

Doing Wrong, Getting Sick, and Dying

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SEVERAL YEARS ago, I spent many long hours in an outpatient medical clinic ministering to patients with stomach, liver, pancreas, colon and related gastrointestinal cancers. One particular remark by a patient lingers with me, though every patient raised the same question in one way or another: "Why do I," the person asked, "have liver cancer? I never even smoked!" That question is both absurd and dramatically relevant although smoking plays a clear role in increasing chances of lung cancer, it is less a factor with other cancers. This simple query exemplified a struggle that many ill people face as they search for a reasonable cause for their fate and wonder what they have done to bring it upon themselves. Few of my clients felt innocent, almost all blamed themselves in some way. Practically none escaped a heavy sense of culpability. These patients raised questions of responsibility, judgment and guilt, which people susceptible to illness—that is, all of us—ask. We cannot help but search for meaning and messages in our suffering.

A sense of culpability in illness and death can provoke much personal anguish. To some extent such anxiety has always been a reality across time and cultures, people have struggled with the connection between human behavior and misfortune, especially sickness and death. Probably even the most rational or secular individuals have never fully believed that their actions, beliefs, attitudes and values are absolutely irrelevant to their infirmities or approaching death.

Today, however, the problem is more intense. For a number of intriguing reasons, today's ill and dying per-

sons believe strongly that they have caused their fate, even if only indirectly or subconsciously. At the same time, ironically, they lack moral and spiritual resources to help them handle the responsibility.

Since the turn of this century, psychology, not religion, has provided the interpretive framework for these questions, in what sociologist Renée Fox describes as a "sin-to-crime-to-sickness evolution" ("The Medicalization and Demedicalization of American Society," *Daedalus*, Winter 1977, p. 11). Problems formerly considered sins that should be dealt with by church authorities are now considered either crimes to be dealt with by legal authority or medical concerns to be cured by the scientific community. Many people feel free to accept or reject a religious judgment that declares a certain behavior immoral. They will change churches rather than behavior. But if psychologists and physicians, now invested with new authority, define the same behavior as psychologically abnormal, sick or cancer-causing, people will eagerly comply with the regimen that the doctors propose. This leads us to tell the sick and dying that they "didn't eat their bran" or suffer from "type A" personality traits, rather than our acknowledging a more complex combination of factors contributing to their condition.

Freud's theory of the death instinct seems to support this idea that we bring our own destruction upon ourselves. Torn eternally between eros and thanatos, we have an inner urge to return to an earlier state of inanimate, inorganic existence, Freud claimed. In the end, we each die of our own "internal conflicts," the self-destructive death instinct killing us when our libido has been used up or fixated. This idea captures the moral imagination of later psychology. Kurt R. Eissler, the first Freudian to devote an entire book to *The Psychiatrist and*

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the Dying Patient (International Universities Press, 1955), argues that we should view death as a psychological event rooted in each person's own personality and individual life history—"the effect of an unconscious actively engaged in the preparation of the lethal end." But it is Edwin S. Shneidman, a psychologist specializing in death and dying, who carries these ideas to an extreme: he maintains that we should revise the death certificate in light of Freud's psychiatric revolution to include the significant role that the deceased's intentions played in hastening his or her own death (*Death of Man* [New York Times Book Co., 1973]). Not only can we indicate whether death came naturally, accidentally or through suicide or homicide; we must also judge whether it was intended, subintended or unintended. This attitude reflects a new understanding of human responsibility, leading psychologists to scrutinize and evaluate an individual's character, values and goals and, in essence, to make moral use of psychological concepts in assessing the implications of illness. They label overeaters, under-exercisers, smokers, the careless, foolhardy and imprudent as "death-seekers," "death-experimenters" and "death-initiators."

Psychological theories of illness have become powerful means for inducing blame and, over time, have influenced changes in medical explanations of disease. The perception that disease is precipitated simply by a sole bacillus that can be isolated, diagnosed and cured by "magic bullets," as René Dubos (*The Mirage of Health* [Harper & Row, 1971]) calls vaccines, has come under increasing suspicion. The elimination of so many infectious diseases such as smallpox, the plague, cholera and tuberculosis gave people hope that all diseases would disappear and led them to conclude that factors of personal responsibility for health were negligible. We still want to believe that medicine will uncover and cure the single cause of all disease.

