Understanding Medical Relationships through a Covenantal Ethical Perspective

James J. Rusthoven

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Relationships between different parties form the core of medical practice. Increasing attention has focused on the possible merits of understanding such relationships as covenantal in nature. Some advocates of a covenant ethic have focused on promise and fidelity as the defining features of this relationship. However, historical and/or metaphysical justification for prescribing a covenantal model varies, with some appealing to the ancient Greek medical tradition while others claim authority in the biblical revelation of covenant initially established by God with humankind.

In contemporary medicine, reliance on rational identification of a common morality without appeal to transcendent authority has become a dominant paradigm of medical ethics. The basis for envisioning a biblical covenant ethic for clinical relationships has a firm foundation in Reformed theology, which has developed the concept of covenant as a central theme. Such an ethic provides a transcendent grounding that is absent from a common morality based on reason alone that dominates much of bioethical thought. The patient-supporter relationship is presented as an integral part of medical practice that can be understood through a biblical covenant ethic as fidelity between a person or community and the vulnerable patient, grounded in the agape love of God for humankind.

Medical ethics has steadily broadened the boundaries of its field since its inception as a distinct discipline in the 1970s. However, one area that remains central to the concept and practice of medicine and that has been the subject of much attention from bioethicists from its earliest beginnings is the human relationships that make up the practice of medicine. Initially, ethical concerns focused on the historical predilection to paternalism that could be traced back to antiquity, and that threatened a contemporary cultural ethos which sought to provide greater empowerment to patients for making medical decisions concerning their care.

Over the past four decades, patient autonomy has gained a firm foothold, falling into line with the pervasive individualism of Western culture. However, the resulting power shift within the patient-caregiver relationship has not

*CSCA member **Jim Rusthoven** is a part-time practicing medical oncologist who has developed a growing interest in medical bioethics in recent years. He has a master's degree in bioethics from the Joint Centre for Bioethics, University of Toronto, and is currently engaged in further graduate studies in the field. Jim also chairs the Biotechnology Reference Group of the Canadian Council of Churches, working to educate the churches and advise government on bioethical issues. He has taught both undergraduate courses in bioethics and the philosophy of science, and graduate seminars in ethics relating to research in developing countries. Jim is married to Thea who teaches French literature, and they have three sons. He particularly enjoys bird watching as a means of appreciating God's good creation; he keeps mind and body fresh through biking and jogging.*

necessarily enriched our understanding of that relationship itself. Some bioethicists and caregivers have promoted a reexamination of medical relationships as a necessary corrective to this emphasis on individual autonomy. Covenantal relationships are often contrasted with contractual relationships, but the comparisons have varied, partially because of the lack of consistency in the use of the terms adopted by bioethicists, theologians, and philosophers.

In this article,[1] I provide the background for contemporary appeals to the application of a covenantal ethic to relationships in medicine, based on both Greek pagan and Christian traditions. I propose that a covenantal framework for engaging in medical relationships can more fully enrich our understanding of such relationships when grounded in the relationship between God and humankind, rather than in appeals to nontranscendent authority such as ancient Greek medical traditions and mythologies or to our rational capacity alone. Some of the merits of such a framework will be exemplified in its applicability to one of the least understood but very important relationships: that of the patient and supporting persons.

Background

Concepts of covenant that have been applied to medicine have drawn upon three main sources of authority to justify such a framework: Greek gods as revealed in Greek mythology, the Hebrew or Christian Scriptures, and abstract concepts such as human reason or trust. Appeal to gods of Greek mythology provides the religious grounding for the Hippocratic medical tradition, represented most widely by the Hippocratic Oath. Among the several gods to whom the taker of this oath appeals, the demi-god Asklepios is most prominently associated with the practice of medicine. The rod of Asklepios, a staff entwined by a serpent that symbolizes the blameless physician Asklepios, is the symbol most commonly associated with medical practice.[2]

Asklepios's persona evolved over nearly a millennium, such that he became the patron god of physicians and guardian of the art of medicine. Described by 700 BC as a demi-god who was born of Apollo and a human mother, he later became recognized as a man-god. In this form, he walked the earth and was considered sufficiently mortal to die and go to heaven, from where he would visit human-

kind as a *daimon* (spirit) in response to prayers for healing.[3] His popularity grew among the lower and poorer classes of Greek and later Roman society, attributable in part to his apparent accessibility to supplicants through divine revelation and healing, condescending actions that apparently no other gods would consider.

Many Greek physicians, including Hippocrates, claimed descent from this hero-physician. Galen (AD c. 129–216) referred to Asklepios as his ancestral god, and he was trained in medicine at the Asklepieion at Pergamon. Asklepieions were temple complexes, the larger ones functioning as a cross between a sanatorium and a modern hospital.[4] So much did Asklepios's qualities inspire the pagan world that some early church leaders compared Asklepios with Christ as Savior, Healer, and Advocate of the poor. Justin Martyr wrote,

> and when we say also that … Jesus Christ … was crucified and died, and rose again, and ascended into heaven, we propound nothing new and different from what you believe regarding … Asclepius, who though he was a great physician, was struck by a thunderbolt, and so ascended to heaven.[5]

Evolving Versions of the Hippocratic Oath

The Hippocratic Oath has been the most important and lasting link to the pagan Greek medical tradition and has been a reference point for ethical expectations in medicine. The Oath begins with the oath taker swearing before various gods to fulfill the oath. He then pledges fidelity to his mentor and the mentor's family for teaching him the art of medicine. After pledging to provide benefit to the sick through dietetic measures, he vows that he will refrain from inducing harm and injustice. Specifically, he will refrain from administering deadly drugs, abortive remedies or procedures, using the knife (surgery), engaging in sexual relations with those whom he calls on to heal, and will hold in confidence what he hears or sees in the course of his healing duties.[6] Ludwig Edelstein has produced compelling evidence that the Oath was heavily influenced by Pythagorean ethics. He suggests that the Oath is not a reflection of common attitudes toward medicine during that time, but rather an ethical code of conduct that reflects the views of a small and relatively

isolated group that may have been trying to reform the profession.[7]

