self. This perspective is informed by the paradigm of the "otherness" of God, the model of a Person who, having no needs, stands apart from the community of being. Perhaps God's isolation is a projection of the human need to maintain power by controlling dependency rather than the presence of an inclusive love for that which is in need.\textsuperscript{31}

For Niebuhr, "self-relatedness" has no meaning apart from "other-relatedness."\textsuperscript{32} If we are to find the presence of the transcendent God, we need to reimagine or reinterpret the metaphor of Imago Dei. God, like us, has needs, and it is through the giving and receiving of trust, one in the other, that God's presence is known through the interdependence of everyone. For the physician, the values of knowledge and trust, a dedication to expertise and a fiduciary commitment, shape his or her self-identity and the "limits" of medical work. The metaphor of trust-as-faith reveals the worth, relatedness, and need which is the likeness all people share in making meaning in their world. Although this metaphor may not be the conclusive result that would enable us to say, "This is the Christian answer" to the question about the contribution of theological ethics to bioethics, in the faith that has its

\textsuperscript{30}Ibid., p. 112-115.

\textsuperscript{31}Holler, pp. 89, 92.

\textsuperscript{32}Niebuhr, p. 105.
investment beyond relativity, in the pluralism of relatedness, there is a freedom of interdependence in moral decision-making.

Implications for a Medical Theological Ethics

The study of the medical profession's commitment to knowledge and a fiduciary relationship with others, the way in which these foci shape and are shaped by the physician's accent of meaning, has highlighted several issues which have a theological resonance. The use of trust as-control in the medical relationship, and the economy of domination which results, echoes theological concerns with alienation in human relations. The resulting theological discussion of faith and trustful dependency brings us to the implications for a medical theological ethics.

A Phenomenology of Illness

A medical theological ethics must recognize the importance of a phenomenological approach to the medical encounter. The experiences of physician and patient are uniquely constituted.33 Michael Gordy asserts that bioethical issues "presuppose a social nexus and have to be discussed in terms of the social relations between people."34 Much has been written about


the need for social contract or covenant in medical relations.^{35} Sellers wonders if the "we-relation" does not precede either of these models. Without limiting the options of contract or covenant, the "we-relation" sets out what is prior: a sense of "we-ness" that takes us across time, "growing older together," in the pursuit of a common understanding of being human.^{36} Thus, an attempt to interpret the meaning of trust and trustworthiness in the structure of medical work must be conditional.

Just as the use of traits or function to define the medical profession presupposes an already existing idea of profession, how can we trust someone or something when, phenomenologically, our trust can never be "final." Our expectations of others, our willingness to trust them in situations of risk, are based on our biographical situations and intentionalities, on past experience, present understanding, and anticipation of future needs. Paradoxically, trust can only be momentary, yet we are called upon to trust beyond the moment. Since the "fullness" of trust can be present only as absent, complete certainty is always already lost. In other words, as Taylor


^{36}James Seller, "Tensions in the Ethics of Interdependence," reprint, pp. 9-10. The "we-relation" is used by Schutz to refer to the relation in which each person constitutes the other as an actor in the everyday world; Schutz, Collected Papers 1, pp. 221-226, 287-356. It is through this "we-relationship" that people come to participate in reality. A reciprocal thou-orientation exists, a relationship of mutual, conscious awareness of the other; George Psathas and Frank Waksler, "Essential Features of Face-to-Face Interaction," in George Psathas, ed., Phenomenological Sociology (New York: John Wiley & Sons, 1973), pp. 171-172.
puts it, there is always a serpent in the garden.\textsuperscript{37} If we are uneasy with the status of trust in relation to physicians, the effort to make trust fully present, to guarantee trustworthiness, represents the turn to self-concern and self-deception in the attempt to recover complete certainty. As a result, deficiency or dependency is believed to be the result of a fall, a breach or break, a condition requiring control. Thus, to be ill is not merely to realize one's dependence upon others; it is to be ashamed and resentful that one cannot control the reality of one's existence. In the quest for control, because of it, we lose sight of the conditional, momentary nature of trust. Since certainty is always already lost, our perception of relativism grows, and trust-as-control becomes the mode of interaction.

In this mode, people long for secure selfhood, yet are unable to secure it. For instance, in the attempt to secure the self against invasion, people look for "territory" where they can be secure and powerful. This militaristic metaphor conveys an image of the self as finite and vulnerable, able to be overwhelmed if left unprotected. This concern leads to a preoccupation with one's own independence, as commitments or alliances with others always limit or bind a self and increase its vulnerability. For the self struggling to be independent, the only real powers beyond the self that are acknowledged are powers that are seen as a threat, and the only kinds of relationships with

\textsuperscript{37}The myth of origin, the expectation that explanation can be discovered, represents the attempt to efface human dependency by making loss and incompleteness "secondary" rather than "original"; Taylor, p. 71. The loss of independence becomes a "fall" from the original situation of complete Being; see James J. DiCenzo, "Heidegger's Hermeneutics of Fallenness," Journal of the American Academy of Religion 64 (Winter, 1988), 667-679.
other persons that are comfortable are those that are distant and superficial (or those in which the self is in charge -- as parent, teacher, doctor).  

