Religion in Organized Medicine

the AMA's Committee and Department of Medicine and Religion, 1961–1974

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ABSTRACT The history commonly told of the relationship between modern medicine and religion is one of steady, even inevitable, separation rooted in the Enlightenment. The divorce between medicine and religion, it is thought, had become nearly total before a recent surge of interest in the spiritual and religious dimensions of health care. This narrative, however, misjudges a persistent sense of spiritual need in illness that medical practice, even today, is unable to entirely ignore. Relying on primary sources, we recount here the little known story of the rise and fall of the Committee on Medicine and Religion and the Department of Medicine and Religion at the American Medical Association between 1961 and 1974. Arising in a context of a widely perceived dehumanization of care and the emergence of new ethical dilemmas at the bedside—concerns with significant parallels today—the initiative garnered striking physician enthusiasm and achieved dramatic successes nationally before coming to a puzzling end in 1972. We argue that its demise was linked to the AMA's contentious

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internal debate on abortion, and conclude with a note of caution regarding the status of normative concerns in medicine's ongoing efforts to address the spiritual and religious dimensions of its practices.

Although the relationship between medicine and spirituality has come to be considered problematic in the contemporary Western world, a concern with spiritual questions in healing and caregiving is as old as the recorded history of medicine itself. Illness ineluctably raises questions of a spiritual nature, of meaning and value, and of one's relationship with other persons and the transcendent. The world's religions have long been vital resources for making sense of one's spiritual experiences in illness and health, for they each posit a specific set of beliefs about the transcendent and constitute a community in which those beliefs and related practices can be taught and shared (Sulmasy 1999). The history commonly told of the modern relationship between medicine and religion, however, is one of gradual, even inevitable, separation, attributed to the growing cultural dominance of scientific biomedicine and the parallel decline of religious authority in the 20th century. Physician interest in the relationship between medicine and religion, it is thought, did not begin to resurface until the 1990s, with the publication of studies regarding the empirical effects of spiritual and religious factors on health. As a 2009 *Time* article observes, not long ago one would have struggled to find a research institute, an academic department, or a decent conference exploring the intersection of spirituality and health. It is only recently that the situation appears to have changed, backed by new public and private money and significant popular interest (Bjerklie 2009).

This modern narrative reveals something of the history of institutional attention on the spiritual and religious dimensions of health care, but it also misses something of the intrinsic, perennial nature of those concerns in the day-to-day medical encounters of patients and caregivers. Though recent published histories of the chaplaincy movement, bioethics, and professionalism cover significant periods of the 20th century and involve important spiritual and religious elements (see, for example, Imber 2008; Jonsen 1998; Myers-Shrik 2010), scholarship has largely overlooked the significant groundswell of interest among organized physicians to collaborate with religion in the mid-20th century. In this article, we use primary source documents to recount the little-known story of the Committee on Medicine and Religion (CMR) and the Department of Medicine and Religion (DMR) at the American Medical Association (AMA) from 1961 to 1974. It is an extraordinary story of physician interest and activity around the spiritual dimensions of medicine, followed by a curious and dramatic ending. Along the way, we reflect on why the CMR and DMR arose and had such initial success, why they failed, and how their rise and fall might inform contemporary efforts to bridge the abiding spiritual concerns of medicine and religion.

Physicians Turn to Religion

The DMR was established at the AMA in 1961 by the initiative of the AMA leadership, led by the Executive Vice President, F. J. L. Blasingame. The Board of Trustees of the AMA, as the CMR would later be told, was "very enthusiastic of the need" for this endeavor. The Board's enthusiasm appears to have been shared widely by leaders beyond the AMA as well. In his first act as the DMR's newly appointed Director, Rev. Dr. Paul McCleave conducted a "needs assessment," interviewing and gathering ideas from state medical societies, major religious groups, and private and public hospitals across the country. Everywhere he went, he reports, there were "heartening, encouraging responses," and he concluded his tour with "reams of ideas from across the country" (CMR meeting minutes, May 24, 1962, and McCleave, Progress Report to DMR, April 1962; Zimmerman Collection). McCleave's tour would set the tone for the vision of the AMA's role in propelling physician engagement with religion. It would be responsive to local needs, acting as a leading facilitator and director of related interests.

Apparently satisfied with the results of McCleave's assessment, the AMA Board convened the CMR in May 24, 1962. The CMR was tasked with advising the Board and directing the DMR in matters of program direction. The CMR would be a "matrix," clarifying and directing the energies of physicians, clergypersons, and others at the intersection of medicine and religion. Its mandate was expansive: it could take full advantage of the AMA's "federation of 54 state and territorial medical associations," which in turn were "composed of almost 2,000 county or district medical societies" (AMA 1962, 3). The AMA had the local reach that the DMR needed to carry out the CMR's recommendations. By being organized under the Division of Field Services, which served "as an operational and liaison arm of the AMA with the state and local medical societies in specified activities," the DMR, under CMR's direction, was well situated to coordinate local engagements among interested physicians and clergy (undated document describing Division of Field Services; Field Services Collection).

