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Introduction

Even in our skeptical age, medicine's status as a science—and indeed, one of the most prestigious of the sciences—is beyond dispute. Yet medicine is also a healing art that blends technical expertise with cultural sensitivity, ethical sensibility, and the capacity for empathy. We argue that to cultivate these traits more fully, medical practitioners must learn to view themselves not merely as service providers, but as members of a long-standing guild bound by particular rituals, doctrines, and ethical obligations—what this article refers to as a normative community. Only then will science and the art of medicine be equipped to meet the challenges of a rapidly changing, dazzlingly diverse society.

This article proceeds in three parts. First, it argues for medicine as a normative community dedicated to the healing arts. Second, it explores this community's ethical dimension, and more specifically, how it might make use the categories of ressourcement and aggiornamento to negotiate the tension between how medicine *is* and *ought* to be practiced. Finally, it considers how the biblical admonition to honor the image of God in all human beings informs our attempts to recover the practice of medicine as a healing art.

The Case for Medicine as a Normative Community:

As a field, medicine has come under intense scrutiny as societies cope with the pressures of spiraling medical costs, outdated health care systems, and the unprecedented challenges of a global pandemic. These realities have prompted Christian clinicians and ethicists from a variety of denominations, for example, Gerald McKenny (1997), Jeffrey Bishop (2011), Michael and Tracy Balboni (2019), Bo Bonner and Kristin Collier (2021), and Farr Curlin and Christopher Tollefsen, 2021), to argue for the need to examine the gap between what medicine *is* and what medicine *ought* to be. Individually and collectively, these clinicians and ethicists issue a challenge to think anew about medical education and practice.

To begin responding to this challenge, this article poses a theoretical question. Specifically, should medicine be conceived as a normative community? What is at stake for medical education and practice in answering this question?

Consider first a definition of a normative community. According to the Catholic theologian Paul Griffiths, a *normative community* is "one that sets up norms, either of doctrine or practice, to which persons must adhere in order to be considered members of that community. Its purpose is to exclude some and include others, to set up conditions that must be met in order for membership in the community to occur and be maintained" (1991, 4–5). This definition has two parts. First, a normative community sets up norms of doctrine or practice. These norms may take the form of a statement of belief (e.g., the Nicene Creed) or of principles (e.g., the mission statement of a charitable organization). Second, these norms of doctrine or practice set boundaries for membership in the community. Adhering to normative beliefs and practices enables one to accrue standing within the community and even hold positions of authority within it, while breaking these norms calls one's communal belonging into question and may even lead to expulsion.

Following Griffiths's definition, medicine is a normative community of a particularly rigorous kind. For clinicians, attaining a medical license and board certification requires countless hours of study, training, and practice—we might say that this process imparts the formation necessary to be the member of a normative community. Nor are these norms merely technical in nature. For example, the obligations that the Hippocratic Oath places on clinicians have both humanistic and scientific dimensions: "I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug."[1] This artistic-humanistic component highlights the ethical context in which medical practice unfolds. When physicians provide care, they not only demonstrate technical mastery of their field but also make judgments as to whether a particular course of treatment is beneficial or harmful, good or bad, right or wrong. Inasmuch as it is bound by the Hippocratic Oath, therefore, medicine is bound by *ethical* as well as scientific or technical norms. The former merit the same careful attention as the latter.

Claiming that the medical community is bound by ethical norms, however, does not mean that these norms are easy to discern. For example, while the Hippocratic Oath enjoins clinicians to do no harm, determining what this centuries-old norm entails in a twenty-first century pluralistic context isn't

1. See also Peabody 1927.

so clear. How have notions of what counts as harm or benefit evolved since the days of Hippocrates? Since the nineteenth century? Since the 1950s? Since practicing clinicians first attained their medical licenses? How does one uphold the injunction to do no harm in a contemporary American context, where patients come from diverse religious, philosophical, and cultural backgrounds characterized by differing and competing notions of what constitutes "harm" and "benefit"?[2]