However, the self also can respond to the interruption of illness by acknowledging the interdependence of people, that the person, though finite and limited, is a whole who is a part of the whole. With this response there is an awareness of mutuality in relation, that the giving and receiving of relationship is not a defensive battle in which one wins as the other loses, but rather an exchange in which self-benefit is derived from some attention to the benefit of the other. This response suggests a revision in an approach to a medical theological ethics.

With the focus on human interdependency, there is a shift from a theological understanding of medical ethical problems as a matter of wrong acts to an understanding of “illness” as alienation from our intended personal and communal relationship. This shift cases the strain which occurs when theological ethics and philosophical ethics become involved in a shoving match over “first principles.” Theological ethics recognizes that sin is not fundamentally an act, but rather the condition of alienation or estrangement out of which harmful acts may arise. Sin is fundamental alienation from our divinely intended relations with God and with each other. Such alienation from the way God intends us to be may give rise to harmful acts, but the act is rooted in the distrust and suspicion of the prior condition. Sin lies in the alienation of a dualistic attitude which sees the body as an object that “acts” in the physical world, but is only made meaningful in terms of its superficial

actions (which to be truly meaningful must be constrained by the higher spirit or purpose). This dualistic attitude leads to a denigration of dependency, and the embodied condition becomes "evil." In this habit of mind, "illness" and "death" become invaders to be combatted. Metaphorically, the sick person's body signifies a war zone in which the battle is fought. Winning or losing becomes the focus for the physician and the public, which models physician attitudes. The person, patient or physician, is lost in the struggle.

The focus of the medical profession on the acquisition and utilization of knowledge to provide "health" care, to rescue the body in distress, follows from the inescapable dependency of our physical lives. However, such a clinical perspective pushes physicians towards an attitude of mastery and control of the environment (e.g., the body in the bed). As long as the motivation for this attitude lies in the denial of mutual dependency, there will be a disregard for the conditions which move in the direction of human wholeness, be this in individual health, in social relations, or in spirituality.  

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40According to Moltmann, "True health is the strength to live, the strength to suffer, and the strength to die. Health is not a condition of my body; it is the power of my soul to cope with the varying conditions of that body:" Jurgen Moltmann, The Power of the Powerless (London: SCM Press, 1983), p. 142. Health is not some attainable goal, a fixed and static state, but a dynamic and fluid condition in which life is embraced.
Piero Camporesi claims that sanctification means growth in holiness (or wholeness and health -- the root word is the same).\textsuperscript{41} It may be that God intends increasing wholeness to be part of human redemption. As with any other belief, this view can be distorted, but it need not be. In medical matters, sanctification can mean growth in acceptance of one's physical existence as well as one's spiritual self-acceptance. As the epoche of the natural attitude reflects trust-as-faith, the person's sense of self and community, in relation to God, may be more fulfilling. A phenomenological interpretation of trust's affect on a physician's "reality" serves to deepen the doctor's appreciation of the relational dimension of his or her work.

**Embodiment**

In developing a medical theological ethics, with an appreciation of the phenomenological approach to medical work, there is a shift from understanding embodiment as either incidental or detrimental to the experience of God, toward an understanding of embodiment as intrinsic to the divine-human experience. A Cartesian dualism has marked much of the

profession's perspective on health care. In this dualism, spirit is opposed to body, with spirit assumed to be higher and superior and the body lower and inferior. In the philosophy of medicine this dualism presents health as superior to illness. The companion of this dualism has been the association of the gatekeepers of health with the spirit and the patient with the body.