Yet despite medical advances, people continue to fall ill and die—but now from different types of maladies. Chronic degenerative diseases (cancer and heart diseases) have replaced acute, contagious, single-microbe diseases, and they often progress in a rather unpredictable and poorly understood fashion. Doctors can offer potentially therapeutic interventions, but no absolute cures. They make only tentative, cautious, understated prognoses. The underlying physiological mechanisms and the means to prevent, control or cure continue to evade medicine. It offers only "half-way technologies," measures that can seldom do more than palliate the symptoms of an already-established terminal disease.

Our inability to prevent, control or cure major causes of death has forced us to question the "one-bug" model. Even though scientists have found cures for some diseases, Dubos and others suspect that the mere discovery of specific bacteria did not itself cause their decline. Rather, other factors—pure food, pure water and pure air—also played a part. The struggle with the complex etiology of AIDS illustrates the dilemma: the

discovery of the virus by scientists at the Pasteur Institute in Paris in 1983 did not automatically unlock the door to a cure; and having the virus will not necessarily make the carrier ill or cause the patient's death at any predictable rate. Researchers therefore call the mysterious influences on AIDS "cofactors," and they call forces that seem to exacerbate cancer and heart diseases their "multifunctional" origins. "Multifunctional origins" might mean anything from the variables of environment to value-loaded judgments about personal habits, behavior, "lifestyle" or even judgments about "the good life and the good society." Some theorists directly link cancer, for example, to a breakdown in close personal relationships or to feelings of loss, anxiety, depression, hostility or hopelessness. For example, when someone we know suffers a heart attack unexpectedly, we find ourselves saying with surprise that the person never struck us as "the kind of person" who would experience heart problems. We have a certain personality type in mind when we make this judgment. Robert Morison goes so far as to argue that Wesleyan or middle-class virtues of cleanliness, prudence and moderation are the significant factors behind high health standards ("Rights and

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Responsibilities: Redressing the Uneasy Balance," *Hastings Center Report* 4, April 1974, p. 3).

Achieving good health and locating the determinants of disease and death are far more complex problems than previously believed. We continue to search for natural, external causes but have hypothesized that illness might also arise from problems like character deficiencies, neurotic or aberrant behavior or misguided lifestyles, or from unjust, oppressive social systems that breed poverty, ignorance and brutality or that fail to be fair in distributing scientific cures. We may no longer believe the religious tenet that because we sin we die. But we have replaced this idea with more insidiously punitive moralisms.

At least this is Susan Sontag's suggestion in *Illness as Metaphor* (Farrar, Straus & Giroux, 1977). Comparing attitudes toward cancer and tuberculosis, she demonstrates that when naturalistic explanations fail, we blame the patient for the illness. For example, before knowing the physiological cause of TB, society portrayed its victims as excessively passionate, reckless or sensuous. Now we know that psychological excesses and moral faults are unrelated to TB's causes. Sontag doubts similar societal myths about cancer—that it is caused by repressing emotions like anger, sexual desire or grief. Such myths suggest that people bear an unfair share of the responsibility for their own illnesses.

Indeed, statistics do show that certain actions can lead

to ill health. Voluntary choices like smoking, overeating or failure to exercise can affect the diseases that are leading causes of death. Temperament, character and habits do influence our well-being; good health requires effort and self-discipline. "Over ninety-nine per cent of us," contends John Knowles, "are born healthy and made sick as a result of personal misbehavior and environmental conditions" ("The Responsibility of the Individual," *Daedalus*, Winter 1977, p. 58). Some suggest that rather than claim a right to health, we consider care for our own health an individual moral obligation or a public duty. H. Tristram Engelhardt even contends that should a smoker get cancer and require treatment that burdens the general community, we can justifiably say "that he or she acted immorally with respect to the responsibility to avoid cancer and its public costs." Those persons are culpable; let them pay for their treatment, he concludes ("Human Well-Being and Medicine," *Science, Ethics and Medicine* [Institute of Society, Ethics and the Life Sciences, 1976], p. 128).