Christian versions of the Oath have been in circulation since the Middle Ages. Allen Verhey speculates that the earliest Christian variation may have originated as early as the sixth century, though the oldest existing manuscript dates back only to the tenth or eleventh century.[8] As least two such versions were transcribed in the shape of a cross. A version entitled "The Oath According to Hippocrates Insofar as a Christian May Swear It"[9] clearly retains some continuity with the classical text but differs from the original in two major ways. First, it replaces the invocation to the Greek gods with "Blessed be God the Father of our Lord Jesus Christ. Who is blessed for ever and ever; I lie not." This attempts to reassign the entire medical context and the relationships that it articulates into the story of creation and redemption as related through the Christian Scriptures. Rather than deriving the power of healing and identity from the Asklepian family of gods, the oath taker seeks professional and personal nurturing, sustenance, and maturity as a follower of Jesus Christ. A second major change from the original text is the omission of the covenantal relationship of the physician to his mentor and the mentor's family. Verhey suggests that this was intended to avoid professional elitism in favor of refocusing the oath on service to the patient.[10]

Covenant and Code: Different Relationships within the Hippocratic Oath

The classical Oath itself alludes to several relationships. Nigel Cameron has stated that one of the essential elements of the Hippocratic tradition contained in the Oath is what he calls its triple covenant, involving deity, teacher, and patient.[11] William F. May, however, agrees with Edelstein that the specified relationship between the oath taker and the patient is not covenantal, but rather is restricted to a code of conduct. Its single covenantal relationship is that between the novice physician, his mentor, and the mentor's family.[12] This relationship is based on a student's promissory reciprocation for receiving the gift of knowledge of the medical art. As such, this relationship is reminiscent of a covenantal relationship if, at its core, it requires the *trust* that a *promise* will be fulfilled, includes an expectation

of supererogatory (heroic) efforts if needed, and involves a long-term if not lifelong relationship. May also suggests that the reference to transcendent powers in the form of the gods imparts a covenant meaning to the entire Oath. The power of the healing profession, specified in the duties to patients and the obligations to the mentor, is derived from an extra-temporal source with which the oath taker makes a promise to fulfill those duties and obligations.[13]

Is the Hippocratic Oath Relevant for Medicine Today?

The Hippocratic Oath has been used as a template for covenantal relationships in medicine. However, the relevance of the Oath to contemporary medical ethics has been questioned. For example, bioethicist Robert Veatch has rejected the Oath and its tradition as too physician empowering, too teleological, lacking any reference to social justice, and too short on deontological obligations to be applicable to medical ethics today.[14] Indeed, there is recent evidence that the Oath is losing its popularity and, in some cases, has been replaced by other oaths.

Robert Orr et al. recently surveyed medical schools and associations regarding their use of the Oath.[15] Among one hundred fifty medical schools surveyed in North America (157 surveys sent; response rate 96%), 98% of graduates took a professional oath in 1993. Twenty-two different versions of the Hippocratic Oath were used and only one school used the classical version of the Oath. Other oaths taken in various schools included the Declaration of Geneva (either 1948 or 1983 versions), an osteopathic oath, the Oath of Louis Lasagna, and the Prayer of Maimonides. While all of the oaths retained a pledge of commitment to patients, others deleted various content items that were in the classical Hippocratic Oath. Items most commonly deleted included the avoidance of sexual contact with patients, a covenantal relationship with a deity, refusing to perform abortions and euthanasia, and an agreement to be accountable for keeping the Oath.[16] The nearly complete disappearance for reference to sexual contact with patients is particularly surprising given its recognition as a problem in contemporary practice.[17]

This study suggests that the Hippocratic Oath is becoming increasingly altered or replaced to reflect

more contemporary goals and values. Cameron observes that modern statements of ethical values retain the Hippocratic form. However, claims that those values stand in the great tradition of Greek medicine lack credibility, as its particular contents are changed to reflect today's values.[18] While this is true with regard to specific sanctity of life issues such as abortion and euthanasia, some content items have been retained as more general features or principles of practice. In analyzing variations of the Oath, Orr et al. found consistencies that they have termed core values of medicine: general commitments to patients and teachers, defined boundaries for certain "ends" of medicine, the insistence on confidentiality, and the restriction of means to treatment. Any appeal to a transcendent Being is being increasingly altered or omitted. For example, the retention of a reference to deities dropped from 30% in oaths used in 1958 to only 11% in those used in 1993.[19]

Contemporary Appeals to Covenant as a Model of Medical Relationships

Against this background of pervasive Greek medical traditions and the intermittent synthesis of Christian ideas, the concept of covenant in medicine has been applied to various contemporary medical contexts to describe normative aspects of different relationships within medical practice and discourse. A recently published statement entitled *The Patient-Physician Covenant* professes that a covenant is at the center of medicine and is a moral enterprise grounded in trust.[20] At least one of its signatories believes that, in this covenant, the physician has a primary fiduciary responsibility to patients, the history of which is traced to the myth of Asklepios. The statement expresses a shared concern that today's physicians are allowing *materialistic self-interest, profit, and commercial interests* to erode what they see as a primary obligation to serve the good of those who seek their help and expect mutual trust.[21]

While the basis for that trust is not explicitly stated, its grounding in *common goodwill* is implied. There is no appeal to a transcendent ideal or power. The primacy of patient obligation is referenced against competing interests in profit-making ventures, particularly in managed care schemes, but the statement does not address the potential *conflicts of obligations* regarding other covenant relationships with one's family, community, and other social groups.[22] Such conflicts can be particularly problematic in a profession at the heart of which is the pursuit of the health of strangers.

Some contemporary bioethicists have tried to link the covenant concept with different relationships in medicine, including medical education. Canadian physician and bioethicist Jeff Nisker has written that a covenantal model captures the moral nature of medicine through the possession of certain *inherent* qualities such as trust, generosity, commitment, empathy, and creativity—qualities not considered part of a contractual model. Bemoaning the "demoralizing climate" that he perceives as a threat to health care and medical education, he suggests that such a model might improve the *esprit de corps* of both.[23] Nisker believes that the effectiveness of the *medical educator-student relationship* will likely be improved if developed covenantally and grounded in the moral nature of the profession. He appeals to *mutual trust* as the source of such grounding, but makes no claim for a transcendent source of authority on which to anchor the justification for his appeal to a covenant model.[24]

In her focus group study of *patient-nurse* relationships, Susan Coffey argues that evidence supports the premise that a covenantal model incorporates well the nature and reality of the patient-nurse relationship.[25] Unlike other studies which have focused primarily on the *caregiver*, this study devotes at least equal time to the analysis of *the patient* and his or her role in the relationship. Coffey acknowledges the ancient roots of the covenant concept, explicitly mentioning Babylonian, Assyrian, Greek, and Mycenaean references and inferences to covenantal relationships. However, she makes no mention of covenant concepts in Jewish or Christian traditions. She seems to agree with May's conceptualization of covenant and its prescriptive potential in improving relationships involving health professionals. Again, however, she makes no mention of his claim that his concept is grounded in Christian belief and tradition.[26] Coffey concludes that a covenant model for the patient-nurse relationship offers a framework for both describing actual relationships and for developing better relationships, through the experiencing of those relationships.