From the phenomenological perspective, such dualism suggests a denial of the suspicion that the body is not fully self-sufficient. As ontological priority is given to the spirit, the body becomes discounted, something to be denied or dominated. Health becomes a priority, and the gatekeeper to health assumes a controlling position over and against the "body." An appreciation of the importance of embodiment shifts this image. I am my body; yet in another sense I am not just my body. "The relationship of person to embodying organism is more complex: not only "mineness" but also radical otherness is inherent in it." In health, I take my body for

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42Often attributed to Descartes' metaphysical postulate, this dualism usually is described in terms of mind and body. As Zaner argues, Descartes did view mind and matter as "substances" or mutually exclusive, self-subsistent, and ontologically distinct entities. However, Descartes also claimed that, even though metaphysically dichotomous, human life in its everyday reality is a unity. Mind and body interact. Within his metaphysics, Descartes was unable to explain this interaction; if everything must be either mind or body and nothing can be both, how can the one be said to be united or to interact with the other? Yet we do experience our own bodies as "intimate"; see Richard Zaner, "Embodiment," in James F. Childress and John MacQuarrie, eds., The Westminster Dictionary of Christian Ethics (Philadelphia: The Westminster Press, 1986), pp.187-190.


granted; in illness, I become aware of its "otherness." With a
phenomenological appreciation of the meaning structures which constitute
perceptions of reality, health and illness become more complexly related: the
presence of one does not remove or erase the "presence" of the other.

I am not suggesting that a realization of one's embodied state erases
forever any sense of well-being or health. The natural attitude works to
reconcile any dissonant concern within the person's frame of reference. If
the natural attitude denies recognition of embodied vulnerability, the body's
presence merely is hidden. People do recover from illnesses and resume a
sense of health in their everyday lives. For some people such a recovery is
easier than it is for others: the person recovering from the feeling of
weakness caused by the flu may resume the activities he or she previously
enjoyed more easily and fully than one recovering from a myocardial
infarction. However, the recovered natural attitude can bracket an
awareness of the "lived-body" experience. One may regain confidence in
one's body, and return to a prominent sense of inviolability. This movement
results in a suspension of doubt in the person's bodily dependence, but it
also interferes with an appreciation of his or her embodied self. The gift of
the body, its "givenness," is not appreciated.

One result of this skewed ontological position has been the assignation
of positive value to the physician and a negative value to the patient. The
physician is associated with health and an image of self-sufficient power
while the patient is deficient, less than autonomous and self-possessed --
one who needs the physician and is dependent upon his or her knowledge
and powers. The presence of the physician then becomes primary and the
recognition of the patient as a mutual partner in medical work is absent.
Recent attempts to invert this relation only serve to replace the priority of the physician with that of the patient; the slave replaces the master as master and the economy of domination continues. We must seek beyond guarantees of autonomy and informed consent in medical care to find a renewal of the fiducial in health care. A review of Christian notions of divine and human relation points the way.

Implicit in the spirit-body dualism has been the notion of divine centrality, impassivity, and transcendence. If the physical is marked by decay and illness, and if the spirit is perfect and healthy, then illness has no connection with the divine other than as retribution for human actions and transgressions. Those who are ill, or dispossessed, or socially unacceptable are relegated to the periphery of society. Since God does not get sick and is without need, human dependency and vulnerability, of which illness is an example, is allowed to have no real connection with our experience of God.

In this theological understanding of the role of trust in physicians' identity, accompanying the attack on dualism is a new appreciation of incarnational theology. This theology emphasizes that the most decisive experience of God is not in doctrine but in the Word made flesh -- and in the Word still becoming flesh. Spiritualistic dualism has conditioned so much of


our response to the physical body that a strong theme in Christianity is the disembodied notion of salvation: Salvation means release from the lower (fleshly) into the higher (spiritual) life. However, salvation in an incarnational faith embraces the redemption of alienated bodies as well as other estranged dimensions of our lives. Grace signifies God's unconditional, unmerited acceptance of the whole person. As a free gift, the possible becomes actual. God's free gift as God becomes present among us (in person of Christ—who-suffers with us).

In a consideration of the application of trust-as-faith to the patient-physician relationship, we must be careful not to stray too far from the practical experience of embodiment. When one is ill, the embodied context of relationship must be reappreciated. The phenomenological quality of health and illness returns us to the discussion of the moral nature of the physician-patient relationship. The person experiencing (popularly assumed to be "suffering") the ontological crisis of illness and the vulnerable existential condition which accompanies it does not have the knowledge or skill to cure his or her own bodily or mental illness or to gain relief from his pain or anxiety. His freedom to act as a person is compromised. Unless the person denies or ignores this condition, he or she must seek the help of another, and must occupy a vulnerable relationship with the professional who possesses what the patient lacks.48 Theology gives new attention to the insight that a more comprehensive approach to health care is crucial to God's design that

we not suffer in isolation and loneliness, but in communion and community.49

Historical and Social Focus

An appreciation of trust-as-faith suggests a shift from understanding the medical profession as ahistorical to understanding it as an historical enterprise. At the same time, there is a shift from understanding illness and health care as private and individualistic issues to understanding them as personal and public ones. Illness will always be deeply personal, but personal does not mean private. On the agenda of policy makers today are social justice issues regarding access to health care. In an era of scarce economic resources and a demand for higher utilization of health care, the position of the physician in health care will be inescapably public. Also, the medicalization of society (the involvement of medical professionals in areas outside of the strict purview of their field) ironically has contributed to the public’s sense of involvement in health care matters. As a result, the image of authority and power associated with the profession is changing. The physician must operate under public scrutiny in a more obvious fashion. This development has a reciprocal effect upon the physician’s self-image, identity, and understanding of his or her work.