"American medicine is at the Committee's disposal," announced McCleave at the CMR's first gathering. These were not empty words. In 1962, the AMA claimed officially to represent over 97% of all eligible American physicians as members.[1] The CMR membership was constituted for success at a national level. In keeping with the AMA's prominence, the CMR included 10 physicians and 10 clergy of national renown. The first chairman of the CMR, Milford O. Rouse, for example, was the Vice-Speaker of the House of the AMA, an appointment that the Board made in recognition of "the importance of this committee" (McCleave 1963b). Rouse would go on to become president of the AMA in 1967 (*Southern Medical Journal* 1967). The assembled committee also reflected its national scope in its diversity: "when you

[1]Compare with the more recent rate of about 15% of U.S. physicians who pay the full annual membership dues, which excludes students and residents (Collier 2011).

think of the background of each member," it was observed in the first meeting's minutes, "you see the faiths of America, various areas of medicine, professional and education areas, and individuals who have done exciting work in this area." The clergy were of Jewish, Mormon, and various Christian denominations; no two clergy belonged to the same religious community.[2]

In his June 17, 1963, address to the AMA Annual Meeting, McCleave stated that the CMR and DMR's ambitious vision, finally, was to create "a climate of communication between the physician and the clergyperson, leading to the most effective care and treatment of the patient in which both are interested" (Field Services Collection). The goal was neither a theoretical search for conceptual clarity nor the pursuit of any particular moral or political agenda. The concern, rather, was practical and basically local in nature: the individual physician and the individual clergyperson in conversation dealing with a particular patient within a particular community. McCleave declared that physicians and clergy were to be coworkers in providing "total care," which was founded on a well-articulated concept of patients as whole persons: "man is a whole being. He is physical; he is spiritual; he is mental; and he is social in his total health. It is widely recognized that a weakness in any one of the four factors of his health can and does militate toward ill health in any one or all three of the other factors." As such, the AMA leaders argued, medicine must acknowledge that "the patient has a faith, and the patient must be treated and cared for within the scope of that faith." For this reason, it was "essential that all of medicine and all of the faith groups of America meet in discussion."

This AMA initiative was both addressing an increasingly felt need and tapping optimism about religious resources for patient care among practicing physicians in the mid-20th century. AMA leaders were no doubt aware of what many perceived to be a "crisis in American medicine." *Harper Magazine*, for example, had devoted an entire issue in 1960 to the challenges plaguing American medicine. Reports protested the "millions of people" who were "bitterly dissatisfied" with their medical care (Sanders 1960, 123), as well as the general "crisis in human relations, a breakdown in communication between doctors and patients" (Greenberg 1960, 132). Physician shortages meant doctors had little time to talk to patients, relying instead on cursory patient exams and indiscriminate prescribing of antibiotics. The avalanche of new medical knowledge and technologies, too much for any one physician to learn, had given rise to innumerable specialties and to fragmented, bureaucratized, and depersonalized systems of health-care delivery.

[2]The first members of the CMR were as follows. Physicians: Milford O. Rouse, TX (Chair); B. Earl Clarke, WI; Willard S. Krabill, IN; Donn G. Mosser, MN; Eusebius J. Murphy, NY; Alonzo P. Peeke, SD; George W. Petznick, OH; J. Stephen Phalen, NV; Paul S. Rhoads, IL. Clergy: Seymour J. Cohen (Jewish), IL; Richard L. Evans (Mormon), UT; John E. Marvin (Methodist), MI; Lawrence Rose (Episcopal), NY; Porter Routh (Southern Baptist), TN; Fulton J. Sheen (Roman Catholic), NY; Granger E. Westberg (Lutheran), IL; Samuel S. Wiley (Presbyterian), TN; Richard K. Young (Baptist), NC; Thomas Zimmerman (Assemblies of God), MO (House of Delegates Proceedings, Nov. 26–28, 1962). Further details about each member can be found in the minutes of the CMR's first meeting (May 24, 1962; Zimmerman Collection).

The *Harper* issue reflected more than a passing gripe; the discontent had been percolating for quite some time among leading thinkers. As early as 1949, Henry Allen Moe, first chairman of the National Endowment for the Humanities, speaking at the American College of Physicians, had noted signs of "a great twentieth-century problem": an overemphasis on "activities that are deemed useful for present progress and power and strength" as opposed to those that "determine the character of people" (Moe 1950, 316). Taking up this theme in 1954, C. Sidney Burwell, former dean of the Harvard Medical School, had likewise cautioned his physician readers: "at a time when medicine has so much to offer patients, it is a tragedy of the first order when its effectiveness is interfered with by defects of character or by bad manners." By manners, Burwell had in mind those essential to "effective contact with patients and their families," those that "demonstrate the physician's concern for his patient and his effort to understand him" (8).

Medicine, it was felt, needed to rediscover the humanity of caregiving and to fight the forces of depersonalized care. Physicians needed to attend again not just to the physical but also to the spiritual dimensions of the patient and the caregiver. Such concerns would later be echoed at AMA forums by some of the leading lights of medicine and religion. "Just as death is the liquidation of human being, dehumanization is the liquidation of being human," warned the eminent Rabbi Abraham Heschel. Speaking at the AMA Annual Convention on June 21, 1964, he declared "the promotion of spiritual homicide, the systematic liquidation of man as a person" to be America's greatest challenge (Field Services Collection). "For the conscientious scientific doctor," one doctor would agree, "his patient is becoming increasingly a bundle of laboratory figures which reduce his awareness of the suffering human being" (Booth and Franzblau 1967, 178). Dr. Howard Rusk, a renowned pioneer in rehabilitative medicine, would lament that physicians had forgotten that they were "physicians first and scientists second" (address to AMA Annual Meeting, June 20, 1965; Field Services Collection). The Most Reverend Fulton J. Sheen would likewise remind AMA physicians that "there are no diseases; there are only sick people. . . . The object of medicine is the human person. . . . Man is much more than a mass of nerves, tissues, blood and organs. The object of medicine is the suffering person" (address to AMA Annual Meeting, June 17, 1963; Field Service Collection).

