Where Is Will Rogers When We Need Him Most?
Toward a Traditional Morality in Biomedical Ethics

by Tex Sample

A community ethic is needed to address issues in the biomedical field. To develop a community ethics moral questions must be expressed in forms indigenous to various groups. A large number of Americans are more oral than literate. This paper details the ingredients of a traditional oral morality capable of engaging biomedical issues and indigenous to people who think in proverbs, stories, and relationships.

Mary was seventy-three years old and in an advanced state of throat cancer with less than a month to live. In consultation with her family physician and her daughter, she agreed to a surgical procedure that would keep her throat open to swallow food in the last weeks of her illness. While on the cart outside the operating room, she consented to the persuasion of the surgeon to insert a feeding tube in her stomach. He told her the other procedure would not really do any good. Mary agreed to it in spite of her own judgment not to have a feeding tube, an opinion she had voiced often to her personal physician, her family, and to the surgeon.

Three days later, furious with herself for consenting to the procedure, Mary dismissed the surgeon and pulled the tube out. I asked her why she had given permission in the first place.

"Well, I don't know," she answered. "He was so clear that he thought it needed to be done, and I didn't know what to say. I mean, I don't know how to talk about such things. He gave me all these reasons, and I knew I didn't want to be kept alive that way, but I just didn't have the right words."

My purpose in telling this story is not to attack the surgeon, although he did an egregiously unethical act by obtaining her permission while she was alone and vulnerable. I am more interested here in why Mary, a very bright woman who was not a dependent victim in her normal affairs, agreed to something she did not want to do. In her comment and in conversations we had following the event, she said in many different ways that she did not know how to talk to the doctor. She was, however, very articulate in discussing the routine issues of her life. Moreover, she was not a person without moral sensibilities. She convinced me in our conversations that she clearly knew she had been wronged. Nevertheless, Mary kept repeating that she did not know how to talk about such things. She did not know how to talk "medicaleze" or how to counter the seeming certitude of the physician's point of view. Mary's characteristic way of dealing with moral questions had not been developed in regard to biomedical issues, and her inability to communicate became a serious problem in this circumstance.

Oral, Not Literate

Situations similar to Mary's occur frequently within a segment of society who do not "do ethics," but who, at least as much as any other group in our society, live out a substantive morality as persons of character. The problem, however, is

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that these people are not adept at doing ethics in its more literate and theoretical forms, nor are they likely to develop these skills. They are oral rather than literate in the way they think about and engage in life; that is, they do not think in conceptual categories, theoretical frameworks, and discursive treatment. Rather, they think in proverbs, stories, and relationships, especially communal and kinship ties. My guesstimate is that forty to fifty percent of the United States population can be so characterized. They tend to be people in the lower half of the class structure who did not go to the university.[1]

Because racial ethnic groups—especially African Americans, Hispanics, and Native Americans—are disproportionately located in the downside of the class structure, they will have larger percentages of people who are oral in this sense.

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These racial ethnic groups, as with many Anglo-European Americans, come from traditions where orality has been important in their history. Moreover, one should not miss the fact that many Asians come out of oral traditions and occupy the bottom half of the class structure. It is also important to understand that all these racial, ethnic groups are different from one another, and that enormous diversities can exist *within* any one of them as well. This is especially so among Asians and Hispanics.[2]

For such oral people, rapid changes in the biomedical field have made the problem of community ethics—the operational live-a-day morality of most people—a more difficult one. The vast range of issues and questions—the high degree of technicality, the theoretical level of the debates, the complexities of competing ethical norms, and the interpenetration of technical expertise, on the one hand, and the growing concern about the participation of people in decisions that so glacially affect their lives, on the other—generate a growing concern about community ethics. An approach to ethics that addresses these issues in terms of a morality indigenous to oral people is clearly needed. In this paper I will explore the outlines of what such a morality would look like.

