HUMAN FRAILTY AND THE BURDEN OF MEDICINE: A MEDICAL RESPONSE

Margaret E. Mohrmann

Margaret E. Mohrmann is the Harrison Medical Teaching Associate Professor of Generalist Medicine; and Associate Professor of Pediatrics, Medical Education, and Religious Studies at the University of Virginia. She is also a Faculty Associate at UVa's Center for Biomedical Ethics. Dr. Mohrmann is the author of Medicine As Ministry: Reflections on Suffering, Ethics, and Hope *(Pilgrim) and co-editor of* Pain Seeking Understanding: Suffering, Medicine, and Faith *(Pilgrim). She is also the narrator of a video, "The Way We Die: Listening to the Terminally Ill," used widely by hospice and AIDS support groups and in college courses on cultural understandings of death.*

DURING THE INITIAL PRESENTATION OF HIS PAPER, Professor Turner mentioned parenthetically that he did not wish to be taken for a Luddite, although he acknowledged the difficulty of avoiding that label for one who wishes to voice an effective criticism, or a prophetic caution, about technology. In response, I would like to offer the possibility of further distancing the argument from the Luddite charge by considering more thoroughly the social situation of medicine, the technological institution to which Professor Turner gives most of his attention.

I do not, in general, disagree with his concerns, nor am I particularly roused to defend medical science against his casting it as one of the villains in his grim picture of contemporary society. Instead, I want to elaborate and, perhaps, complicate the arguments somewhat, using

Professor Turner's helpful and revealing model of ontological frailty, social precariousness, and compensatory interdependence. My intent is to elucidate ways in which the complex and often troubling process of medicalization demonstrates just how deeply medicine is embedded within society and affected by experiences of frailty and precariousness, experiences that it also engenders and encourages. That is, I suggest that it is important to understand medicalization and the increasing encroachment of medical technology as a reciprocal or mutual process—as a two-way street.

To begin, it will be helpful to reflect on the characterization of medicine as Cartesian, a widely accepted description that colors Professor Turner's paper throughout. I do not dispute the claim—it is too obviously true to be arguable—but wish to draw it out a bit. When we label a practice or mode of thought as "Cartesian," we usually intend at least two related points simultaneously. One is that there is a mind-body split of some sort in play; the other is that, in the context of that split, mind is being chosen, given precedence over body. Descartes famously did not say, *"in corpore, ergo sum"* [I am embodied; therefore, I am]. However, when we apply the label "Cartesian" to medicine, we should note that this second point, the preferred identification with mind, applies only to one side of the medical equation. That is, when medicine speaks of itself and its practitioners, it understands existence to be coterminous with mind: Medicine thinks; therefore, it is. Doctors are notoriously disembodied persons. But patients, who are also certainly split apart by medicine's Cartesian wedge, exist for medicine as bodies. The good thing to say about this, as Paul Ramsey frequently reminds us in *The Patient as Person,* that ur-book of biomedical ethics, is that medicine has much to teach the world of abstractly cogitating scholars about the moral necessity of attending to actual human bodies.[1] Although it may be something of a generalization to say simply that medicine allots mind to the doctors and body to the patients, that way

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1 Paul Ramsey, *The Patient as Person: Explorations in Medical Ethics* (New Haven: Yale University Press, 1970).

of stating it gives a fuller and, I believe, more accurate sense to the use of "Cartesian" when speaking of medicine.

This view of Cartesian medicine relates directly to Professor Turner's thesis and its implications. He has said that the body "is constitutive of our being-in-the-world, but in contemporary societies the dominance of biotechnology has brought about an erosion of a sense of common ontology." One can also argue the reverse: Biotechnology heightens "body consciousness," the awareness of our shared ontology and vulnerable embodiment. To make this point, we must go further into the phenomenon of medicalization than Professor Turner has taken us. For I would argue that medicalization occurs, or is triggered, when a situation of social precariousness is *perceived* as ontological, embodied frailty—that is, when it is read as physical disorder or affliction—and then is presented as such to medicine. Medicine's Cartesian thinking leads it to agree with that interpretation, to identify the problems patients bring as body problems, matters of individual human physical frailty, rather than to look beyond the embodied person for the possible social circumstance that has given rise to the metaphorical, corporal concern. Over against Professor Turner's repeated complaint about the dearth of bodily metaphors, medicine is one arena in which corporal metaphors are alive and thriving, whether they are routinely recognized as metaphors or not.