Physicians were also becoming conscious of new clinical moral quandaries. The 1940s and '50s had been a time of dramatic medical discoveries, such as that of streptomycin, synthetically produced penicillin, the polio vaccine, the external cardiac pacemaker, kidney transplantation, and the first human heart valve replacement (Bordley and McGehee 1976). Leading scientists were holding unprecedented academic conferences to discuss the new social and ethical problems that had accompanied recent progress in medicine and science (Jonsen 1998). By the 1960s, physicians faced new dilemmas: a deformed baby who might have quickly died just a few years prior, McCleave would note in 1963, could now live,

albeit never to play, work, or return affection; a comatose patient could be kept alive for years by artificial means; and in the midst of new technological promises, physicians still needed to tend to the mysteries of a dying patient's faith and the grief of families left behind (McCleave 1963a; address to AMA Annual Meeting, June 17, 1963; Field Services Collection). Physicians faced "decisions, decisions, decisions," and it was "impossible to put in a little black book that if a patient is found to be in a particular diseased circumstance, you can say this is to be done or that is to be done" (McCleave 1963b, 242). Yet there were no established forums of enquiry for such moral concerns: according to Albert Jonsen, a leading historian of the field, bioethics would only become "a discernable stream that could be given a name" a decade later (Jonsen 2006, 24). The first bioethics centers did not emerge until 1969–70, and even those were staffed originally largely by theologians and philosophers, as opposed to the more contemporary professional "ethicists" (Callahan 2012).

Concerns about ethical dilemmas at the bedside and the erosion of human qualities in medicine—its art—thus appear to have motivated the physicians' turn to religion in the early 1960s. In the absence of any secular authority, physicians would have looked to religious traditions, including, in particular, the Roman Catholic tradition, as obvious resources for dealing with ethical dilemmas. Religions not only had long histories of experience in medical care, but they also encompassed theological traditions that provided principles and casuistic (case-based) methods for grappling with moral dilemmas. Religions also promised to help imbue medicine with a renewed sense of vocation and reorientation against the perceived crisis of depersonalized and dehumanizing care. "Medicine is a sacred art," argued Rabbi Heschel in his 1964 remarks to AMA physicians: "Religion is not the assistant of medicine but the secret of one's passion for medicine" (Field Services Collections). Rouse, the chairman of the CMR, agreed, stating, according to a DMR brochure entitled "My Patient, Your Parishioner, the Same Person," that: "We need no less of the science of medicine, but more of the art, and a large measure of the art lies in the spiritual capacity of individual physicians" (Field Services Collection). Drs. Edward Rynearson and Howard Rusk, in addresses to the 1963 and 1965 AMA Annual Meetings, spoke of religion as a source of emotional strength in their own work, and in his address to the 1964 Annual Meeting, Dr. William Menninger alluded to the power of religion to reduce "selfishness," "prejudice," and other failings, and instead to cultivate "humility" and "love." "Love in the doctor," Rev. Fulton Sheen exhorted attendees at the 1963 Annual Meeting, "is to be patient, tolerant, and benevolent. One can only have this kind of patient love when one sees in every single person an immortal soul, more precious to the Lord than the universe itself" (Field Services Collection).

Physicians' turn to religion, moreover, was buoyed by what Robert Putnam and David Campbell (2010) describe as a general "high tide" of religion in America in the 1950s, "channeled primarily through conventional and even establishment institutions" (83). In a 1957 Gallup poll, for instance, given a choice between the

statements "religion can answer today's problems" or "religion is old-fashioned and out-of-date," 81% of Americans chose the former (87). More specifically, proponents seeking to engage religion would have found some reason for optimism in the impressive developments in clinical-pastoral education (CPE) and pastoral counseling. The first clinical training program for theological students had been established by Anton Boisen in 1925 and rapidly inspired many similar programs across the country, eventually leading a group of physicians and theologians in 1930 to create the Council for the Clinical Training of Theological Students (CCTTS) (Myers-Shirk 2010). The movement shared a commitment to the scientific method (the case study method), hospital or field experience, and cooperation with other professionals, including psychologists, psychiatrists, medical doctors, and social workers. Professional alliances, in the minds of these early CPE leaders, were strategically important for locating ministers in a newly developing matrix of professional culture, so they stressed the unique role of the clergy on the health-care team. By 1962, of the 235,000 active Protestant ministers in the United States, an estimated 8,000 to 10,000 had completed clinical pastoral training, becoming the subject of a large national survey, *The Churches and Mental Health*, commissioned by the Joint Commission on Mental Illness and Health (McCann 1962). The field was firmly established conceptually as well by this time, with two scholarly journals: *The Journal of Pastoral Care* (started in the mid-1940s) and *Pastoral Psychology* (started in 1950).