However, sifting out the elements of moral responsibility poses slippery problems. Engelhardt's statement comes dangerously close to encouraging primitively moralistic judgments; we cannot possibly account for all of a disease's causes. For example, societal values and the media heighten the glamour and appeal of smoking. Nor can smoking be directly correlated with being generally irresponsible. No one, Daniel Callahan observes, has successfully demonstrated "that smokers are, as a group, generally less responsible, less moral individuals than nonsmokers" ("Health and Society: Some Ethical Imperatives," *Daedalus*, Winter 1977, p. 31). Also, people who show no signs of certain unhealthy behaviors may still fall ill from the same diseases that ail people with problem behavior traits. "For that reason, if for no other," says Callahan, "it would be impossible to *prove* that someone's disease was the result of his culpable willful responsibility."

WE DO NOT know how widening our sense of responsibility harms or helps our ability to deal with illness. With some problems like alcoholism, to relieve persons of blame and help them accept the fact that the illness is external to emotional, moral or spiritual faults paradoxically inspires them to be more responsible. They then live within the known physical limitations of the illness and take precautions. On the other hand, if we hold people responsible for their own health, we at least grant them a certain measure of autonomy and dignity—we consider them capable of responsible action and decision-making. Culpability thus functions as a "virtue," according to Robert M. Veatch.

The discussion raises still more questions. Is it "simply sinful," as Morison says, "for a middle-aged man with a family to smoke cigarettes . . . clearly and willfully increasing the probability that he would be unable [due to illness and death] to fulfill his responsibility to his family or indeed, to society at large" ("Rights and Respon-



sibility," p. 4)? If people have a right to healthcare and yet are irresponsible in their personal habits and behavior, have they limited their right in any way? Is the individual accountable, and to whom? In general, how much sacrifice of individual health can society demand in the name of general health? Or, on the other hand, how far should society go in using medical means to satisfy personal and sometimes idiosyncratic wishes?

A deeper problem, however, is that mainstream culture does not provide ill people with resources to help them face these questions. They no longer have language with which to express the condemnation that they feel. The liver-cancer patient does not know how fully to account for the possibility of having failed to meet responsibilities or of being guilty for the onset of illness. People lack what Frederick Hoffman calls the "compensatory forces of remorse and penance" necessary to comprehend commission and atonement ("Morality and Modern Literature," in *The Meaning of Death*, edited by Herman Feifel [McGraw-Hill, 1959]). Moral responsibility for death is thrust upon them. Yet they are directed away from confessional and willed levels of moral development and understanding and are left with a poorly balanced, distorted moral economy: they cannot calculate their proper responsibilities for death as a predictable result of understandable causes. Without a developed ethical sense and a way to account for moral deficiencies, people can no longer prepare for death.

Personal anguish about culpability before illness and death was better managed within the modern medical model, which was developed at the turn of the century. The medical establishment at that time exhaustively explained illness and death in rational, scientific, "morally neutral" terms. Doctors certified that the causes of disease resided in micro-organisms, not in personal.

moral or religious factors. This assertion eliminated religious questions of meaning, mystery or moral imperative. People no longer used the concept of divine providence to explain death; they considered religious, spiritual and moral meanings superfluous. They felt blameless and by attributing illness to natural causes, the physician supported that view.

Today, medical explanations no longer remove patients' culpability. When medical explanations fail, people are left to construct the meaning and moral message of their illness on their own. This process evokes profound anxiety and sometimes oddly punitive responses. Patients may blame themselves for behaving or even thinking the wrong way. Conversely, "good" patients who have purposely not smoked, for example, expect "rewards" for their good behavior, such as being spared heart disease or lung cancer. People who contract one of these diseases become deeply troubled when doctors cannot determine its natural cause; they may develop a vague, haunting sense of moral failure. Furthermore, their sense of justice is upset when, as happens all too often, those who compliantly avoid behavior that might aggravate their illness recover no more quickly—or in some cases even more slowly—than others who are less "well behaved." Such an experience is very disillusioning.