49 The prevailing view has been that the body... is a fragment of the Universe, a piece completely detached from the rest and handed over to a spirit that informs it. In the future we shall have to say that the Body is the very Universality of things.... My matter is not a part of the Universe that I possess totaliter: it is the totality of the Universe possessed by me partialiter;" Pierre Teilhard de Chardin, Science and Christ (New York: Harper and Row, 1968), pp. 12ff.
A sociological and phenomenological study has shown that knowledge and fiduciary commitment are defining foci of professional status. I am proposing that trustfulness and trustworthiness are essential for the practice of the medical profession. Trust is not essential as an attribute, nor to enhance the physicians' function. A review of the phenomenological dynamics revealed by bracketing shows that "changeless" perceptions and understandings are not changeless; fixed structures of meaning have a way of being interrupted. Once we appreciate the historical and social nature of trust, we can say that trust is a virtue because it necessarily enables people to overcome shocks to and allows the reintegration of human relationship, over time, under fluid conditions. Trust itself is not an absolute condition; blind or unquestioning trust distorts relationship as much as skepticism. As distrust becomes tinged with the economy of domination, it begins to acquire an element of alienation even as it structures human relationship, and consequently, the individual's image of him or herself and others. However, trust-as-faith provides a critical appreciation of human frailty and susceptibility to the economy of domination as well as the willingness to give one's presence to another in relationship.

A Return to "Practice"

There is another aspect of the turn to a medical theological ethics. If the "horizon of meaning" of the phenomenology of illness is adopted, illness

50 The deeper we sink into 'system,' the more alienated we become from our true selves. Man is the animal who regrets his choices, no matter how well they may have been made"; David R. Carlin, Jr., "The Failure of Success: Politics and the True Self," Commonweal 16 (Jan. 13, 1989), 8.
is that aspect of human existence that calls into question a person’s sense of personal and communal stability. What formerly seemed to be so dependable suddenly is abrogated. Rather than focusing on the application of moral principles to health care issues, another approach to an understanding of the important meaning of trust in physicians’ “practice” focuses more on issues of community, interdependence, responsibility, care, and non-maleficence. Varying views of community as the focus of moral life can be found in the work of thinkers such as Alasdair MacIntyre, H. Tristram Engelhardt, Martin Buber, and Stanley Hauerwas.  

Each of these scholars concentrates in his own way on the interdependence of persons which underscores the moral life.

There are two essential elements in the concept of a “practice” or a community. The first is that there is a common purpose or common center around which people gather. Engelhardt, for instance, defines community as “a voluntary association of individuals through a common concrete view of the good.”  

People who agree on the end or ends of life, or on what is morally permissible or required action and what is not, may join together voluntarily to pursue these ends. Hauerwas states that, “a community is a group of persons who share a history and whose common interpretations

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about that history provide the basis for common actions.\textsuperscript{53} The members of the Christian community, for instance, may be led to worship, act nonviolently, or become involved in AIDS work through their common understanding of the gospel message. The nature of this relationship is best seen as one of commitment to the common purpose.\textsuperscript{54} If the people lose this commitment, their community will fragment.

An exception to this circumstance highlights the second feature of community. If persons lose their commitment to the common center, their community may still function if they retain their commitment to each other. The other central feature of community lies in the common bonds of its members.\textsuperscript{55} In the struggle to retain commitment to each other, the original purpose may become modified or reinterpreted in order to accommodate the changing perspectives of the members.

Any viable community such as the medical profession will evidence these two general features. Its members will to some extent be committed to

\textsuperscript{53}Hauerwas locates the grounds for moral community in a commitment to Christian narrative and character; \textit{A Community of Character}, p. 60.

\textsuperscript{54}The vision of community presented by Buber is of a circle: "$[T]he relations of persons] with their true Thou," the radial lines that proceed from all points of the 'I' to the Center, form a circle. It is not the periphery, the community, that comes first, but the radii, the common quality of relation with the center. This alone guaranteed the authentic existence of the community"; Buber, p. 115, quoted in Michael F. Duffy, "The Challenge to the Christian Community," \textit{Religious Education} 83 (Spring, 1988), pp. 191-199.

The radii indicate the relationship that must exist between each member of the community and the common center or purpose.