The path-breaking effect that these developments in CPE had for medicine's turn to religion is illustrated by Granger Westberg's 1961 book, *Minister and Doctor Meet*. Westberg, a chaplain who held joint faculty appointments in the Medical and Divinity Schools of the University of Chicago at the time, was considered a "pioneer in pastoral counseling work" and served as a member of the CMR for 10 years (*Pastoral Psychology* 1955, 54). In his book, Westberg discussed the possibility of greater collaboration between ministers and doctors and the need of both groups to incorporate the principles of psychiatry in their communications with patients. From the foundational conception of the "whole" person to the emphasis on a collaborative approach to patient care, the CMR's agenda appears to have been influenced by Westberg's book. The reference list of over 400 peer-reviewed articles and books concerning "The Relationship of Health and Religion" that the CMR initially consulted was also one that Westberg had compiled in 1962 (Zimmerman Collection).

Organized physicians' turn to religion in the 1960s was therefore sustained by compelling reasons. Far from a passing fad, the initiative appears to have been grounded conceptually in a centuries-old tradition of humanistic medicine—of medicine as both art and science—and in its perceived erosion in the face of depersonalized systems of care, as well as in the new practical dilemmas of conscience at the bedside. The needs for which religion was to be a response, moreover, were not special preoccupations of the AMA leadership alone but were shared broadly

by those engaged in health-care issues. These were concerns worthy of national attention, and the CMR and DMR were set up to serve on the national level as the primary medium for coordinating and directing the diversity of religious responses to the perennial concerns of the medical art and its object, a person with a spirituality and a faith. Physicians and their partners nationwide would embrace the initiative enthusiastically.

"The Fastest Growing Program of the AMA in the Past Fifty Years"

In their first year, the CMR and DMR conducted exploratory studies in the areas of mental health, hospital chaplaincy, medical, theological, and nursing school curricula, and clinical pastoral training centers, as well as a series of ambitious pilot programs on medicine and religion in nine states and 27 counties. This was in keeping with their concern to mobilize and direct the efforts of physicians and clergy in their local communities. Suggestive of the initial embrace, the AMA House of Delegates heard in 1963 that "the program and the concept have received widespread acceptance and support from state and county medical societies, religious groups, and other related organizations" (Proceedings, Dec. 2–4, 1963). Writing more personally, McCleave noted that the initial response was "beyond our expectations."

The CMR and DMR fostered dialogue between medicine and religion on several programmatic fronts. On the public front, they engaged primarily physician audiences, not only to elicit their interest in the role of religion but also to respond to existing demand. For instance, a well-attended medicine and religion conference was held on the opening day of every Annual Meeting of the AMA, beginning in June 1963 (AMA 1970). Renowned physicians and clergy were invited to speak, including Rabbi Abraham J. Heschel, Rev. Fulton J. Sheen, and Drs. William C. Menninger, William H. Masters, and Virginia E. Johnson. In 1967, the only year for which there is extant data, an estimated 3,000 people attended the annual session—a number that is difficult to imagine today (Hiltner 1967; McCleave, address to AMA Annual Meeting, June 18, 1967; Field Services Collection). Riding the tide of interest that year, in response to "much interest" among physicians, the CMR partnered with a newly formed Department of Medicine and Religion at the *Journal of the American Medical Association* (Rhoads 1967). The partnership produced a series of 13 articles between 1967 and 1968, each featuring a column by both a member of clergy and a physician around a particular issue or question. Addressed were a wide range of topics, such as transplantation, clergy and hospitalized patients, end of life, truth-telling, community health clinics, missionary service, and grief.

In April 1963, the CMR divided itself into Subcommittees on State and County Society Activities, Medical and Nursing Education, Theological Training, and Hospital Chaplaincy (CMR meeting minutes, April 19, 1963; Zimmerman Collection). Later, in 1965, a Subcommittee on Medical Missions would replace the

one on Hospital Chaplaincy before itself being dropped by 1968 (CMR meeting minutes, April 23, 1965; Zimmerman Collection).[3] Some trial and error was to be expected, but the first three subcommittees would go on to constitute the CMR's core. The medical and theological education subcommittees aimed to equip students for cross-disciplinary communication by familiarizing them with the concepts and vocabulary of the other. The CMR and DMR created curricular materials, and state committees of medicine and religion partnered with other state committees in efforts to work with medical schools. By 1972, the CMR reported success with nine medical schools that were "conducting and continuing education courses on medicine and religion" (Board of Trustees meeting minutes, April 28, 1972). In theological education, an extensive survey, regional meetings, and pilots were conducted in 1965 to assess needs, which then culminated in the publication of a *Theological Seminary Education Program Guide* and a *Program Guide for County Societies and Theological Seminaries* in 1968 (Robert F. Etheridge to Thomas Zimmerman, Jan. 25 and July 3, 1968; McCleave, annual report to Board, Aug. 11, 1967; Zimmerman Collection).[4] An incredible 150 seminaries would soon indicate interest in working with county level committees to such an end (Board of Trustees meeting minutes, April 28, 1972).

The structural heart of all the CMR and DMR's efforts was the state- and county-level committees on medicine and religion. Practically, state and county committees worked with their local theological and medical institutions and facilitated events bringing physicians and clergy into conversation. They were central to the CMR's stated vision of creating local communication forums . Their establishment and support was also where the CMR and DMR enjoyed the most dramatic successes. By 1965, in less than three years of the CMR's establishment, they had helped create state committees on medicine and religion in 49 states, Puerto Rico, and the District of Columbia. That year, 700 county-level medical societies each organized between one and eight programs for physicians and clergy (House of Delegates Proceedings, Nov. 30–Dec. 2, 1964). In 1969, the last year in which specific numbers were reported, the state committees had helped 40%—presumably of the approximately 2,000 county medical societies in the country—hold one or more programs in religion (House of Delegates Proceedings, Nov. 30–Dec. 3, 1969).