James Li expresses concern that physicians are misplacing their priorities because of increasing demands on their allegiance to third parties.[27] To him, the problem can be distilled into contractual versus covenantal views of the *patient-physician relationship*. A contract is struck in a climate of inherent mutual mistrust and generally involves relatively equal parties that are primarily concerned about their own welfare. By contrast, a covenant is based on trust (what he calls a "last will and testament" type of relationship) and the partners are generally considered unequal in one or more respects. The welfare of the more vulnerable party is a primary concern of both parties.

Kyle Brothers has borrowed from the Judeo-Christian traditions in his appeal for a covenantal patient/physician relationship that accommodates the patient as the "vulnerable other."[28] However, he seems to reduce this special covenant relationship to empowerment of the patient through dialogue, sensitivity to patient beliefs, and helping the patient to sort through options based on those beliefs. Once again, no appeal to a link with a relationship with a transcendent being is mentioned.

Grounding of Covenant Relationships in God's Relationship with Humankind

From a Christian perspective, any valid relational covenant between humans can only be properly and completely fulfilled if recognized as necessarily reflecting the relationship with the transcendent God. Scripture teaches that the covenant theme runs throughout redemptive history, but its importance for a systematic theology varies within different Christian traditions. It is particularly within the Reformed traditions that the idea of covenant became a central theme in a biblically derived theology. Yet, even during the Reformation period, unanimity among the leading Reformers was illusive regarding a common view of the covenant within theological alternatives to that of the Roman Catholic Church. Indeed, within specific post-Reformation traditions today, there remain different interpretations of the position of covenant within the theologies of tradition founders.

From a Reformed Christian perspective, Scripture instructs that one should relate to others as a reflection of the gracious gift of covenant that God established with humankind. As theologian Louis Berkhof put it, "… from the beginning" God "*condescended* to come down" to the creatures who bore his image and, "by positive enactment, *graciously* established a covenant relationship."[29] The relationship between God and humans is thus covenantally qualified but administered in various ways throughout redemptive history. As John Stek has summarized, "… in [the Reformed] tradition, covenant became a theological *concept* utilized to *construe* the *nature* of the God-human relationship, and was necessitated by the ontic distance between Creator and creature."[30]

Many Reformed leaders during the Reformation and immediate post-Reformation period adhere to a *postlapsarian* or redemptive covenant of grace as the first covenant, necessitated by sin. That is, God did not strike a covenant relationship with humankind until after the Fall into disobedience. This covenant was generally considered to have been initiated in the Noahtic and Abrahamic covenants,[31] the first of a series of covenants through which God attempted to maintain a relationship of trust with chosen remnants after sin entered the world. However, later followers and interpreters of these early leaders have suggested that some, including John Calvin, may have considered the *prelapsarian* (pre-Fall) relationship between God and Adam at creation to be also covenantal.

Peter Lillback has argued convincingly that, by its nature, God's covenant is unconditional from God's perspective but conditional from the human perspective.[32] That is, God dispatches a purely gracious arrangement which he will not break, but for the individual human, obedience is a necessary response without which God's gracious covenant could be jeopardized in divine judgment. According to Lillback, Calvin saw all humans accepted into a *common covenant* or adoption, which they could nullify through disobedience. That general or common covenant forms a *covenant community for all humankind*. Within that community are those who, by special election, will remain bound to God, though they will stumble and must be constantly on guard against disobedience. The non-elect, by contrast, will break the common covenant.[33]

The idea of a *prelapsarian* covenant has come to be known as the *covenant of works.* Calvin alludes

to *conditionality* in the earliest relationship between God and Adam. Life for Adam and Eve was conditional on a continuing obedience to God, and such conditionality suggests a covenantal relationship.[34] Furthermore, suggests Lillback, Calvin sees the prohibition to eat of the tree of knowledge of good and evil as a test of obedience at a time when humankind had not been perfected. Adam needed to grow in wisdom through obedience to God. Lillback argues further that, for Calvin, the tree of life is *a sacrament*, a pledge of life, a seal, which then implies a covenant promise:

> One [example of sacrament in the wider sense] is when he gave Adam and Eve the tree of life as a guarantee of immortality … Another, when he set the rainbow for Noah and his descendants as a token that he would not destroy the earth with a flood. These Adam and Noah regarded as sacraments … because they had a mark engraved upon them by God's Word, so that they were proofs and seals of his covenants.[35]

Humankind's relationship with God determines its relationships *within* humankind. Humans should act with gracious authority toward those who depend on them (just as God does toward them), while acting in gratitude and obedience to those in authority over them, as they do to God. In contemporary bioethics, principles-based ethics dominates bioethical discourse and decision making. Its framework consists of the principles of autonomy, beneficence, non-maleficence, and justice reputedly derived from a common morality knowable by all through reason alone.[36] Principles-based ethics has been rightly criticized for lacking grounding outside of intuition and reason.

By contrast, a biblical concept of covenant, grounded in a common divine-human covenant at creation (i.e., a prelapsarian covenant or covenant of creation[37]) as revealed in Scripture, could be helpful in providing a normative ethical framework and grounding for medical relationships. Perhaps most importantly, a biblical covenant ethic has a missional dimension; that is, it could also resonate with those who adhere to a common morality. A creation covenant between God and all of humankind that forms the moral grounding for covenant relationships in medicine may be persuasive as a more meaningful, normative alternative to principles-based ethics.

Christian Bioethicists' Views of Covenant in Bioethics

As reflected in their different confessional traditions, Christian bioethicists express quite variable Christian views of covenant in this context. I will review several different biblical covenant views held by Christian ethicists, beginning with a covenant view of Christian ethics that I have found very helpful and to which several prominent Christian writers in bioethics have referred. I will then address concepts of covenant formulated by various Christian bioethicists, as they apply to medical ethics.