Basic Ingredients of a Traditional Oral Morality

A traditional oral morality usually contains at least five basic ingredients: an empathic core, communal knowing, relational thinking, the perceptive story, and the crystallizing proverb. Each of these will be subsequently defined and explained. My intention, however, is not to argue that these five ingredients are distinctive of traditional people only. Rather, I contend that traditional oral people do not as a matter of basic practice use literate forms of discourse; therefore, they are far more likely to depend on these ingredients as basic dimensions of their engagement with the world and, hence, of their grappling with morality.

The Empathic Core

Martin Hoffman points out how central empathy is in moral development. By empathy he means "an affect (feeling) response more appropriate to someone else's situation than to one's own." Such empathy comes early in moral development. Hoffman tells the story of a seventeen-month-old boy who, while watching the physician give another child an inoculation, began to hit the doctor out of empathic solidarity with the other child.[3]

It would be a mistake, however, to associate empathy only with early development. Hoffman discusses empathy in its mature development where it is subtle, complex, and capable of sensitive, affective distinctions that contribute to informed and genuine morality.[4]

Among traditional oral people, mature

empathy takes on a central role because these people are not working with propositions, concepts, and theory in a literate sense. Rather it is the feeling of empathy itself that becomes capable of complexity and richness. Indeed, the more moral one becomes in this form of life the more capable of intuitive sensitivity and sensibility. The capacity to feel more deeply, to know intimately the struggles of people in moral living, is a highly developed one. To speak of a person of character in a traditional life is to acknowledge this kind of empathy, an empathy embodied in practices of relating to and caring for other people.

Therefore, trying to understand what it would be like "to be in the other person's shoes" takes on added importance. One can see this in countless expressions used by traditional people: "I just know I wouldn't want to be treated that way." "Just think how you would feel if someone treated you that way." "Do unto others as you would have them do unto you."

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Communal Knowing and Relationship Thinking

Hoffman points out that the empathic core develops in early, intimate relations with parents and, as socialization goes on, in wider friendships and communal networks. We come "to know how the other feels" in the familial and communal relationships. It is in this live-a-day experience that we arrive at an empathic sensibility. that is, we come to know what it means to have hurt feelings by seeing this modeled by parents or others in close relationships.

In this process we learn to think relationally, that is, to think in terms of the impact of an event or issue on one's family or neighbors. This means that the empathic core is bonded to these relationships and takes on cognitive and explanatory significance. Thus, when a medical issue is considered, it will be thought through in terms of family and community relationships.

In Mary's case, she was profoundly concerned about what her prolonged hospitalization would do to her daughter and to the legacy she hoped to leave to her. The financial legacy—not large but important to Mary—represented her entire life's work, one that she did not want depleted by futile medical procedures that would do little but prolong the agony of her now brief future. Her daughter represented the beneficiary of her legacy

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and the chance, eventually, to pass on that small bequest to her grandchildren.

Such thought is usually accepted as appropriate for such family considerations, but hardly adequate for social policy and larger issues before the society. I argue, however, that communal knowing and relational thinking can address social policy questions quite directly. For example, the approach that needs to be taken with many social policy questions is to address them in terms of more personal and familial illustrations and to show how a given policy replicates such cases and the responses to them. For example, one could illustrate the process of using surgical directives precisely in a case like Mary's, stating concretely what would happen and how things would proceed. One could argue the issues in terms of concrete options. There is probably no better way of addressing social policy with the wider public. It can eliminate technical jargon and raise questions not always brought to the fore.

Biomedical professionals often talk with an ostensible situation in mind. As a result, considerations are often taken for granted. These considerations are not so much neglected as presumed. Yet, these very considerations may be quite important to oral people who are new to medical procedures. They think in terms of concrete cases and lived relationships. My point is that a traditional oral morality has more than adequate resources for addressing the complexities of medical issues and their moral dimensions provided these are done in an indigenous form.