\textsuperscript{55}"Buber's image of the circle is again appropriate, as the arcs that connect the persons along the periphery may be taken to represent the bonds or commitments between them"; Duffy, p. 192.
a common purpose or center and to one another. Insofar as community is
sought as an end, perhaps because of its general value for human good, there
are two ways it can be pursued -- by attaining agreement on ends or by
promoting the sorts of bonds between people that are necessary for the
community to exist. Given the pluralistic culture and the fragmentation of
society into atomistic individualism, agreement on a common end or purpose
to which all can agree is not likely.\textsuperscript{56} The other possibility is to foster the
relevant commitment between people.

One of the appeals of this approach to a discussion of theology and
bioethics lies in its assumption that community is one essential aspect of
human life and in its emphasis upon the relationships between people rather
than on a prior debate about the “rights” or “autonomy” of individuals.\textsuperscript{57}
Rights, duties, obligation, or moral principles such as autonomy, beneficence,
and justice are grounded in the fact of human community. A focus on the
commitment between people has the virtue of underscoring the need to
appreciate the historical and social structure, the mutuality of relationship,
and an economy of authority and power in human relations that are the

\textsuperscript{56}See Engelhardt, pp. 17–44. “Atomistic individualism” is discussed in Robert
Bellah, et al., \textit{Habits of the Heart: Individualism and Commitment in

\textsuperscript{57}Duffy, pp. 190–191. Hauerwas reacts to the failure of post-Enlightenment
moral arguments to resolve moral pluralism. Hauerwas wants to ground
moral argument and action in the distinctiveness of the Christian ethic. “The
church serves the world first by providing categories of interpretation that
offer the means for us to understand ourselves truthfully, e.g., we are a
sinful and yet redeemed people”; \textit{A Community of Character}, p. 109. While
this view is meaningful to those who share the tradition, the church still
exists in a world in which such claims are not shared.
bases of moral life. However, if commitment to a common center (God or the national interest) is lost, if commitment to each other is moving toward an atomistic individualism, on what do we ground moral relations? Is there a theological basis for relationship in a pluralistic world?

The two central features of community are commitment to a common end or purpose and a commitment to other members. One crucial aspect of these commitments, that is, an outgrowth of the essential bonds that make a community a community, lies in the willingness of persons to be present to one another in times of suffering and need. Presence is essentially a matter of availability to and caring for the other. Its opposite is captured in the concepts of indifference, abandonment, and desertion. When persons are suffering or in need, and are left to their own resources, the community necessarily fragments.\(^{58}\) This commitment to be present to one another is correlative to the commitment to a center. If one commitment is weakened, the other begins to erode. If one is reinterpreted or modified, the other will change as well.

In the postmodern, pluralistic world, commitment to a broadly based center of community is problematical. The fragmentation of mutual concern and presence follows. As the taken-for-granted understanding of a common center slips away, there is movement towards atomistic individualism. For people to live in community, they must be present to each other. However, as their common center, end, or purpose erodes and becomes absent, their appreciation of mutual presence of neediness results in alienation, separation, and the effort to eliminate need by domination of the roots of

\(^{58}\)Duffy, p. 193.
neediness. In a culture of criticism characterized by a hermeneutics of suspicion, this drive for domination is directed ostensibly at others, but more basically at oneself.\(^5\)

The themes of presence and commitment are vitally important in a discussion of the community within a community which is formed by the relationship of doctor and patient. The physician is a member of a particular community, the profession of medicine, as well as a member of the community of everyday life that is shared with the patient and the family and all others. The two people may have no common center or commonly agreed upon purpose other than the one negotiated between them or the concern that brings them together. While there are various models of relationship which purport to exemplify the means to maximize the benefits of this community, the primary emphasis in a pluralistic world must lie on the assumptions of careful knowledge and trust between them. The present model of the medical relationship, grounded in the biomedical model of illness and emmeshed in a climate of suspicion, results in a relationship in which the giving and receiving of knowledge and trust are brokered by self-interested, self-seeking adversaries. Thus, the community of two is threatened.