Medicine also encourages us to read our social instability as individual, physical vulnerability. It does so because that is what it works with, what it knows, and because it has what appears to be a wonderful history of success in relieving signs of frailty. We can perhaps agree that, for the most part, that record of success can more truthfully be attributed to political and economic developments and to public health ventures than to what happens in doctors' offices or even in medical scientists' laboratories. But the point is that "medicine" is widely perceived to be capable of assuaging the pains of human existence. Therefore, people are rewarded for reading their social shakiness as physical infirmity by having a reputable place to take it for repair.

Professor Turner's particular illustration of this process is the field of reproductive technology and the medicalization of birth, not to men-

tion of conception and gestation. It is an apt example: Reconceiving the socially precarious condition of childlessness as the individual physical disorder of infertility is a clear instance of medicalization. But there are many others. Consider these few: A teenaged boy, significantly shorter than average, has no physical disease or hormonal disorder of growth but seeks medication that may add a few inches to his stature. A middle-aged woman, entering menopause, seeks medication and then cosmetic surgery to prevent or reverse physical signs of aging. A businessman, burdened professionally by the effects of his personality traits on his sales record, seeks medication that will smooth out his psychological idiosyncrasies and enable him to work effectively. On a broader scale, politicians and citizens, bewildered by escalating acts of violence in their communities, seize the possibility of reconstruing violence as a "public health problem," and turn to medicine for the equivalent of a vaccine or a sewage treatment plant to prevent or, at least, detoxify violence.

Socially precarious situations, like aging or behavior outside social norms, are medicalized *both* because medicine thinks it can and should handle them (medicine believes its own triumphal history and would like more) *and* because we frail humans want medicine to fix them. Taking pills or undergoing invasive procedures may be easier to accept than the need for fundamental personal or social change. When people say they would rather be shot than, say, pay higher taxes for better schools, we may need to take them at their word. This is a somewhat different take on the current status of corporal metaphors.

While there are some things that medical science can do to relieve the examples of medicalized distress I have given, it is very unlikely that it will have anything like the level of success achieved in eradicating smallpox or treating bacterial pneumonia. Helping that teenaged boy grow a few more inches may be of significant benefit to him, but it will not approach the problem of discrimination on the basis of height in our society. However, this observation raises another important point about the origin and maintenance of medicalization. When that teenaged boy, troubled by his stature, comes to his physician for help, the doctor will be hard-pressed to justify telling him only that the problem is social and that he should seek a social solution. That is, it is one thing to

worry about the misreading of social issues as individual disease in general; it is quite another to face an individual so afflicted. Wherever the cycle of medicalization may be thought to begin—with medicine's claims or with an individual's needs or with society's failings—it is difficult to make the case that the cycle must be ended at the point of encounter between a suffering person and one who wants to help. Just as it is essential to consider the meaning of actual bodies, not just the idea of embodiment, it is also important to think at times about actual medical practice, whether in the clinic or in the laboratory, rather than only about medicine as an institution.

Thus, persons bring their social uncertainties, read as bodily afflictions, to medicine for relief. Medicine usually understands its first obligation to be to provide—or discover or invent—modes of relief, rather than to redescribe an affliction as a social disorder and send the putative patient elsewhere (where?) for salutary change. Medicalization, then, means more for medicine to do, more problems to take on, but with diminished prospects of genuine or uncontroversial solutions. Therefore, one sure consequence of ever-increasing medicalization is a parallel intensification of the precariousness of medicine as a social institution.

The heightened instability of medicine is evident in a number of relatively recent developments. As Professor Turner notes, the "McDonaldization" of medicine is clearly one manifestation. Speaking as a physician, I can say that virtually all of us in medical practice over the past few decades have experienced, and most of us have grieved, the economic strategies that have bureaucratized our once charismatic profession. Even if the doctor's charisma was largely our own illusion, we liked it and mourn its passing, and wonder where to locate healing power now.

Golden arches in front of the hospital are not the only sign of medicine's social precariousness. The most striking recent change in medical education in the United States is a marked increase in attention to teaching about the doctor-patient relationship and its central importance to practice and even to healing. This has occurred in the face of burgeoning constraints that endanger, or at least significantly devalue, that relationship. The impetus behind such an apparently quixotic cur-

ricular project is illuminated, perhaps even explained, by Professor Turner's contention that we compensate socially for awareness of our frailty and precariousness by attending to our interconnectedness. Furthermore, following closely upon this attention to the clinical relationship, novel medical curricular offerings which fall within a rather loosely defined domain of "spirituality and medicine" have been developed in a majority of U.S. medical schools. Both of these sorts of educational initiatives seem to represent medicine's recognizing and trying to deal with the tangled disorders of persons and society that show up in clinics every day, and with its own manifest professional helplessness in attending to them.