The Perceptive Story

Oral people also think in stories, arguably the most powerful way we have to think about human life. Nothing can embody a point of view, sustain its memory, and provide an ostensible circumstance like a story. Stories resist abstraction, provide a sense of the history-like make-up of human life, and are the best form we have for the display of the motives and actions of characters who take on life-like patterns of human foibles, limitations, dilemmas, moral wisdom, and courage. Because narrative is the most concrete way we can think and talk about human life, it bears nuances in a way that only the most careful and exhaustive—and often exhausting discourse—can provide. [5]

Literate people often characterize narratives as "anecdotes," suggesting that such stories have a "thin"—not systematic and not widely applicable—status in the consideration of important issues. Such a reductionistic view of story fails to see how traditional people use narratives in their live-a-day lives. Using one story to answer all questions is not a simplistic device, but rather a complex art that depends on a host of stories and a sensitive empathy to bring them into play, a range of practices developed in a community and brought to maturity only through extended practice. Some traditional oral people are far more skilled at this practice than others, but that is true in any practice. Moreover traditional people know who the "sages" are in their lives and who, therefore, they need to talk to.

With oral people the answer to a question often eventuates in a story, as does the making of a point, although in oral practice a story does not so much make a point as that it is the point. When asked about her terminal illness and how she felt about it, Mary turned almost invariably to a story out of the history of her family or friends. These stories rarely needed explanation. By the time Mary had finished the story, the point had been made.

The concrete, situated character of a story, its capacity to speak to a broader range of concerns through the rich particularity of its setting, and its capacity to construct a "world" and the people in it are deeply significant in oral practice and constitute a sophistication of the first order.

The Crystallizing Proverb

In an oral cultural, the wisdom of a people is crystallized in proverbs. These proverbs cover an extraordinary range of circumstances and issues. For example, Sister Ann Nielson has compiled a catalog of six thousand proverbs gathered from her years of work in east central Africa. These proverbs address virtually every dimension of African life.[6]

Moreover, these proverbs are not a simplistic set of moralisms by which one platitudes life. Through them, an enormous range of statements are differentially brought into play, often in complex tension with one another, in facing situations with competing claims and tough choices. While literate people often stereotype such proverbs as bromides and clichés, such mischaracterizations usually result from seeing these phrases in print, where language gets "frozen" and where proverbs lose the vitality of being used at a propitious time in the thinking and talking of the lived lives of an oral people.[7]

For example, in the United States proverbs abound in traditional oral conversation. "If it ain't broke, don't fix it," is a frequently heard proverb. Someone might say that such a proverb is too complacent in circumstances where ameliorative action is needed, but such situations are covered by yet other proverbs such as "the good is the enemy of the best." These proverbs can be directly

applied to medical circumstances, particularly to situations in which medical treatment is elective, but not necessary. In such cases one can decide whether the choice is that of a situation that "ain't broke" or one in which failure to obtain treatment is less than the best in its complacency about the status quo.

In Mary's case, she could use a proverb to express to the surgeon that "the treatment is worse than the disease." At this stage of her illness she knew that giving up fluids and food would result in a process of dying that would be far preferable to one in which medical technology was simply exhausted—finally—in keeping her alive.

Furthermore, oral people have a tacit understanding in the use of such proverbs. These sayings cover not only a wide range of issues but a depth of understanding not conveyed in a literal reading of the statements themselves. In oral subcultures like those in the United States traditional people have a sweep of such adages and maxims, and it is a mistake to see such usage as simplistic.

Finally, in the proverbs—as well as in stories and other expressions of life—one finds frequent hyperbole and humor. The hyperbole not only makes the expression memorable but the overstatement itself suggests that more is going on, more is being said than a literal reading of the comment. The hyperbole points to a larger range of life issues.

The humor is perhaps the most complex dimension of traditional oral communication and cannot receive here the attention it deserves. Sometimes it is used to point out the frailties of self and others. Sometimes it points indirectly to pain and loss in some seeming attempt to understate what cannot be adequately conveyed more forthrightly. The juxtaposition of humor and tragedy amplifies the discord of a world where the ambiguity of vitality and death exist inextricably together, the one so terribly calling into question the other that together they point beyond themselves toward some "absence" in hope of resolution.