\(^5\)For a discussion of the culture of criticism, see Giles Gunn, *The Culture of Criticism and the Criticism of Culture* (New York: Oxford University Press, 1987). The expression “hermeneutics of suspicion” is attributed to the work of Karl Marx, Sigmund Freud, and Friedrich Nietzsche. This use of hermeneutics seeks to interpret in order not to be deceived. The use of hermeneutics to “replenish” meaning is the intent of Paul Ricoeur, Martin Heidegger, and Hans-Georg Gadamer; ibid., p. 194. The role of biblical narrative in subverting and renewing culture is presented by Herbert Schneidau, *Sacred Discontent: The Bible and Western Tradition* (Baton Rouge: Louisiana State University Press, 1976).
Physicians do not care for the other because he or she carries the cross of illness. Hauerwas, in treating the theme of "imitatio," writes that the cross is more than a "general symbol of the moral significance of self-sacrifice." Rather, "the cross is God's kingdom come." However, if we set aside the notion that the cross represents God's selfless giving, and see it as symbolizing the violation of love, it is no longer the goal of love, but an expression of the length to which God will go in order to restore broken community. The physician, then, cares for the patient because we all share a mutual neediness, represented by the commonality of illness. Physicians make the commitment to be present in the face of, in spite of, pain and suffering. The patient in the bed mirrors the physician's self. The continual presence of the other, and the corresponding demand for care and trust, cannot be denied or eliminated. Attempts to do so by idealizing selflessness and self-sufficiency demean the self and other, and lead to domination and self-annihilation. These attempts to absent otherness only create emptiness within the self which is experienced as self-hatred, inadequacy, and self-negation. Self-abnegation is not the central feature of fiduciary regard. By making it so, we have confused the profession's tradition of service.


Conclusion

The Mutually Sustaining Presence of Trust-as-Faith

We have focused on the challenge which relativism and subjectivism present to the medical profession in an effort to formulate an orientation for trust-as-faith which can provide meaning in a world of historical reality. Any attempt to discover the original "idea" or essence of the profession is doomed to failure. Even the idea of such a truth is ambiguous in that it depends upon the social and intellectual conditions of the particular age.62 The answer to any question must depend on the way in which the question is asked, and there is no one way to ask questions of the past. The question will be formed from a subjective interpretation of available data, and the answers become relative.63

I have argued that any view of the medical profession is shaped from the present interpretive point of view and becomes, therefore, an abstraction. Any attempt to conceptualize a definitive view of the essential traits or function which definitively defines the "good" physician implicitly becomes a criticism of the present conceptualization, and the criticism is advanced always from a particular point of view. Thus, it is important to understand the way in which the physician trusts his or her horizon of

62See Morgan and Pye, pp. 222, 244-245.

63Troeltsch, "What Does 'Essence of Christianity' Mean?" ibid., pp. 122-181. "According to our own inward working through of the Christian idea and according to the conscientiousness of our grasp of the historical material, we will arrive at various conceptions of the line of development, and in accordance with the points of view thereby achieved we will conceive of the seminal potential of the original form in various ways. That which for one person belongs in the development of the essence is for another a disruption of the continuity" (p. 152).
meaning to provide definitional limits to medical work. This horizon is constituted by confidence in medical knowledge and skill, and the taken-for-granted assumption by the physician that he or she is trustworthy. However, when this assumption is bracketed, the meaning of trust requires recreation.

The medical profession has cultivated a degree of trustworthiness in the way its accent defines the practitioner's personal and professional self-image, and the "face" of competence and beneficence that it presents to the public. The way in which the physician regards his or her work is fiduciary in nature. However, while it enhances patient care, it also benefits the profession's prestige and authority and aids in monopolizing the health care market. In last one hundred years, socially and politically the fiduciary commitment of medicine has helped the medical profession organize itself into an institution controlling its work with the justification that this control is for the good of the patient. The growth of a strong taken-for-granted attitude towards technical expertise (viewed as a "good" by the profession, as a major characteristic delineating the profession and distinguishing it from "quacks") turns the physician into a paternalistic, domineering figure who acts with the "best of intentions" while furthering his or her own interests and power.64

Unfortunately, as a result of a distorted relationship which denies mutual dependency, a concern with the depth and commitment of physicians' fiducial nature is developing. I do not think that moral dilemmas

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64For a treatment of the movement of medicine to power and professional status grounded in technical expertise, see Paul Starr, The Social Transformation of American Medicine (New York: Basic Books, 1982).
are the result of this concern, but conflicts over autonomy and authority find expression in it and push the parties towards contract and litigation as a means of resolving the issue. The language of law is used as the assumption of a common understanding of the meaning of trust is called into question.

Trust, as a response to others and a reliance on others, has something to do with relationships of mutual dependency. The medical professional is in a mutually dependent relationship with the patient and also with the public which "permits" or "licenses" his or her practice, which gives to him the trust that is fundamental to his work (literally, the trust that allows the doctor "to cut someone"). If mutual trust is to exist in a fundamentally precariously lived, pluralistic existence, each person must be willing to surrender something of his or her self-control and accept the vulnerability that accompanies the dialectical structure of social existence. This surrender goes beyond contractual confidence, yet stops short of blind faith. It leads to the nature of trust and faith as fides and fiducia in a covenantal relationship.