In their role as central facilitators, the CMR and DMR provided the ongoing support necessary to ensure the success of local committees. They published *A Manual for the State Medical Society's Committee on Medicine and Religion* (DMR 1966), which detailed step-by-step instructions on setting up county committees, circulating newsletters, conducting state workshops for county society committee

[3]The Subcommittee on Hospital Chaplaincy was from the beginning intended as an exploratory one. The CMR soon concluded that the DMR would play a supportive role to the leadership of others in this area, such as that of the American Hospital Association.

[4]Questionnaires were mailed to 269 seminaries in October 1965, of which an impressive 74% were returned. Subsequently, 29 regional meetings of theological representatives were conducted, and pilot studies involved 11 seminaries.

chairs, planning a program at annual state society meetings, exhibit set up, and media and publicity. A detailed curriculum, *A Program Guide for the Committee on Medicine and Religion: State and County Medical Societies*, was similarly published and distributed to assist committees with program content (Zimmerman Collection). In more hands-on efforts, the DMR also divided the nation into four regions, which enabled a full-time staff member to meet with each one of the state level committees in an assigned region one or more times a year to assist with programming (McCleave, annual report to Board, Aug. 11, 1967; Zimmerman Collection). Starting in 1967, the DMR held "exceptionally well attended" annual workshops and conferences for state committee chairs, through which it heard about needs, received suggestions, encouraged enthusiasm, and increased understanding of program purposes and goals (House of Delegates Proceedings, Nov. 26–29, 1967). The DMR also coordinated inter-committee communication by circulating a biannual newsletter detailing the national, state-, and county-level activities in medicine and religion for four years starting in 1971 (Field Services Collection). The DMR staff and CMR members, moreover, spoke frequently at the events and conferences of state- and county-level committees and helped promote their agenda in communities nationwide: Director McCleave, for instance, reported in 1967 that he had appeared on 37 local TV shows that year (Annual report to Board, Aug. 11, 1967; Zimmerman Collection).

Importantly, the CMR and DMR set the vision and tone of these many efforts at the local level. They created and circulated widely resources to state and county committees, including model exhibit booths, program guides, and various brochures on medicine, religion, and the basic concepts of the whole person and physician-clergy communication. The CMR and DMR also produced popular films, one in 1963 and another in 1969 (Field Services Collection). The first film, *The One Who Heals*, was designed to elicit discussions with a series of open-ended vignettes of situations involving physicians and clergy in the care of patients. The film won the Council on Non-Theatrical Events Award in 1965 (House of Delegates Proceedings, Nov. 28–Dec. 1, 1965) and, according to a third-party estimates, reached an estimated audience of 22.9 million through 1969 (Zimmerman Collection). The second film, *A Storm—A Strife*, which focused "attention on problems with children, health, and marriage," reached an estimated audience of 57,277 in nine months.

As the 1960s drew to a close, the CMR and DMR's efforts at the local level were bearing sustained fruit. There are no outcomes data with which to measure the success of these various efforts, nor would that have been the expectation for such programs at the time. Nonetheless, some specific evaluative observations are warranted. The following is a sampling of some state-level activities as reported in 1970: Connecticut's state committee successfully established chaplaincy programs in several of the hospitals in the Hartford area; the District of Columbia's committee was involved with nine seminaries in a pilot program; California's state committee held area workshops for chairs of county committees that involved several hundred members; Illinois's committee initiated an awards program to "recognize

the physician and the clergyman who have contributed most to the professional dialogue"; Maine's committee planned a series of institutes with physicians and clergy in mental health and set up departments of medicine and religion in several hospitals in the state; Pennsylvania's committee provided teaching materials that were being used at the University of Pittsburgh Medical School and achieved wide circulation of its newsletter detailing the medicine-religion activities of the county medical societies (CMR meeting minutes, Feb. 20, 1970, Appendage D; Field Services Collection). In 1968, according to an internal report of DMR activities, 25 state committees were hosting medicine-religion programs at their state annual meetings (Zimmerman Collection).

Significant activity is evident also among county committees of medicine and religion. For example, the 1970 CMR report notes that the committee in Maricopa County, Arizona, was holding monthly panel discussions at various hospitals in its area with an average audience of 25 to 50 invited physicians and clergy (CMR 1970). Many other county committees organized full-day seminars, generally in local hospitals, designed to familiarize clergy with the committees' workings. These committees also helped set up long-term programs at hospitals and educational centers: the committee in Orange County, California, for instance, was offering clinical training to theological students at Southern California College, Costa Mesa, as of 1970 (Field Services Collection).

Finally, the CMR and DMR reported institutional participation from beyond the AMA as well. Though it is unclear whether any concrete joint ventures were implemented, the Proceedings of the House of Delegates indicate that between 1970 and 1972, an increasing number of other organizations, such as the American Cancer Societies, American Heart Association, Veterans Administration and Military Hospitals, and local community hospitals and other institutions were seeking involvement, and that many programs had been planned. Perhaps more important to the AMA initiative's stated goals, religious leaders were enthusiastically involved in programming. In 1969, for example, the various state committees reportedly involved 510 physicians and 300 clergy members, while the county-level committees included roughly 2,500 physicians and 1,500 clergy (CMR meeting minutes, Feb. 21, 1969; Zimmerman Collection).