One way to deal with this complexity is to table the question of ethical norms altogether. This is precisely the move that the thinkers mentioned at the start find so troubling. For Curlin and Tollefsen, for instance, it has become commonplace for physicians to see themselves primarily as providers of services, as well as for patients see themselves as trying to purchase and consume the best care that they can. This fundamentally flawed arrangement, which Curlin and Tollefsen describe as the "provider of services" model, frames the patient-physician relationship as a simple exchange of goods and services akin to a salesperson helping a customer select the right product. But this is not the unproblematic transaction the "provider of services" model portrays it as. What this model does *in fact* is apply the norms of consumerism to economize and instrumentalize the patient-physician relationship. It places physicians under immense pressure to maximize efficiency and profit. They are incentivized to view the patient as, to paraphrase Bonner and Collier, a fragmented body to be mended rather than a whole person in need of healing. And on the terms of this model, patients are incentivized to see the physician as just another technician in the vast, impersonal machinery of the medical industrial complex from whom they extract care. Physician and patient alike, therefore, are conditioned to view each other as means to an end rather than as fully realized human beings.[3]

The question, therefore, is not *whether* medicine is a normative community, but *what kind of* normative community it should be. Tabling the question of ethical norms subjects medicine to the norms and whims of the market. To cultivate a different vision of what *medicine* should be, we must think deliber-

2. For comparison, consider then-Cardinal Joseph Ratzinger's words: "Today, having a clear faith based on the Creed of the Church is often labeled as fundamentalism. Whereas relativism, that is, letting oneself be "tossed here and there, carried about by every wind of doctrine," seems the only attitude that can cope with modern times. We are building a dictatorship of relativism that does not recognize anything as definitive and whose ultimate goal consists solely of one's own ego and desires," Homily delivered April 18, 2005.

3. Cf. Cavanaugh 2008. In Cavanaugh's telling, the logic of the market catechizes us into an economized way of life. By understanding ourselves as members of the Body of Christ, Cavanaugh argues that we should consider every interaction with one another with an eye toward whether they contribute to the flourishing of every person involved.

ately about what medicine's *norms* should be. Which raises the question: What would it mean for medicine to function as a normative community amid the philosophical and religious diversity that characterizes the contemporary US?

Enacting Normative Community: ressourcement and aggiornamento

By way of response, we turn to Catholic theology—and more specifically, the categories of ressourcement and aggiornamento. The French term *ressourcement* may be translated as a "return to the sources." It encourages a renewed appreciation for historical traditions and deploys them to evaluate and reform contemporary thought and practice. This restorationist impulse shines through in the work of figures such as Curlin and Tollefsen and Bishop. The Italian term *aggiornamento* roughly means "bringing up to date." It suggests an attentiveness to contemporary issues and a commitment to adjusting one's inherited beliefs and practices to address them. While aggiornamento doesn't dismiss tradition, it does prioritize present issues and concerns—hence why the term became synonymous with the proceedings and outcomes of Vatican II.[4]

In theology, these approaches are often oppositional, with the former advocating a return to traditional categories and practices to reform the present and the latter calling for reconfiguring traditional categories to meet contemporary concerns. But in our view, the tension between these methods can be productive—even essential—to helping communities address the tension between what *is* and what *ought to be*. Ressourcement draws on the past to gain critical perspective on the present. It thereby deepens our sense of the gap between the actual and the ideal. Aggiornamento takes contemporary developments and concerns seriously. It thereby helps us be

4. In *A Culture of Engagement* (2016), Cathleen Kaveny analogizes aggiornamento and ressourcement to openness and identity. In her telling, the culture of openness, on the one side, is marked by *aggiornamento*: "a process of bringing the church up to date," whereby Vatican II's Pastoral Council, especially in *Gaudium et spes*, assumed that "there would be a strong basis of cooperation among Catholics and a wide range of persons with goodwill, particularly on matters of social justice" (4). On the other side is the culture of identity, which started with the election of Pope John Paul II. Whereas the culture of openness sought to cooperate across "religious, cultural, and national boundaries" (4), the culture of identity found John Paul II "urg[ing] the church to defend a 'culture of life' against a secularized Western 'culture of death' that denied the existence of absolute truth and devalued the vulnerable, particularly the very young, those afflicted with severe disabilities, and the very old" (5). In this vein, American Catholics "emphasized the importance of a full-bodied, distinctively Catholic commitment that permeates and orders all aspects of one's life, including one's political activities" (5). Whereas the culture of openness emphasized aggiornamento, the culture of identity emphasized ressourcement: "the retrieval and renewal of the tradition on its own terms" (5).