Patients, too, are dealing with their human frailty and medicine's scientific helplessness, most obviously by turning in larger numbers to what medicine calls "alternative" or "complementary" medicine, much of which is characterized as *not* Cartesian and as attending explicitly to interconnections of body, spirit, and society. Attention to spirituality and medicine teaching and to patients' involvement in other modes of healing raises the issue of religion. Given Professor Turner's concerns about the loosening or even loss of *religio* and *communitas*, it is worth noting a well-documented current interest, among medical professionals and patients in the U.S., in religion and in spiritual practices outside major religious traditions.

Professor Turner associates *religio* with "a shared set of experiences of birth, maturation, procreation, and death." Surely, however, given his own emphasis on vulnerable embodiment, it can be claimed that *religio* also binds us precisely in our shared experiences of ontological frailty, our susceptibility to physical and emotional pain, suffering, disability, and disaffection. It seems clear that, even if medicine wants to and tries very hard to decrease basic human frailty, it has not, likely will not, probably cannot. Are these shared, embodied experiences of inescapable human frailty not enough to foster bonds of *religio* and *communitas*? Professor Turner's arguments lead one to surmise that reproductive technology is a dominant source of his fears about the socially destructive effects of biotechnology, an observation which authorizes another question: Is reproduction really that singularly important to the generation and maintenance of *religio*?

As regards the matter of reproductive technology and the medicalization of birth, there is indeed much to question, even to lament about medicine, in the person of mostly male doctors, taking over the birth process from wise caretakers, in the person of mostly female midwives, and from the bodily wisdom of pregnant women themselves. However, I must take exception to Professor Turner's claim that "The risks of pregnancy are an effect of scientific interventions." While it is true that interventions may create some risks and increase others, pregnancy has always been a risky business for women.

The medicalization of reproduction may have been designed to reduce "surprises," but for most of human history the worst "surprise" about pregnancy has been maternal death. Prior to the advent of both routine hand washing and contraception, pregnancy and, in particular, childbirth were by far the leading causes of death of young adult women. Some women died in the process of giving birth, and even more women died as a result of physical and emotional depletion from carrying, delivering, breast feeding, running behind, and mourning the deaths of large numbers of children, often in conditions of marginal nutrition and less-than-marginal social support.

Even while admitting considerable dismay at the consequences of regarding pregnancy as a treatable illness, even while casting a permanently skeptical eye on technologies that distance the process of reproduction from the bodies of women, it must be said that attention to *women's* experience of the entire array of reproductive interventions requires that we also value the significant benefits to women from technology that has made pregnancy safer and more nearly chosen. To read the risks of pregnancy as solely the effects of scientific intervention suggests, at best, inattention to the cumulative experience of the women who become pregnant and incur the risks.

Beyond the issue of medicalization, though perhaps not beyond the matter of *religio*, I shall conclude with one caveat in regard to Professor Turner's effort to ground universal human rights in suffering and sympathy, "the ubiquity of human misery." While his arguments, reminiscent of the work of David Little and others, are cogent, it is important to note that such a basis for human rights means that rights may be

honored largely because of compassion for the inevitable suffering of embodied persons. Compassion, however, is also a primary motive for precisely the sort of biotechnologic encroachments that Professor Turner fears. It is, for example, widely claimed that compassion for the suffering of infertile couples is the driving force behind the development of new reproductive technologies.

The right of persons to come freely to medicine to solve their corporal woes stimulates, and is often said to authorize, medicine's beneficent interventionist urges. Sympathetic responses to human misery may, at times, render medical practitioners unable to recognize or reluctant to honor other rights—and other needs—of persons. Any theory of universal human rights based in human suffering and sympathetic sentiments must explain how those rights can include *both* the right to expect attention for and seek relief from suffering *and* the effective right to refuse a particular well-intentioned, socially-sanctioned mode of relief. Moreover, perhaps one could ask of such a theory whether it also entails a right not to lose one's compensatory interconnectedness when one does not want certain compassionate interventions by a sympathetic society. The entanglements of ontological frailty, social precariousness, and compensatory interdependence are indeed complex and illuminating, just as Professor Turner claims.