General evaluative perceptions of key members within the AMA validate the CMR and DMR's impressive achievements throughout the 1960s. Taking stock in 1969, for instance, the Review Committee on Medicolegal Activities concluded in a memo to the AMA Board of Trustees that "the importance of this activity and its beneficial efforts in demonstrating the interest of medicine in serving the people of this country cannot be overemphasized" (March 26, 1969; Zimmerman Collection). Walter Bornemeier, President-Elect of the AMA in 1970, then publicly praised the CMR as "the fastest growing program of the AMA in the past fifty years," calling it "one of the finest things that the AMA has done" (address to AMA Annual Meeting, June 21, 1970; Zimmerman Collection).

A Puzzling Termination

Despite its dramatic success, however, the CMR was suddenly abolished in 1972, and the DMR was quietly dissolved just two years later. The Board of Trustees, not the House of Delegates, made the decision, and in its report to the House of Delegates, the Board made clear that the report was for the House's information purposes only (House of Delegates Proceedings, Nov. 26–29, 1972). Minutes of the CMR and the Board, and the proceedings of the House of Delegates, indicate little formal discussion or warning prior to the puzzling termination. But given the CMR's obvious success, one is led to wonder why it was terminated so abruptly.

In addition to the CMR, five other councils and committees of the Board were abolished in 1972, including the Council on Drugs, Council on Occupational Health, Council on Voluntary Health Agencies, Council on National Security, and Committee on Medical Aspects of Automotive Safety. In public communications, the Board explained these decisions were driven by budget difficulties. For example, in its report to the House, the Board referenced an article in the journal *Institutional Investor*, which predicted a dire financial outlook for nonprofits throughout the country. The termination of the councils and committees, the Board reasoned, was necessary as an "effort to construct a 1973 budget not only in balance but with a reasonable surplus to be used along with existing reserves to meet future unpredictable contingencies" (House of Delegates Proceedings, Nov. 26–29, 1972).

But why these particular councils and committees? The Board pointed to a 1969 report of the management consultant firm Cresap, McCormick, and Paget, which had completed a review of the AMA's management structure that year. The firm had pointed to "duplication, overlapping, and absence of identifiable priorities," which the Board acknowledged as valid. This management-related reasoning is also echoed in the minutes of the Board, which urged in the "interest of economy, more efficient performance of AMA programs and better priority allocation" (Board of Trustees meeting minutes, Oct. 21, 1972). The Board's suggestion, then, was that the CMR's contribution to the AMA was too costly relative to its value to the AMA.

A closer examination, however, raises serious doubts about whether the Board's public reasons adequately explain the decision to end the CMR and its work. As already described, the CMR's work extended to every corner of the United States and was marked by depth and quality. Moreover, the CMR's ambit did not overlap with that of other committees. No other committee or council was working in the arena of medicine and religion, much less fostering cooperation between physicians and clergy. Even its involvement in moral dilemmas, which were frequent topics of discussion in medicine and religion programs, was irreplaceable at the time. Religious communities provided not only traditions of moral guidance but also methodologies for ethical analysis, and, since the field of bioethics was only beginning to emerge at this time, a secular alternative to religious reasoning about medical ethics was not yet established. An AMA Judicial Council existed but it was preoccupied largely with questions of what has been called "medical etiquette"—such matters as fee splitting,

advertising, the size of one's signs, and relations with osteopaths, chiropractors, and quacks (Haller 1981; Veatch and Fenner 1975). Not until much later, in 1985, the year that its name was changed to the Council on Ethical and Judicial Affairs, did AMA members mention the Judicial Council as possibly doing the kind of work the CMR had done and might have continued to do.[5]

Indeed, the Board consistently heard an unambiguously positive opinion of the unique value of the CMR to the AMA. In March 1969, its own Review Committee for Medicolegal Activities, after extensive formal review of the CMR, reported:

> The program and activities of the Committee and the Department of Medicine and Religion create a favorable and positive public image for the American Medical Association. Because of the nature of these programs and activities and the manner in which they are conducted, there has been much favorable publicity. There may be many physicians who are not directly aware of the scope and effect of these programs, but benefits from the programs appear to be widespread. The members of the Review Committee believe that there are countless physicians and clergymen who have been brought together and who are caring more effectively for patients and their families because of the activities of the Department and the Committee. The importance of this activity and its beneficial effects in demonstrating the interest of medicine in serving the people of this country cannot be overemphasized. (Zimmerman Collection)

The Review Committee extended its positive assessment to cost concerns as well, stating that the "Department of Medicine and Religion has conserved and used judiciously the funds budgeted for the activities and programs of the Department and the Committee. The Committee meets only once each year and the total expenditures involved are minimal." Indeed, when the CMR was eventually terminated, the AMA would save just $44,000 out of a total projected budget of $37 million for 1973 and a 1972 surplus of $742,000 (*AMA 1973 Budget Summary,* Board of Trustees Collection; Board meeting minutes, Oct. 21, 1972). In view of its assessment in 1969, the Review Committee recommended against "curtailing the budget or the programs of the Committee and Department of Medicine and Religion." The next Review Committee report to the Board in April 1972, just six months before the Board's decision to abolish the CMR, would echo the 1969 judgment: it too recommended that the CMR and DMR "should continue as presently constituted" (Board of Trustees meeting minutes, April 28, 1972).