Christian Covenant Relationships: Directed by Love and Reflections of the Covenant with God

Joseph Allen defines a covenant relationship as requiring several key elements. It must be constituted through willing acceptance of entrustment among the parties. As a result, the parties become part of a moral community with mutual obligations to each other that endures the test of time. He distinguishes entrustment from trusting (and trustworthiness) in that trusting connotes a disposition to commend ourselves to someone else, whereas entrustment goes further, by placing ourselves or something of value to us into the hands of another.[38]

Allen distinguishes two types of covenants. The *inclusive covenant* is wholly creational in scope, involving all living creatures and all of humanity. The relationship does not require active and conscious reciprocation; the creatures need not be capable of covenanting with God. Rather, the covenant affirms their value as creatures of God's good creation, with human beings having a special responsibility for its care. This inclusive covenant was established at creation: "The Christian proclamation is that God has created all people to live in covenant with God and with one another."[39] By virtue of this covenantal arrangement, all persons are God's children, whether they agree to it or not. As in the relationship of a child to its parents, we preconsciously entrust ourselves to God's care through the creational covenant. Allen calls this the most fundamental human relationship. However, it is never fully realized in this world, even among those who wholly and faithfully keep their obligations. It is also maintained by an eschatological hope that "stands in judgment upon the brokenness of all human communities."[40]

Allen also speaks of *special covenants* through which other moral responsibilities are shaped. They are distinguished from the inclusive covenant in their initiation by human beings with human beings, and in their special defining requirements, rights, and obligations. They also have common features, such as the need for faithfulness to the relationship, concerns for the needs of others, and respect for the worth of other participants. These types of covenants are inseparable to be fully meaningful. We are in relationship through both types at once. Our participation in the inclusive covenant is *concretely expressed* through our participation in our special covenants. Through the inclusive covenant, we are reminded that God is (or should be) the center of our moral life. This covenant forms a unifying meaning with the special loyalties of our special covenants.[41]

Allen also considers how the inclusive covenantal relationship with God provides the grounding for the moral life expressed through the special covenants by way of his steadfast love. He draws similarities between the Hebrew concept of godly love within covenant, as expressed in the Hebrew word *hesed,* and God's faithful love within the covenant expressed in the Greek word *agape* in the New Testament, confirming the unchanging nature of God's love within the covenant in redemptive history. Allen gives several characteristics of God's covenant love. In describing the binding nature of this love and its importance for each member of a covenant community, he stresses the individual worth that this love imparts to each member; we are worthy throughout our very being, at a deeper level than our moral worth. God loves us because he created us and covenanted with us from the beginning. Our worth is born out of the covenantal relationship.

Another characteristic of God's covenant love is its inclusiveness. Allen acknowledges the theological problem of interpreting Scripture's teaching regarding those who qualify as covenant participants. He makes the careful distinction between those to whom God's love is extended (i.e., those in the inclusive covenant), and the church as the community that responds positively and self-consciously to the new covenant in Jesus Christ. God will meet our individual needs but we must seek his kingdom and his righteousness. Accordingly, salvation is couched in communal terms as the restoration of true participation in the faithful covenanting community.

Two particularly important characteristics of his covenant love are the steadfast and reconciling nature of God's love. God's enduring responsibility goes beyond the legally stipulated, time-limited criteria of a contract. Unlike the legal release from responsibility that contract breaking allows, covenant with God entails a unilateral promise to keep that covenant *no matter what*. However, with this commitment comes a righteous stipulation, to seek repentance from the covenant breaker and to accept forgiveness when repentance is heartfelt, so that covenantal integrity can be restored.[42]

Allen describes special covenants involving human relationships in terms parallel to that of the inclusive covenant with God. While special inter-human covenantal relationships can be seen through the same characteristics that constitute the covenant with God, these characteristics are often distorted through sin by one or more parties within the covenant. Allen believes that the most neglected characteristic of covenant love in our time is the commitment to faithfulness to others. It is the commitment to take responsibility for the effects of our actions on others over time, and our commitment to care for others over the long term.

Covenant as a Framework for Bioethics: Christian Perspectives

Throughout his formative work from the early days of bioethics as a discipline, Paul Ramsey has tried to distill the covenant concept into *covenant-fidelity*. Expressed as Christian neighborly love with no requirement for reciprocation, he distinguishes this idea of a covenant relationship from a more secular idea of universal brotherhood or that of a cosmopolitan spirit.[43] Unfortunately, his covenant-fidelity theme is not systematically well developed. Robert Veatch, initially raised in the Methodist tradition and a firm believer in autonomous patient choice, proposes inventing a moral framework through a social contract by "rationally pursuing enlightened self-interest." For Veatch, a covenant is a *special contract* based on mutual loyalty and trust. He replaces covenant language with a Hobbsian interpretation of binding relationships, emphasizing public and legal aspects.[44] By contrast, Thomist bioethicists Edmund Pellegrino and David Thomasma favor the concept of a covenant of trust embodied

in an ethic of virtue, in which the physician pledges fidelity in a binding promise to help. They reject models of the physician/patient relationship that effectively reduce the relationship to a legal contract, a commodity transaction, or a purely biological healing relationship, in favor of one that they describe as a covenant of trust embodied in an ethic of virtue and trust.[45]

William F. May has perhaps most fully articulated the covenantal relational types in a medical context. For May, covenantal relationships go beyond a material framework to encompass a different *spirit* that is internal. This spirit goes *beyond the temporal limitations* of a contract and thus prevents the expedient neglect of obligations and promises. Covenants have a "gratuitous, growing edge," cutting deeper into personal identity and promoting fundamental change in a person's being in the relation-building process. For patient-caregiver relationships, this enables the caregiver to *transformationally* go beyond expressed wants and become more attentive to patients' deeper needs. Furthermore, it offsets the inherent power inequity in the relationship, allowing the more powerful caregiver to accept more responsibility for the more vulnerable partner, and reflecting back on God's condescension for the sake of covenant.[46]

From a Reformed perspective, Kenneth Vaux adds a *community dimension* by advocating an ethics of *koinonia* whereby covenanting communities of faith resist societal models of autonomous, self-ruling, and self-serving selves. Instead, we should exercise committed allegiance to God alone and, in his spirit of gracious acceptance and forgiveness, exist primarily for each other rather than ourselves. Hessel Bouma III and his colleagues have also written about covenantal ethics from their neo-Calvinist Reformed tradition. They agree with Allen on the distinction between an inclusive and special covenant. However, unlike Allen who seems to encompass *all living things* including humanity in this inclusive covenant with God, Bouma et al. seem to consider the inclusive covenant as Christians being in covenant relationship with God *and with all of creation*.[47] Thus, the temporal side of this covenant seems to be a post-Fall relationship between believers and God along with the rest of creation. This is a very different inclusiveness than that expressed by Allen, who includes all of humanity as well as

other living things on the temporal side. An inclusive covenant idea that encompasses all of humanity from the time of creation has appeal for Christians and perhaps also for non-Christians, in that it shows the primeval-creational, and thus inclusive, grounding of covenant rather than a more exclusive, salvific one. This may provide a better point of contact for bioethical discourse with non-Christians, for whom religious beliefs may be tied to exclusivity of certain participants.