MAINLINE THEOLOGY approaches these questions only obliquely, if at all. In the past people perceived suffering and death as possessing some moral and religious message. But in the modern world, we've stripped these experiences of such meanings. Individuals now lack the spiritual and philosophical resources to help adjudicate accusations of blame, guilt or negligence in the face of illness and death. The religious and moral explanations of earlier centuries seem nonsensical, antiquated, empirically inconsistent. In our demythologized world we calmly and coolly try to accept that death belongs to the essential nature of life—no more, no less. Thus many people who feel guilt or responsibility for an illness have nowhere to turn for explanation or support.

Likewise, the church's rituals for dying have become largely a lost art. The experience of facing impending death forces the individual to reassess her life in wholly unfamiliar moral and spiritual ways, for which she is unprepared and inexperienced. The church's traditional moments of witness, exhortation, sorrow, pardon, absolution, prayer and silence have been replaced by Elisabeth Kübler-Ross's renowned five stages of denial, anger, bargaining, depression and acceptance. These are experienced internally and privately, unlike the church's rituals, which involved close moral and religious scrutiny of one's relations with oneself, one's neighbor and one's God. Without this religious support, people face death and God with a confusion and dread for which they no longer have words to name or comprehend. Medical ethicist Kenneth Vaux warns that in an age when we relate ill health to misbehavior—in much the same manner that

sin and sickness were once equated—people need a theology of culture that undergirds our health-policy ethics.

The problems are too big for an easy solution, but the church can certainly approach them more effectively than it has. Theologians and ministers should seriously attempt to retrieve significant historical resources as well as contemporary reflections. New conceptions of our responsibilities for doing wrong, getting sick and dying will come from creative dialogue between moral and religious traditions—whether buried in Augustine or Freud—and from encountering people's experiences with dying.

Augustine can help us construct such a theological response. Although Schleiermacher scolds him and other early church fathers for arguing that sin causes death, Augustine's understanding allowed him to discuss moral and religious realities that escaped Schleiermacher—and escape us today. We may find the idea of death as "curse" due to God's "judgment" abhorrent and alien. Yet these terms, understood in the context of Augustine's world, reveal his attempt to elucidate deeper issues.

Augustine understood something of what many cancer patients struggle to articulate: that at some level humans bear responsibility for how they live and die. Likewise he understood our dire need for acceptance despite our failings. But his definition of acceptance differs dramatically from those of Kübler-Ross and others, for his entails moral and religious sensibilities. This allows him to speak directly to the fear, despair and guilt we feel regarding illness and death. For Augustine, death demands a "penalty paid in the name of justice and piety," a penalty which can be paid not by humans, but by God. Rather than a passive, narcissistic peace, acceptance entails three rigorous activities: "the avoidance of sin and the cancellation of sins committed, and the award of the palm of victory as the just reward of righteousness" (*City of God*). Hence a good death is not a human act existentially lived out but an act of faith and reconciliation. It requires the sorrow of repentance, a certain salutary agony of self-denial, endurance in devout faith, and reconciliation with others and God. Through these acts, death, an evil in itself, is turned to good advantage; it becomes a way to true life.

Paul Tillich attempts to describe the same reality in language less foreign to our post-Enlightenment ears. While he moves beyond Augustine's traditional formulations, he attempts to retrieve value from the ideas behind them. He maintains that death is a law of both nature and morality. On the one hand, we have to die because we are dust; death is part of the natural order of living. But, on the other hand, "we have to die because we are guilty. That is the moral law to which we, unlike all other beings, are subject" (*Shaking of the Foundations* [Scribner's, 1948], p. 70). Even if religion no longer validates a direct connection, people fear and recognize on some level that they have brought misfortune upon themselves by not doing what they should have done or by subverting the rightful order of nature. Although

natural to every finite being, death also stands over against nature. People must, as they stand above existence as free beings, ask themselves, "Is it true and good existence?" And they must demand that it be so. Since this demand is never fulfilled, our awareness of having to die becomes the painful, guilt-ridden realization of the loss of the eternal—a loss for which each of us is responsible, despite its tragic universality. This explains, if only in part, why cancer patients raise questions about their own responsibility in causing or preventing their illness, and why people have trouble accepting disease and death as simply natural parts of life.