Is it possible that the Board expected the work that the CMR had successfully overseen to continue without it? To be sure, the Board had indicated its hope that the abolished councils and committees' work would continue on a smaller scale

[5]The opinion was voiced in an AMA survey conducted in response to a resolution calling for the reestablishment of the Committee on Medicine and Religion in 1985; the name was amended as Committee on Medicine and Human Values before being passed (House of Delegates Proceedings, June 16–20, 1985).

by being absorbed into other committees or councils, through liaison relationships with other related organizations, or by the staff of the relevant department. The CMR fell into the last of the three; the DMR was allowed to continue with a smaller staff and budget. Extant records do not reveal whether the Board considered this to be truly sustainable. However, Arne Larson, the Director of the DMR as of 1970, seems to have anticipated a domino effect, foreseeing the demise of many state and county committees as a result of this move (undated letter to unknown addressee; Field Services Collection). Regardless, any possibility that the Board hoped otherwise did not last long. The DMR was shut down just two years later, sometime between 1974 and 1975.[6] Moreover, history would bear out the fact that with the CMR and DMR's demise, a rapid undoing of their work would follow. An AMA survey in June 1981 revealed that of the 42 responding state societies, just eight characterized their committees as "very active" as opposed to "not very active," "inactive," or unresponsive, and 19 reported having no formal committee on religion at all (House of Delegates Proceedings, June 7–11, 1981).

AMA's Abortion Politics and Religion

The Board's official reasons for abolishing the CMR are unconvincing, especially in light of the fact that other less successful committees, such as the Committee on Quackery and the Committee on Television and Radio, were preserved (House of Delegates Proceedings, Nov. 26–29, 1972). We now recount the story of the CMR and DMR's involvement in the AMA's controversy over abortion, and suggest that the CMR may have been a casualty of the AMA's abortion politics. Although there is no direct textual evidence that the abortion controversy played a role in the Board's decisions, it is unlikely that such a reason would have been entered into official accounts. The evidence that abortion politics was a background factor, however, is compelling.

In the first half of the 20th century, abortion was largely illegal and dangerous. The 1960s was a time of intense, divisive national debate over the issue as states began to reconsider their abortion laws. Within the AMA, the debate formally began when the Board established the ad hoc Committee on Human Reproduction (CHR) in December 1963 to update AMA policies on abortion and other reproductive issues (House of Delegates Proceedings, Nov. 30–Dec. 2, 1964). This action was consistent with a general medical perspective that viewed abortion as a form of birth control, but as the most drastic and dangerous type—one that could still be distinguished from the physician's responsibility to promote effective family planning (Imber 1986). From the beginning, however, abortion proved to be a politically challenging topic. The CHR took its time reviewing state laws and the policies of

[6]The DMR's last newsletter was distributed near the end of 1974, and there was a resolution in the House of Delegates requesting the reestablishment of the DMR in June 1975.

various legal and medical associations on abortion and other reproductive issues, and the Board brought a modified version of the CHR's recommendations before the House of Delegates, the AMA's policy-making body, for approval in November 1965. The CHR had taken a medicolegal approach, framing its proposals around the observation that state laws were variable, confusing, rarely enforced, and often too restrictive. It proposed that the AMA seek to standardize state laws to "reflect medical conscience and public opinion" and recommended criteria for therapeutic abortion that closely reflected those of the American Law Institute's model statute (House of Delegates Proceedings, Nov. 28–Dec. 4., 1965). This model statute had been adopted in 1962 and permitted abortions for the physical or mental health of the mother, fetal abnormality, and rape or incest (Jonsen 1998).

This medicolegal approach, however, proved unsatisfying to the House, which rejected the CHR's proposal following public testimony before its Reference Committee. In its summary of the testimony, the Reference Committee reported a prevailing sense that the report left unaddressed several broader issues at stake: "moral-ethical-spiritual-religious elements"; medical elements; and the "customs, usage, tradition, and orientation of society in each state." The discussions had attracted widespread interest and had evoked "expressions of deep personal conviction"; the abortion issue, it felt, could not be resolved by consideration of any one element alone (House of Delegates Proceedings, Nov. 28–Dec.1, 1965). Indeed, by this time, according to the sociologist Jonathan Imber (1986), the abortion debate had expanded beyond questions about physicians' medical responsibilities. For one, physicians were unable to agree over the appropriate indications for determining the therapeutic necessity of an abortion, and opinion polls of physicians had consistently exposed their internal divisions over the issue. Moreover, pharmaceutical companies were marketing new forms of contraception, and the rise of the women's movement had helped to reshape family planning decisions into matters not primarily of the efficacy or safety of contraceptive means but of personal and economic liberation. Theologians too were beginning to be engaged in a serious manner; Paul Ramsey and Richard McCormick, for instance, would soon emerge as articulate voices on the issues (Jonsen 1998). It had become clear to AMA physicians that abortion could not be limited to medicolegal concerns.