Bouma et al. speak of covenant in much the same way as Allen and May, noting distinctions from contracts: endurance over time, a gift-giving nature, and a mutual shaping of the individual and their communities through covenanting relationships.[48] They also all speak of a kinship between deontological and covenantal ethics, in supporting some basic minimal rights and duties of individuals who are included in covenantal responsibilities. However, they acknowledge that such a moral minimalist view can also be characteristic of an individualism that prioritizes the individual over the community. They clearly distinguish the more demanding and expectant nature of covenant relations from the more limited and legalistic expectations of contractual ones.[49] They also see the rooted importance of the covenant with God toward all other covenant relationships.

In summary, the covenant theme plays a central role in the redemptive narrative that is taught in Scripture. It has its deepest roots in God the Creator, and points to lasting joy and peace through the sacrifice and resurrection of Jesus Christ. From these roots grow nurturing relationships between human beings, which hang on created relational structures, which in turn are given direction through the covenant relationship with God. It is from these roots that medical relationships can be most normatively fulfilled in a sphere of human endeavor defined by healing, relieving, and consoling. Without acknowledging and living out that relationship with God, all other relationships are incomplete, unfulfilled, and plagued by our sinful natures. As Spykman puts it,

> Covenantal religion defines the fundamental structures undergirding all human relationships and every societal calling … It embraces every earthly institution—marriage, schooling, labor, social service, science, art, even politics.[50]

Relationship of Patients and Supporting Persons As Seen through a Covenant Ethic

Considerable literature exists concerning the need to maintain good communication and to avoid paternalism in caregiver-patient relationships. Application of a covenantal ethical approach for each type of relationship in medicine is beyond the scope of this article. However, one relationship that has been much less explored than the patient-caregiver relationship, and that can be richly understood and expressed through a covenantal framework, is the relationship of the *patient and supporting individuals*. Paul Ramsey was one of the first bioethicists to allude to the importance of empowering patients *and those who support them* to make moral judgments regarding the patient's care.[51] This means patient participation and decision making with caregivers may be enriched by a meaningful covenantal relationship with supporting persons.

In a practice involving chronic progressive or life-threatening illness such as cancer and dementia, it is particularly important to strongly encourage patients to bring a trusted *Other* to clinic visits. This would preferably be the same person each time, to allow some relation building with that person and the caregivers, as well as to identify a point person who would communicate with others about the welfare of the patient. The support of this person reduces the patient's sense of vulnerability and provides an additional set of attentive ears and another interpretive mind that can help the patient comprehend and incorporate what is related by the physician. The relationship can also empower the patient to participate in better decision making at each decision node along his or her clinical course. It can give the patient strength to endure the sufferings associated with progressive disease. In certain situations, such as the donation of an organ from a relative or good friend, it is imperative that the caregiver ensure that the recipient and donor understand the implications, both the benefits and the risks, of the effects of the gesture on their ongoing relationship.

The relationship of the patient with such Others may be best developed through a biblical covenantal model. That person or persons will usually have an established pre-illness relationship with the patient based on trust at the onset of illness.

Such supporting Others will have to offer time and interpretive expertise, over and above other obligations or duties owed to individuals with whom they have distinct special covenantal relationships. Rearranging a schedule of family activities or taking time off work in order to accompany a patient to a clinic is one example. Providing daily care to change a wound dressing, or to ensure regular communication in order to keep a sick friend at home and out of the hospital, is another. As perceived through a biblical covenantal ethic, these relational bonds and obligations are grounded from creation in the grace offered by God to humankind, his special creation. Christians are directed by gracious love as the ordering principle, and this love justifies our thoughts and actions; just as Christ loved us, so we follow his way in our covenant love for others.[52]

In many cultures, it is normal and expected that family and/or friends become intimately involved in the care of a loved one. In cultures with close-knit, extended families in particular, involvement in care and decision making is expected and can be very comforting for a terminally ill loved one. In certain cultures, however, it has been perceived as normal for family members to use their influence on vulnerable loved ones, to withhold information, or to deceive them, out of fear that the truth will not be in their best interest. In most western cultures, this is now perceived as coercive and paternalistic.[53]

In his explorations of intergenerational relations in the context of illness in elderly family members, Drew Christiansen considers filial responsibility toward the elderly as a basic defense of the dignity of the elderly against the vulnerabilities created by failing health and reduced self-reliance.[54] In our society, this can create a tension between a societal-bred predilection toward autonomous freedom with its independence from Others, and a perceived risk to revert to paternalism with increasing dependence of elderly family members. In response, Christiansen rightly points out that caregiving always takes on another feature of covenantal relations: *sacrificial* character. In a family context, caregiving should normatively flow from an established covenantal relationship of promise and trust that lasts a lifetime. With illness comes another aspect or phase of that same relationship rather than the creation of a new relationship, as often occurs between patient and professional caregivers. Its core of promise, its inherently virtuous character in the domestic

sphere, and its long-term commitment qualify the relationship as covenantal even more deeply than that with their professional caregivers.

In a recent study of women with primarily breast and gynecologic cancers, 90% of subjects named a family member as their primary support, healthcare proxy, and/or emergency contact person. While over 80% named a first-degree relative to all three roles, only 57% of the time did a single person fill them all. Preexisting close family bonds formed the core of trust and comfort for the large majority of patients; yet, some members were perceived as better suited to provide specific manifestations of that support.[55]

For those without families and who rely primarily on friends or neighbors, the support relationship can take on a more tentative character, depending on whether the relationship has functionally developed to replace lost or unknown family relations prior to the illness. However, the strength of the bond of fidelity and sacrificial potential may be as strong as, or stronger than, any familial relationship.