When death comes as more than fate—when it comes as condemnation—only one response can suffice: forgiveness. This takes into account the whole human experience, not only fear of extinction, but also fear of judgment and the recognition of guilt, sin and human brokenness. Since we cannot freely realize our dreams and possibilities and inevitably fail to make the most of the gift of life, we can accept death only "through a state of confidence in which death has ceased to be the 'wages of sin,'" the "state of being accepted in spite of being unacceptable" (*The Courage to Be* [Yale University Press, 1952], pp. 169-70). Understanding Tillich's pithy

phrase—"acceptance without suspending judgment"—might lead us to a fuller understanding of the complex association between doing wrong, becoming ill, and dying. The language of acceptance should not lead us to shallow "forgiving and forgetting"; forgiveness involves renewed participation in human community and objective powers of acceptance. Both Tillich and Augustine believe that this comes only through deeply suffering and paying a "heavy price," and undergoing a "tremendous toil," not wholly on our own but through faith. Otherwise, it is "simply a self-confirmation in a state of estrangement" says Tillich (*The Meaning of Health* [Exploration Press, 1984], pp. 56, 224).

Veatch claims that death is "our last quest for responsibility" (*Death, Dying and The Biological Revolution: Our Last Quest for Responsibility* [Yale University Press, 1976], p. 11). Now more than ever before, we have more opportunity for such acts as leave-taking, and for directing to some extent the mode and timing of our deaths. Yet paradoxically, numerous factors prevent us from fully taking on this "last responsibility." Time is ripe to begin to reclaim some of the resources that might lead us to a more nuanced formulation of the relationship between moral responsibility, illness, and death. ■

Social Consciousness and World Maps

JOHN P. SNYDER

IN 1973, German historian Arno Peters announced at a specially called press conference that he had developed a new map projection—a way to view the round world as a flat map—that finally overcame the problems and limitations of the Mercator Projection, commonly used for geographical maps. Most wall maps of the world seen by American schoolchildren in classrooms and by adults on TV and elsewhere are Mercator Projections.

From its initial announcement, the Peters Projection has been surrounded by controversy. In over 40 articles on the subject, cartographers have vigorously denounced a number of Peters's claims for the map, while he and his supporters

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have argued that his is the only world map that meets the concerns of people interested in social issues. UNESCO (the United Nations Educational, Scientific and Cultural Organization), the National Council of Churches, and Lutheran and Methodist groups are among the organizations supporting Peters's map.

Peters's principal claim is that his projection shows all parts of the world in proportion to their true areas, while the Mercator Projection greatly distorts relative areas so that Europe, the Soviet Union, Canada and Greenland are shown as far larger relative to South America and Africa than they really are. The latter regions include important parts of the Third World that are populated primarily by dark-skinned peoples, and the former regions are populated mostly by light-skinned, industrialized peoples. Peters concluded that the Mercator Projection draws its popularity in large part from exaggerating the sizes of white-dominated

regions and thus reflects a racist attitude—a serious charge if actually true.

There is no question about it: small Europe does show up more prominently on the Mercator Projection than it does on others that maintain correct area relationships (and there are scores of these besides Peters's). If this unfortunate bias deserves to be corrected, why do cartographers object so strenuously to the claims Peters makes for his projection?

Their objections fall into two general categories: first, the simplistic proposal that the Peters Projection should be used exclusively (except possibly for navigation), and second, the number of incorrect statements made about the projection, and therefore (by implication) about other projections.

Promoting the projection as a cure-all for mapping woes is indeed highly simplistic. No one flat projection,