The covenantal relationship between doctor-patient which can create responsiveness and responsibility is a "tripartite concept: a covenant [which includes] not only an involvement with a partner in time, and a responsive contract, but the notion of a change in being...." Inasmuch as people are born into a world marked by an accent of reality developed over time, all that they know of the world is given to them from their social milieu. In this sense, biological life and a sense of "life" are both gifts. Receiving this gift is only one half of the relationship involved in the everyday world. Receiving is completed by the giving someone returns to the world. In contributing to society by our presence, thoughts, and actions, we add to the social matrix out of which society continues to develop. Just as we need the social realm in order to exist, we need to receive from society and we need to return something of ourselves to the world in order to exist meaningfully. "Receiving" becomes a correlate to "giving" in a relationship; the way we receive care is as important as the way in which we give it. The three

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68 May, in Reiser, et al., p. 69.

69 Keith-Lucas recognizes that an important characteristic of the helping relationship is that it is mutual, not merely one-way; Allan Keith-Lucas, Giving and Taking Help (Chapel Hill, NC: The University of North Carolina Press, 1972), p. 47. Thus, the doctor gives of his or her expertise and dedication, yet receives in return from the patient, among other things, the "license" to practice the art.
covenantal dimensions are included in the "we-relation," grounded in its constitutive elements of interdependent giving and receiving.  

In conclusion, the recognition of interdependence presents the possibility of a mutually "sustaining presence" in the medical relationship. In place of a univocal economy of domination, a dialogically oriented medical model reminds us that theology cannot look down upon human health and illness from some unaffected vantage point. Theology itself partly is dependent upon human experience for its structures of meaning. Every theological perception contains elements conditioned by human experience, and every human experience can be perceived and interpreted through some religious perspective. The difference between a univocal and a dialogic method is the difference between a theology of medical care in which the taken-for-granted perceptions of theology are imposed upon medicine, and a

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70 The natural attitude of the world into which people are born represents (or gives) a sense of reality to them through relationships of all kinds, principally social, and they in turn re-present (or give back) themselves to reality. Ideally, each participant is able to give and receive freely with hope for some equal degree of reciprocity. However, this exchange exists on any level: the person in a vegetative coma receives the gift of care on which his or her life may depend. While this person cannot give back an equal degree of animated response to the care-giver, nonetheless a relationship exists. The person who is in relationship with the patient-person does receive something (be it aggravation, financial burden, or unwanted responsibility). If the gift of the patient does not meet the needs of the caregivers, they may choose to give up their responsibility, although this decision is made in the context created by the "we-relationship." The attempt to design a system to weigh in some objective manner the benefits and burdens of any we-relationship is problematical and necessary, but if it becomes as mechanistic as the contractual relationship which grows out of a climate of distrust and self-protection, it will be inadequate.
medical theology in which medicine suggests theological perspectives. There must be an appreciation of mutual presence in medical encounters.

However, this presence is not a passive experience. Trust based on blind faith, on passive surrender to another, must be distinguished from trust that is earned after having first acknowledged to oneself, and then shared with the other, what one knows and does not know about the decision to be made in an uncertain situation. Interdependent human relationship is reciprocal and mutually enlivening. In the we-relationship, encounter is juxtaposed to experience. For Buber, the "It" is experienced, while the "Thou" is encountered. The Thou cannot be "experienced" as if an objective event. For Buber the Thou is partly an It, but also is much more. In encounter there is no mediator between the Thou and the I. The two are necessary for the completion of the other. The encounter is a present event and for as long as it lasts, the present is actual and complete. One form confronts and fulfills the other in a "we-relation."

71 Hauerwas uses the term "suffering presence" to describe the traditional dedication of physicians to being present to those in need, even when nothing can be done; see Suffering Presence. Shep develops the phrase "sustaining presence" as a corrective to the image of the physician as an all powerful, authoritarian figure. The image of the doctor as "sustainer" allows for the recognition of the profession's superior knowledge and expertise while emphasizing the fiducial commitment to remain in relationship with patients even when nothing can be done; see Born to Die? Both authors reject the abandonment of the patient by the physician who finds that the possibilities of active treatment are gone. Both authors see presence as an active condition, enlivening the relationship between both parties even in a situation where intervention is useless.

72 Buber, pp. 58, 61, 67.

73 Ibid., p. 62.
As we have seen, the world of daily life, of everyday reality, is made up of multiple levels of reality or provinces of meaning. Each of the finite provinces of meaning may receive the "accent of reality," may be attended to as real. There is no formula of transformation which enables one to pass smoothly from one province to another. The transition is always experienced as a "shock" as one moves from one accent with its own concerns, language, objects of relevance, actions, and habits to another one. Only by a "leap" is that passage possible.\textsuperscript{74} Giving up the meaning structures of one province is an unsettling experience. The perception of choices and the freedom to choose involve a person in existential anxiety. It is tempting to escape this anxiety by renouncing the struggle for self-assertion by seeking self-security and domination.