May advocates that whoever assumes a caregiver role, particularly for the dying, needs what he calls *the covenantal virtue of courage*. He describes courage in this context as "a matter of keeping one's dislikes and fears under bridle for the sake of the good. It is firmness of soul in the face of adversity." Thomas Aquinas distinguishes an active and a passive courage; the former connotes attack while the latter manifests endurance.[56] As deliverers of care, professional caregivers tend to advocate active courage, sometimes characterized in their pugilistic metaphors such as fighting the disease with active therapy, while the supporting Others must bring forward endurance, expressing the covenantal character of their role more passively, as in the tradition of Job's friends.

As a pioneer of our contemporary care of the dying, Elizabeth Kubler-Ross urged that professional caregivers develop a kind of intimacy in their relationships with the dying, an almost mystical merging of the two. May, however, disagrees, acknowledging a distancing that occurs over time as health deteriorates, reflection about death intensifies, and the individual draws upon those with whom he or she has more closely shared life experiences, i.e., the faithful and supporting Other.[57] But

even such a covenantal faithfulness is marked by *strangeness*. The dying loved one is on a different path; or, rather, is hurrying faster down his or her path into strange territory. Like the friends of Job, sometimes the virtue of silent perseverance—just being there—is the passive courage that preserves the covenantal bond despite the strangeness.[58] Most assuringly, Scripture teaches that in our weakness the Spirit helps us. Even when we do not know what to pray for "… the Spirit himself intercedes for us with groans that words cannot express."[59]

Richard Zaner notes that spatial context may also give a distinctive character to patient/supporter relationships. A hospital room, for example, becomes the domain of the vulnerable. During a vigil of severe illness where death may not be far ahead, nursing staff come and go in shifts and physicians may make a daily visit for several minutes, but the closest covenanting ones often stay throughout the day and into the evening. Particularly when members of the same family take turns, there is a *covenantal continuity* of support. Indeed, the focus shifts so that the vulnerable one becomes dominant. Entry into the room feels intrusive. Those in a supportive role also increase their influence, bringing information and expressed needs to caregivers in other parts of the ward, or even outside the hospital.[60]

The patient-supporter relationship is special in the medical encounter. In many ways, it is the most stressful, the most risky, the most self-sacrificing, indeed, perhaps the most covenantal of all medical relationships. While most often an extension of an established covenantal family relationship or one of true friends and companions, the patient-supporter relationship can test that covenant in its demand for courage and fortitude. Similarly, the larger supporting Christian community should also seek its covenanting role in such times, particularly when it professes Christ, and exists to forward reminders of the covenantal joys and expectations of the God-believer relationship among believers in times of health and in times of distress. As believers, we need to work hard in our own communities to muster the courage and fortitude to be covenantal helpers to our ailing church body members. In many of our faith communities, we pledge at infant baptism to help to raise a child in the faith. Should we develop a similar pledge to provide covenantal support for each other in times of illness? ⊙

Notes

[1] This paper was presented in part at the annual meeting of the American Scientific Affiliation, August 1–4, 2008, at George Fox University, Newberg, Oregon.

[2] This symbol has often been confused with the caduceus of Hermes, the symbol of a winged wand entwined by two serpents. However, some of Hermes's traditional roles, such as the patron god of thieves and the guide of souls to the underworld, might make this an ethically dubious symbol for the practice of medicine.

[3] James E. Bailey, "Asklepios: Ancient Hero of Medical Caring," *Annals of Internal Medicine* 124 (1996): 257–63.

[4] Robert A. Wilcox and Emma M. Whitham, "The Symbol of Modern Medicine: Why One Snake Is More Than Two," *Annals of Internal Medicine* 138 (2003): 673–7.

[5] Bailey, "Asklepios: Ancient Hero," 260–2. This is reminiscent of the tactic used by Paul to show the Athenians the connection between their unknown god and the living God. See Acts 17:22, 23.

[6] Ludwig Edelstein, "The Hippocratic Oath," in *On Moral Medicine: Theological Perspectives in Medical Ethics*, 2d ed., ed. Stephen E. Lammers and Allen Verhey (Grand Rapids, MI: Wm. B. Eerdmans Publishing, 1998), 107.

[7] Ludwig Edelstein, *Ancient Medicine: Selected Papers of Ludwig Edelstein*, ed. Owsei Temkin and C. Lilian Temkin (Baltimore, MD: The Johns Hopkins University Press, 1967), 6–39.

[8] Allen Verhey, *Reading the Bible in the Strange World of Bioethics* (Grand Rapids, MI: Wm. B. Eerdmans Publishing, 2003), 7, n. 20.

[9] W. H. S. Jones, *The Doctor's Oath: An Essay in the History of Medicine* (New York: Cambridge University Press, 1924), 23–5. Recently, another Christian Physician's Oath was approved by the Christian Medical and Dental Society's House of Delegates. See Kenneth A. Feucht and Byron Calhoun, "The Hippocratic and Other Oaths: Past and Present Proposal for an Oath for Christians," *Journal of Biblical Ethics in Medicine* 10, no. 1 (1994): 28, 29.

[10] Allen Verhey, "The Doctor's Oath and a Christian Swearing It," in *On Moral Medicine: Theological Perspectives in Medical Ethics*, 116, 117. Verhey believes that the Christian version of the Oath reflects an attempt to transform a rational and professional ethic through attention to the Christian story. He suggests that it does not disown a natural morality and piety, but rather reforms it. This has echoes of many Thomist moralists who suggest that Christianity provides the "motivation" for fulfilling universal moral commitments rather than a true re-forming of morality through Scripture. See Lisa S. Cahill, "On Richard McCormick: Reason and Faith in Post-Vatican II Catholic Ethics," in *Theological Voices in Medical Ethics*, ed. Allen Verhey and Stephen E. Lammers (Grand Rapids, MI: Wm. B. Eerdmans Publishing, 1993).

[11] Nigel M. de S. Cameron, *Life and Death after Hippocrates: The New Medicine* (Wheaton, IL: Crossway Books, 1991), 23–45.

[12] William F. May, "Code, Covenant, Contract, or Philanthropy," *Hastings Center Report* 5 (December 1975).

[13] William F. May, *The Physician's Covenant* (Philadelphia, PA: Westminster Press, 1983), 111. Edelstein, on the other hand, believes that such references to deities were more related to appeals for fame and fortune than any acknowledgment of transcendental authority for their healing powers. See Edelstein, *Ancient Medicine*, 61.

