

Moral Medicine

D. Brendan Johnson, Divinity '21

Medical schools have an almost mythological air that one breathes in from the first moment on campus – the white coats, the stethoscopes, the heroic doctors performing life-saving surgeries in the middle of the night. Even broadly within American culture, medicine is seen as the place where bright and eager do-gooders eventually wind up – side by side with their classmates there in order to fulfill their parents' dreams.

This image holds much truth. There are few tasks more important than caring well for a suffering person. This may explain why my dissatisfaction during my first two years of medical school also brought me shame – shouldn't I find this more fulfilling?

My nagging feeling of dissatisfaction was not from medicine itself, but from the blinders that medicine seemed unable to take off. Our ethics classes narrowly focused on identifying which family member is legally allowed to decide to take grandpa off of the life-sustaining ventilator, or on discussing the acceptability of taking gifts from patients. Important, but not deep. I learned from the New Yorker Magazine – not from my lectures – that the average American life expectancy has declined for three years in a row. If that weren't bad enough, America spends nearly double what our peer nations spend on healthcare, but we do not get better results. Five years after a new cancer diagnosis, nearly 40% of older Americans have gone bankrupt. This disturbing and inchoate realization – that American medicine is not only in the business of fixing problems, but also profits off their continued existence – eventually led me to the Initiative in Theology, Medicine, and Culture at Duke Divinity School. Somehow, medicine needed a value system outside of itself which could interrogate it and reveal its potential.

Those moments of dissatisfaction became the seeds of my research interests at Duke. Here, they have flowered. These interests have led me to critical questions about the ethos of professional medicine itself. If Americans are dying younger every year while medicine's speed and intensity only grows, we must ask fundamental questions about the moral commitments of medicine. My research and interests have therefore circled around the nexus of Social Medicine and Liberation Theology. Liberation Theology – whose insights have also been taken up by secular organizations like Partners in Health – is a movement which began in the slums of Lima by a Catholic priest with a fundamental insight: that God has consistently acted on the side of the oppressed throughout history. This is especially seen in the prophets' call for justice and Jesus' life and death among those on the margins. If God's actions and ethical exhortations center upon on “the widow, the orphan, and the stranger” (Deuteronomy 10:18), our ethical responses will follow God in making this “preferential option for the poor.”

This means the status of the poor becomes the ethical standard by which we measure the success of our actions, of our profession, or of our society – not by the success of the stock market, not by the national ranking of our medical school, not by the might of the military, not by the size of our homes, and not by the “gold stars” we attain. Instead, we are defined by alternate criteria. We are defined by the health and dignity of a homeless man in Durham, by justice for indigenous communities locked away in the reservations near my Midwestern hometown, and by the

survival of a young Appalachian family whose community is threatened by environmental degradation. Justice and love must be at the heart of our moral life.

Social Medicine attempts to embody this insight in its fight for human health. Because healthcare only determines a small part of health outcomes – structural, social, and behavioral effects outweigh those from biology alone – Social Medicine takes seriously its task to look beyond the clinic or hospital if we are to work for health and justice. It attempts to give dignity and justice to the poor and forgotten through healthcare. Because of this, it can end up siding more often with struggling patients than professionals who want to preserve their status. Living out the “preferential option for the poor” is what Social Medicine calls “accompaniment.” Research has shown that medical accompaniment has enormous clinical benefits, and our ethical and theological reflections show us that it is the right thing to do.

I volunteer at a clinic for the homeless in Durham. This spring, a homeless woman died of to a disease which had sent her cycling in and out of the hospital. While the medical care she received while hospitalized was excellent, she died because her medication needed refrigeration, and she lived in a tent.* My time at Duke has helped me to hear the call her death makes upon medicine – and to respond.

**Identifying information has been changed to protect patient privacy.*