In the face of the uncertainty of dependency and vulnerability, the "will to accept responsibility," the will to respond to others, requires courage and trust. Trust is not the blind acceptance of risk; it is the courageous choice to rely on another in spite of the threat of dependency. Shelp writes of an "alliance of uncertainty" which creates a bond between physicians and patients, promoting a mutual compassion that makes presence possible to each other.\textsuperscript{75} The leap of faith that enables a person to be present to another

\textsuperscript{74}Maurice Natanson, "Introduction," in Schutz, \textit{Collected Papers} 1, p. xliii; Schutz, "Multiple Realities," ibid., p. 232. Schutz gives many examples of such "leaps"; see the discussion on pp. 231-259.

represents a moral effort to trust that includes the "courage to fail," the
courage to be vulnerable and dependent on others.76

Superficially, the development of a technologically or scientifically
based health care is motivated by the desire to satisfy our desires (wants) in
regard to health. On a deeper level, though, the development is fueled by the
desire to eliminate our dependency. The shift in self-conception by the
profession (and the public's conception of the profession) from that of an art
to that of a science fosters the development of domination. Research into
disease, the growth of medical technology and technique, contributes to and
fuels the view that the physician is the life-giver or denier of death. This
view gives the medical professional a great deal of power within the natural
attitude of the everyday world. However, this gift of power is shaped by, and
in turn shapes, the view of the relationship between life and death. If it is
fueled by the denial of dependency, it can become domineering and
oppressive. The doctor who is seen as the giver of life struggles in the face of
death to meet the needs of the patient through the use of technology and the
manipulation of information. The patient fearing death who gives away
control, autonomy, and responsibility is unable to receive death
meaningfully if it should appear. A paternalistic relationship can be the
result of a denial of neediness in both parties, and worse, the physician may

76 For a discussion of Kierkegaard's idea of the "leap of faith," see James
Collins, "Faith and Reflection in Kierkegaard," in Howard A. Johnson and Niels
Thulstrup, eds., A Kierkegaard Critique (Chicago: Henry Regnery Co., 1962),
207-227; and Mark Taylor, Journeys to Selfhood: Hegel and Kierkegaard
(Berkeley: University of California Press, 1980). Also, see Renee Fox and
Judith Swazey, The Courage to Fail (Chicago: University of Chicago Press,
1974).
make himself absent from the patient out of a sense of shame at having
failed to deny death (itself a denial contained within the attitude of the
profession which has denied it’s own neediness in the face of the correlative
gift of life and death). True trust is possible only in the acknowledgment of
suffering. Any attempt to rid the world of all suffering is Promethean.77

Dependency cannot be eliminated. The concern for human dignity, self
control, and autonomy all represent the inability to accept and express
mutual needs. The turn to consumerism as the basis for the professional-
client relationship may counter philanthropic conceit, but it also may be the
denial of neediness. A need for communication and relationship can be
replaced by the demand for accountability in the contractual arrangement.
The only needs covered are those specified within the contract. The
physician becomes a caretaker held accountable by the one who pays the
biis. Within such an arrangement there does not seem to be the possibility
for the nurturance of body and soul called for by the covenantal
relationship.78

A medical theological ethics holds out the “Faith” that medicine can be
responsive and altruistic, without becoming paternalistic and domineering.
The physician who is able to give up the need for power by accepting the
ambiguities and limitations of his or her “art” is better able to accept the
needs and concerns of patients. Since every act of giving implies a loss, to be

77Smith, p. 275.

78Doctor and patient are correlative entities; each gives and receives purpose
and meaning from the other. They can become a “sustaining presence”
(Shelp) or a “suffering presence” (Hauerwas) to each other. William May’s
images of the physician contributes to this discussion as does his work on
covenant as a model for health care; The Physician’s Covenant.
able to accept one's own neediness and incompleteness enables one to give
more selflessly, not out of the conceit of denial but out of a sense of mutual
concern and caring. The person who acknowledges his or her dependency is
better able to face the responsibility and obligations of the patient, who must
relinquish some self-control to the doctor in trusting acceptance of the caring
relationship. In the covenantal model, the doctor who gives care receives
trust; the patient who gives trust receives care. Each one finds some
ontological fulfillment in the needs of the other regardless of the outcome of
treatment. A shared view, a mutual presence, replaces the single view of the
expert in a relationship of "fidelity that exceeds any specification."79

79May, in Reiser, et al., p. 70.
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