[14] Robert M. Veatch, "The Hippocratic Ethic Is Dead," *New Physician* 48 (1984): 41–42, 48. Veatch reiterated this position in his 2008 Gifford Lecture, suggesting that claims by contemporary physicians that they follow the Hippocratic ethic are irrational if they are not members of the Greek cult. He goes further, to accuse patients of irrational behavior if they tolerate health professionals who claim to practice out of a professional code whose moral views are at odds with their own religious or secular tradition. In what seems to be a return to a more universalist approach to ethics, Veatch considers the possibility that religious and secular moral traditions can be harmonized, as a rational alternative to Hippocratic ethics.

[15] Robert D. Orr, Norman Pang, Edmund D. Pellegrino, and Mark Siegler, "Use of the Hippocratic Oath: A Review of Twentieth-Century Practice and a Content Analysis of Oaths Administered in Medical Schools in the U.S. and Canada in 1993," *The Journal of Clinical Ethics* 8, no. 4 (winter 1997).

[16] Ibid, 380.

[17] For a review and commentary of sexual contact with patients, see American Medical Association, Council on Ethical and Judicial Affairs, "Sexual Misconduct in the Practice of Medicine," *Journal of the American Medical Association* 266 (1991): 2741–5; N. I. Gartrell et al., "Physician-Patient Sexual Contact: Prevalence and Problems," *Western Journal of Medicine* 157 (1992): 139–43.

[18] Cameron, *Life and Death after Hippocrates*, 58–9.

[19] Orr et al., "Use of the Hippocratic Oath," 385.

[20] Christine K. Cassel, "The Patient-Physician Covenant: An Affirmation of Asklepios," *Annals of Internal Medicine* 124 (1996): 604–6.

[21] Recent studies suggest that such concerns are being addressed in various ways. The increase in women in the physician work force, for example, has been coincident with greater physician interest in making time for better healthy family relations through more part-time practices and taking leaves-of-absence. Evidence exists that these changes do not adversely affect patient outcomes. Training programs are putting greater emphasis on developing good relationships with patients through increased sensitivity to diverse backgrounds and beliefs. There is also greater attention among professional organizations to improving ethical behavior, to the avoidance of conflicting patient-care responsibilities, and to minimizing the influence of commercial interests and profits related to pharmaceutical companies on medical care. For further readings on these topics, see Reshma Jagsi, Nancy J. Tarbell, and Debra F. Weinstein, "Becoming a Doctor, Starting a Family—Leaves of Absence from Graduate Medical Education," *New England Journal of Medicine* 357 (2007): 1889–91; Patricia Parkerton, Edward H. Wagner, Dean G. Smith, and Hugh L. Straley, "Effect of Part-Time Practice on Patient Outcomes," *Journal of General Internal Medicine* 18 (2003): 717–24; Anthony L. Suchman, Kathryn Markakis, Howard B. Beckman, and Richard Frankel, "A Model of Empathic Communication in the Medical Interview," *Journal of the American Medical Association* 277, no. 8 (1997): 678–82; Chris MacDonald, "Will the 'Secular Priest' of Bioethics Work among the Sinners?" *The American Journal*

of Bioethics 3 (2003): 1–4 (InFocus); Robert Steinbrook, "Controlling Conflict of Interest—Proposals from the Institute of Medicine," *New England Journal of Medicine* 360 (2009): 2160–3.

[22]Joseph Allen distinguishes between an inclusive covenant involving God and human beings, and special covenants that involve interhuman relationships within distinctly different social structures. See Joseph Allen, *Love and Conflict: A Covenantal Model of Christian Ethics* (Nashville, TN: Abingdon Press, 1984). May also makes this distinction, but the inclusive covenant seems to differ from that of Allen in its scope. See William F. May, *Testing the Medical Covenant: Active Euthanasia and Health Care Reform* (Grand Rapids, MI: Wm. B. Eerdmans Publishing, 1996), 53.

[23]Jeff Nisker, "A Covenant Model for the Medical Educator-Student Relationship: Lessons from the Covenant Model of the Physician-Patient Relationship," *Medical Education* 40 (2006): 502–3.

[24]Others have expressed concern that problems in medical education go beyond a lack of mutual trust, to include increasing demands on physicians' time to be more administratively efficient and accountable, and a lack of time for students to reflect on their experiences, resulting in less time for teaching and less-effective learning, respectively. For further reading on these problems, and reflections on dealing with the emotional toll of patient care, see Ronald A. Arky, "The Family Business—To Educate," *New England Journal of Medicine* 354 (2006): 1922–6; and David A. Landis, "Physician Distinguish Thyself: Conflict and Covenant in a Physician's Moral Development," *Perspectives in Biology and Medicine* 36, no. 4 (1993): 628–41.

[25]Sue Coffey, "The Nurse-Patient Relationship in Cancer Care as a Shared Covenant: A Concept Analysis," *Advances in Nursing Science* 29 (2006): 308–23.

[26]Ibid, 309.

[27]James T. C. Li, "The Patient-Physician Relationship: Covenant or Contract?" *Mayo Clinic Proceedings* 71 (1996): 917–8.

[28]Kyle Brothers, "Covenant and the Vulnerable Other," *Journal of the American Medical Association* 288 (2002): 1133.

[29]Louis Berkhof, *Systematic Theology* (Grand Rapids, MI: Wm. B. Eerdmans Publishing, 1949), 215.

[30]John Stek, "'Covenant' Overload in Reformed Theology," *Calvin Theological Journal* 29 (1994): 12–41.

[31]E. Clinton Gardner calls these "promissory covenants," and distinguishes them from morally obliging covenants that involve commandments, through the obedience to which, faithfulness and responsibility toward the relationship is expressed. In either case, God's covenants with Israel define their self-understanding as God's people, expressed in how they live out their faith in Yahweh. See E. Clinton Gardner, *Justice and Christian Ethics* (Cambridge: Cambridge University Press, 1995).

[32]Peter A. Lillback, "The Continuing Conundrum: Calvin and the Conditionality of the Covenant," *Calvin Theological Journal* 29 (1994): 65.

[33]Peter A. Lillback, *The Binding of God: Calvin's Role in the Development of Covenant Theology* (Grand Rapids, MI: Baker Academic, 2001), 224, 225.

[34]Peter A. Lillback, "The Continuing Conundrum," 65. For God, however, the covenant had no conditions. That is, he vowed to keep his end of the covenant no matter what.