effective at addressing the gap between the actual and the ideal. We believe that medicine would benefit from cultivating this healthy tension. On the one hand and consistent with ressourcement, medicine needs to be reminded of and uphold axiomatic commitments about which ideals the medical profession has upheld over the centuries, and what it will and will not do in light of these ideals. The approaches and sensibilities of ressourcement, therefore, can help medicine cultivate a sense of itself as a normative community. On the other hand and consistent with aggiornamento, healthcare providers need to calibrate to our particular contingent circumstances. The approaches and sensibilities of aggiornamento can help medicine function effectively as a normative community in a contemporary pluralistic setting where, as Jason Heron puts it, people "deeply and lovingly embedded in their traditions can and must speak with those analogously embedded in other traditions" (Heron 2019, 134).

Commenting on ressourcement and aggiornamento, Cathleen Kaveny advocates for Catholic Christians to move into a "culture of engagement." Through bringing into conversation different modes of interaction, Kaveny notes that cultures of engagement may do the following: In some cases, they can add illuminating nuance, depth, and color to each other. In other cases, the threads from one tradition can unsettle the gaze of the observer who is looking upon another conversation by highlighting problematic premises or placing unanticipated problems in bold relief (7).[5] For Kaveny, what's important for American Catholics to note is that they "participate not only in their religious tradition, but also in the secular, liberal, democratic rights-based tradition that currently dominates American political life" (9). One can't stand outside either their American or Catholic identities; rather, the goal is to "achieve some critical distance in order to evaluate the strengths and weaknesses of both identities" (9).

We do not believe that either ressourcement or aggiornamento can meet the daunting challenges of the present on their own. Here we differ with those who uncritically embrace one approach at the exclusion of the other. The Orthodox Christian clinician and philosopher Tristram Engelhardt, for instance, argues that ancient Christian commitments need to fund medicine education and practice over and against contemporary secular commitments.[6] The Orthodox theologian David Bentley Hart forcefully challenges this view in his recent book, *Tradition and Apocalypse* (2022). For Hart, it is a forward-

5. Cf. Hollenbach 2002, ch. 6, who advocates for "intellectual solidarity" in response to the facts of philosophical and religious diversity. See also, Weaver 2020.
6. See, e.g., Engelhardt 1986, 1991, 2014.

looking vision of a healed and redeemed world—not a pining for an idealized past—that gives Christianity (and by extension, Christian ethics and Christian bioethics) its normative-orientational vision; it allows Christian bioethics to inhabit the tension between the *already* and the *not yet*, between what *is* and what *ought to be*. To embody this eschatological orientation, we must be attentive to present needs and concerns while drawing on the resources of the past. For medicine, this means upholding the oath to do no harm while gleaning insights from the array of normative communities with which it shares the pluralist present. Medicine must, in other words, counterpoise ressourcement with aggiornamento.

Envisioning What Medicine Ought To Be

In closing, let us turn to a touchstone for Christian ethics more broadly: the charge to honor the image of God in all human beings. As contemporary debates rage over who belongs to what group and who is entitled to which rights and protections, the biblical text reminds us that we are all in a sense strangers and sojourners in need of care (Lev 19.34). In light of this fact, how do medical practitioners remain (or become) stakeholders in the normative community that is medicine? In asking this, we're reminded of the normative salience of the Hippocratic Oath for the practice of medicine and of how Jesus's admonition to see the face of God in all humans and particularly those on the margins accentuates this charge (Matt 25). Both classical and modern versions of the Hippocratic Oath hold that physicians are obligated to *every* individual who is ill. Yet millions go un- or under-treated. Both versions of the Hippocratic Oath emphasize prevention before cure. Yet millions are left undiagnosed or ignored. Both versions prioritize that the *patient is a person* to be cared for. And yet many physicians instead only see an illness as a problem to be solved. In these and other examples, we witness divergences between the Hippocratic Oath's normative ideal and the actual practice of medicine, between physicians and patients as members of a covenanted community and physicians and patients as mutually estranged. To both grasp and address the gap between is and what ought to be, medicine must recover its identity as a normative community committed to holding the impulses of ressourcement and aggiornamento in productive tension. Only then will medicine actualize its potential as a healing art that mediates between the normative ideal and the broken present.[7]

7. We presented an earlier version of this article at the Conference on Medicine and Religion (2022). Many thanks to audience members for comments and questions. Further

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