These few notions only touch the surface of a profoundly rich dimension of traditional life, one needing far more appreciation and attention than it receives. This is not to romanticize oral tradition; proverb, story, and relational thinking and practice can be as morally misused as any cultural formation. There is no range of human activity that is without moral ambiguity. Yet, oral expressions of morality also carry their own "correctives" in the rich practices of a tradition wrought out in the challenges met in the hard angular realities of lived life.

Community Ethics and Traditional Morality

My contention, then, is that we need the development of a community ethic to meet the challenges of emerging issues in the biomedical field. Such an ethic, really a morality, needs to be indigenous. It will need to take seriously the practices of traditional oral people if it is to reach a vast group of people in the United States, not to mention an even larger public in the wider world. A community ethic addressed to the people under consideration here can be assisted by more literate and academic forms of ethics provided they are prepared to function in oral forms. Anything short of this will remain largely irrelevant to such people and will, by its absence, serve to keep such folk from decisions that are rightly theirs to make. Perhaps even worse, it will separate medical professionals and others in the helping professions from sharing fully in an approach to morality that offers an enormously rich wisdom in facing the challenges before us.

Fortunately, this morality is at work informally in a host of places. In facing the medical issues before them, traditional oral people develop proverbs and stories as a matter of course. A growing appreciation of these indigenous forms and the intentional use and legitimizing of them is needed in biomedical practices. Some people in the bioethics field are already learning from this important resource, but a more disciplined inquiry and practice of such a morality is needed.

Following is an example of an oral morality in action.[8]

Epilogue: A Fantasy

Let us say that Mary had experienced a traditional oral use of morality around medical issues and that she had been exposed to these questions in terms of a community ethic that had developed a repertoire—a set of "recipes"— about using stories, proverbs, relationships, and communal wisdom in connecting with medical questions, especially around the issues of dying. This is the way her conversation with the surgeon *could* have gone, had she had greater awareness and practice of the morality she already knew but had not developed in relation to the medical procedures in question and the eminence of her own death.

I will assume that the physician is still determined to do the procedure and has not changed in his approach to the situation. Further, I will assume that the conversation between them is one in which Mary will have to defend her wishes in traditional oral ways against the advice of the doctor.

The surgeon: Mary, in giving further consideration to your case I want your permission to change what we've scheduled to do in the surgery this morning. The surgery on your throat will not really be effective and you are simply going to starve if we don't put in a feeding tube. I want your consent to do so."

Mary: I don't want a feeding tube.

Surgeon: But, Mary, it will allow you to keep your strength a lot longer.

Mary: Doctor, when I was growing up, we had a fellow in Simpson County named Arthur Honeycutt. Arthur was crazy, but he was harmless and we loved him. There was an old car with a frozen engine out at the junk yard, and the junk yard people "gave" it to him to fix up and drive. There was no way to fix it and Arthur couldn't drive anyhow, but he kept doing things to that car to make it run. It gave him something to do and he enjoyed it. Every day the junk yard people would give him something to work on it with. One day it would be an old tire, the next a battery, and he kept putting a little gas in it from time to time, and he would regularly change the oil. But the car never went anywhere, Doc.

Well, I'm not going anywhere either, and I don't want to be putting more gas in a car that won't run. That was good for Arthur, but I ain't crazy.

Surgeon: The point is we can extend the time you have with your daughter and friends.

Mary: Do you think that I want to teach my daughter that I am so afraid of death that I am going to prop myself up until I'm a breathing cadaver and she's sitting here like a morgue attendant?

Surgeon: But you can sustain your strength. . .

Mary: Doc, there's no need to put a new wheel on a worn out axle.

Surgeon: We can give you days more, perhaps weeks. . .

Mary: Look, I'd rather spend three days dancing than ten days with a headache. I'd rather spend three days talking than ten days in a coma.

[Mary knew that prolonging her life/death would require more and more morphine and longer periods of time when she was unaware of what was happening around her, something she decidedly did not want.]

Surgeon: We can prolong your life.

Mary: Doc, you're not talking about prolonging my life. You're talking about prolonging my death. I need to get on with it. Let it take its course. Besides, you need to remember, *I'm* not terminal; my disease is.