[35]John Calvin, *Institutes of the Christian Religion*, ed. J. T. McNeill and trans. F. L. Battles, *Library of Christian Classics* 21 and 22 (Philadelphia, PA: The Westminster Press, 2006), IV.XIV.18, 1294. Bavinck also believes that the life of Adam and Eve bore the marks of a covenant before the Fall (Herman Bavinck, *Gereformeerde Dogmatiek* II [Kampen: Kok, 1928], 530). Furthermore, Spykman agrees with the link of sacrament and covenant before the Fall: "Already in the Garden [the covenant] was sacramentally sealed in the sign of that very special tree of life." See Gordon J. Spykman, *Reformational Theology: A New Paradigm for Doing Dogmatics* (Grand Rapids, MI: Wm. B. Eerdmans Publishing, 1992), 265.

[36]For a complete review of principles-based ethics and justification for its utility in bioethics, see Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 5th ed. (Oxford: Oxford University Press, 2001), particularly pp. 397–408. As one point, the authors ask the reader whether the "heap of obligations and values unconnected by a first principle [that] comprises the common morality" can really be coherent (and thus justified) or is such coherence "more an article of faith than a demonstrable achievement?" (p. 407). Even the authors themselves sense the need for authority outside of common consensus about morality. A biblical covenant ethic can provide what they seek, and more.

[37]Meredith Kline, quite rightly I think, suggests that the unity of covenant in Scripture be designated the Covenant of the Kingdom, while the Covenant of Creation be considered to refer to the covenant established at creation and maintained by the grace of God despite the Fall. The Covenant of Redemption refers to the new covenant in Christ, not as a replacement for, but rather as a fulfillment of, the Covenant of Creation as it was intended to be from the beginning. See Meredith Kline, *By Oath Consigned* (Grand Rapids, MI: Wm. B. Eerdmans Publishing, 1968), 36, 37.

[38]Allen, *Love and Conflict*, 31–4.

[39]Ibid, 39, 40. Allen is not entirely internally consistent about the all-inclusiveness of this covenant. He speaks in another chapter about inclusive covenant as the whole of humanity created to live in covenant with God and one another. This suggests a less-inclusive covenant confined to human beings (see p. 132).

[40]Ibid, 40, 41. Spykman ties closely the covenant and the kingdom since God's kingdom was covenanted into place at creation. Both covenant and kingdom reset the direction for childlike faithfulness and obedient servanthood, not only within the good orders of creation, but also within the structures of the fallen creature (see Spykman, *Reformational Theology*, 259).

[41]Ibid, 44, 45.

[42]Ibid, 60–9, 71.

[43]Ramsey was one of the most prolific and eclectic early Christian bioethicists. He borrowed extensively from several theological traditions, as his theme of covenant evolved into greater emphasis on community and law. See Paul Ramsey, *Basic Christian Ethics* (New York: Scribner's, 1951), particularly p. 94 ff., and David H. Smith, "On Paul Ramsey: A Covenant-Centered Ethic for Medicine," in *Theological Voices in Medical Ethics,* ed. Verhey and Lammers.

[44]Robert M. Veatch, *A Theory of Medical Ethics* (New York: Basic Books, 1981), 125, 126.

[45]Edmund D. Pellegrino and David C. Thomasma, *The Christian Virtues in Medical Practice* (Washington, DC: Georgetown University Press, 1996), 80, 105.

[46]William F. May, *Testing the Medical Covenant*, 69, 70.

[47]Hessel Bouma III, Douglas Diekema, Edward Langerak, Theodore Rottman, and Allen Verhey, *Christian Faith, Health, and Medical Practice* (Grand Rapids, MI: Wm. B. Eerdmans Publishing, 1989), 83–94. It should be mentioned that these authors seem to define "inclusive" differently from Allen and May. Bouma et al. speak of the inclusive covenant as Christians in covenant with God and with all of creation. Allen, in most of his writing, speaks of all living things within the inclusive covenant in that their value as God's creatures is affirmed in such a concept (see Allen, *Love and Conflict*, 39). Like Bouma et al., May seems to refer to the mandate of the New Covenant to spread the message of Christ to all of humankind (see May, *Testing the Medical Covenant*, 53; May, *The Physician's Covenant*, chap. 4).

[48]Ibid, 84.

[49]Ibid, 89–92.

[50]Spykman, *Reformational Theology*, 359.

[51]Paul Ramsey, *The Patient as Person* (New Haven, CT: Yale University Press, 1970), xii, 2–7, 124.

[52]Oliver O'Donovan speaks of the summary of the law in Matthew 22 as the ordering principle of Christian ethics in providing unifying order to the moral field and to the character of the moral subject. It provides interpretation of other principles and rules for moral actions. See his *Resurrection and the Moral Order* (Grand Rapids, MI: Wm. B. Eerdmans Publishing, 1994), 197–203; 226–44.

[53]For more on these cultural differences and changes to these practices in recent years, see M. Costantini, G. Morasso, M. Montella et al., "Diagnosis and Prognosis Disclosure among Cancer Patients. Results from an Italian Mortality Follow-Back Survey," *Annals of Oncology* 17 (2006): 853–9; James Hallenbeck and Robert Arnold, "A Request for Nondisclosure: Don't Tell Mother," *Journal of Clinical Oncology* 31 (2007): 5030–4; Kerry W. Bowman, "Cultural Pluralism in Health Care: A South African-Canadian Comparison," *Annals of the Royal College of Physicians and Surgeons of Canada* 35 (2002): 114–6. It should also be noted, however, that some Christians believe that paternalism, withholding the full truth, and outright deceit may be justified in medical settings if motivated by a desire to help the afflicted achieve ultimate union with God. This position has been articulated by the Eastern Orthodox bioethicist H. Tristram Engelhardt Jr. in *The Foundations of Christian Bioethics* (Lisse: Swets and Zeitlinger, 2000).

[54]Drew Christiansen, "Intergenerational Relations," in *Duties to Others*, ed. Courtney S. Campbell and B. Andrew Lustig (Dordrecht: Kluwer Academic Publishers, 1994), 247–57.

[55]Don S. Dizon, Jennifer S. Gass, Christina Bandera, Sherry Weitzen, and Melissa Clark, "Does One Person Provide It All? Primary Support and Advanced Care Planning for Women with Cancer," *Journal of Clinical Oncology* 25 (2007): 1412–6.

[56]May, *Testing the Medical Covenant*, 71.

[57]Ibid, 72.

[58]Job 2:11–13.

[59]Romans 8:26b.

[60]Richard M. Zaner, "Encountering the Other," in *Duties to Others*, ed. Campbell and Lustig, 17–38, particularly 24, 25.

Reviewers in 2009

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