Surgeon: I wish you would reconsider.

Mary: The treatment is worse than the disease, Doc. If that feeding tube would get me to the Friday night dance, I'd do it in a minute. But under the circumstances, I'll just take it as it comes.

In the fantasy above, Mary and her physician

are in a contested relationship to represent the experience of many traditional oral people when their wishes are other than those of more literate professionals. However, there are many health care professionals who know this oral morality "in their bones," and who can and do engage people like Mary in proverb and story and in the relational thinking so central to their lives. What is needed is the development—out of the wisdom of oral people—of the proverbs, stories, and relational "logic" that can engage the complex and complicated issues burgeoning in the biomedical field. This means the gathering and the practice of a host of such sayings, narratives, and communal frameworks in the performance of health care. It is the most helpful direction we can take presently in the development of an indigenous community ethic.

End Notes

1. For a broader discussion of traditional oral people and their indigenous practices of thinking, learning, morality, faith, and social change, see *Ministry in an Oral Culture: Living with Will Rogers, Uncle Remus, and Minnie Pearl* (Sample, Tex, 1994, Louisville: Westminster/John Knox). I am aware of the increasing role of electronic media in our culture, and this, too, would be an important focus for a discussion of community ethics, which I cannot give attention here. See, however, the work of Walter Ong who argues that new forms of communication are an electronic orality (1994. *Orality and Literacy: The Technologizing of the Word.*London: Routledge and *The Presence of the Word: Some Prolegomena for Cultural and Religious History.* Minneapolis: University of Minnesota Press).

2. On racial and ethnic characteristics see Derald W. Sue et al, 1981. *Counseling the Culturally Different: Theory & Practice.* New York: John Wiley & Sons, and David W. Augsburger, 1992. *Conflict Mediation across Cultures: Pathways and Patterns.* Louisville: Westminster/John Knox Press.

3. Martin Hoffman, 1987. "The Contribution of Empathy to Justice and Moral Judgment," in *Empathy and Its Development,* Edited by N. Eisenberg and J. Strayer. New York: Cambridge University Press, 48. For a fine review of the literature see also Paul C. Vitz, 1990. "The Use of Stories in Moral Development." *American Psychologist* 45(6): 709-720.

4. At this point Hoffman's work is a welcome departure from the reductionistic views of moral development theorists like Kohlberg who focus too much on cognitive and rationalistic processes and give too little attention to feeling. Kohlberg's approach privileges the experience of males, focuses too much on literate expressions of morality, and is oblivious to his work's captivity to class. See Lawrence Kohlberg, ed. 1984. *Essays in Moral Development,* 2 vols. New York: Harper & Row. Carol Gilligan's work is a helpful discussion of gender issues, 1982. *In a Different Voice: Psychological Theory and Women's Development* . Cambridge: Harvard University Press. Gilligan, however, is not sufficiently attentive to issues of class. For a discussion of the issues of gender that is focused on class see the careful work of Judith L. Orr. 1990. "A Dialectical Understanding of the Psychological and Moral Development of Working Class Women with Implications for Pastoral Counseling." Ph.D. diss., School of Theology at Claremont.

5. See John Milbank, 1990. *Theology and Social Theory: Beyond Secular Reason.* Cambridge: Basil Blackwell, and Stanley Hauerwas and L. Gregory Jones. 1989. *Why Narrative? Readings in Narrative Theology* . Grand Rapids, Michigan: William B. Eerdmans.

6. Sister Ann Nielson, "Chewa Proverbs," unpublished manuscript, n.d.

7. Neil Postman characterizes print as freezing language. See 1986. *Amusing Ourselves to Death.* New York: Penquin Books. See also the anthropological work of Jack Goody, 1987. *The Interface between the Written and the Oral.* Cambridge: Cambridge University Press. Barbara Ehrenreich characterizes professional talk in her 1989.*Fear of Falling: The Inner Life of the Middle Class.* New York: Harper Perennial. See also the work of Alvin Gouldner. 1979. *The Future of Intellectuals and the New Class.* New York: Seabury Continuum.

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