Having been instructed to treat the topic more comprehensively as a social and moral/religious issue, not just as a medicolegal one, the CHR invited the DMR's Director to assist in its deliberations. Religion was thus formally brought into the politics of abortion within the AMA. According to the minutes of the CHR, McCleave participated in at least two meetings, once in 1966 and again in 1967. The DMR (and, presumably, the CMR) endorsed the CHR's efforts to permit abortions under "very limited" therapeutic conditions (CHR meeting minutes, March 4, 1967; Board of Trustees Collection). McCleave sought support for the CHR's position from religious bodies, such as the World Council of Churches, and persuaded the CHR to include the various religious positions on abortion

in its policy proposal (CHR meeting minutes, Feb. 26, 1966, and March 4, 1967; Board of Trustees Collection). Given these efforts, the House would later be told that McCleave had attended all CHR meetings, and that along with the views of the legal, mental health, and maternal and child care representatives, the Roman Catholic, Protestant, and Jewish positions had been considered (House of Delegates Proceedings, June 18–22, 1967).

In 1967, "recognizing that there are many physicians who on moral or religious grounds oppose therapeutic abortion under any circumstances," the CHR proposed that the AMA adopt a policy statement only as a guide for component and constituent societies rather than push for changes in state laws. This statement, using more conservative language than the version in 1965, would recommend limiting abortions to "documented" cases of rape, incest, endangerment to the mother's life, or the possibility of an incapacitated or mentally deficient infant, and only at an accredited hospital with the written concurrence of two physicians (House of Delegates Proceedings, June 18–22, 1967). The House resolved in favor of this proposal, thus, capping three and a half years of contentious political debate within the AMA. Significantly, moreover, it drew religion into the AMA's institutional politics—a situation for which the CMR and DMR were relatively ill-suited, given their core mission of fostering dialogue among the diverse religious beliefs of AMA physicians rather than advocating specific political stances.

Soon after the 1967 policy vote, the Board dissolved the CHR before its previously scheduled meeting in April 1968 could take place, and it overruled its unanimous opinion that the CHR's specific mandate had not yet been fulfilled (CHR meeting minutes, Oct. 28, 1967; Board of Trustees Collection). The 1967 achievement at the AMA, moreover, would last only for three years. Before 1970, ongoing national trends toward the liberalization of abortion laws in the legal system drove a significant shift in momentum in favor of advocates of liberalization, with a dozen states overturning previous legal bans on abortion (Jonsen 1998). These developments anticipated the 1973 Supreme Court decisions *Roe v. Wade* and *Doe v. Bolton*—the first affirming the right of women to have an abortion, and the second striking down the constitutionality of therapeutic abortion committees, leaving the decision in the hands of the individual woman and her physician (Imber 1986). Legal changes were clearly moving in favor of physicians at the AMA, who in 1967 had stated that "all women should be masters of their own reproductive destinies" (House of Delegates Proceedings, June 18–22, 1967). The Board, moreover, would prove in 1970 to be a powerful proponent of further liberalization of AMA policy on abortion.

In November 1969, the AMA Section on Preventive Medicine brought to the House an unequivocally worded resolution—a prelude to the fight to come. The resolution asserted that contraception was a recognized universal right; people should have a choice among anti-fertility methods; conventional methods were not always effective; access to proper contraceptive methods was limited; many

women and families were poorly suited to parenthood; many laws interfered with a woman's right to choose whether to bear children or interfered with the physician's medical judgment, causing clandestine abortions to flourish; and the AMA's policy was unduly restrictive. As such, it resolved that the AMA rescind its policy, and "seek repeal of all state abortion laws, so that all women, for whatever reason, can have abortions performed under safe, healthful conditions by qualified practitioners of medicine" (House of Delegates Proceedings, Nov. 30–Dec. 3, 1969). This strongly worded resolution, however, was not adopted by the House.

The brewing controversy came to a head seven months later, at the AMA's biannual policy meeting. A flurry of resolutions pushed for abortion to be considered a medical decision to be made solely by the patient and her physician (House of Delegates Proceedings, June 21–25, 1970). Signaling a significant interest in the debate, the Board brought its own resolution to the House, Report D, seeking to overturn the AMA's 1967 policy. It recommended that "the House of Delegates establish a policy on abortion that would permit the decision to interrupt pregnancy to be made by the woman and her physician," with the caveat, "no physician should be required to perform an abortion and no hospital should be required to admit a patient for abortion."[7] This Report D of the Board would become the focus of debate during public hearings.

At the public Reference Committee hearings on abortion policy during the June meeting, extensive testimony again ensued, evoking "feelings of deep personal conviction indicative of the polarization of the medical profession on this controversial issue." The testimony was evenly divided, with half saying abortion should be practiced under the Medical Practice Act, "so that the decision to interrupt pregnancy would rest solely with the woman and her physician," and the other half arguing for the retention of the AMA's 1967 policy. This, the Reference Committee observed, was a "remarkable shift in testimony on abortion . . . as contrasted to the opposition to liberalization expressed by the testimony before a similar Reference Committee only six months ago."

Evident in the summary of public testimony is the significant weight the Board's Report D carried, becoming a reference point for both proponents and opponents. Report D enjoyed the presence of several allies within the AMA leadership. In its relatively short, two-paragraph summary of testimony, the Reference Committee specifically noted that representatives of the Council on Mental Health, the Council on Environmental and Public Health, and the Committee on Maternal and Child Care supported the intent of Report D. The AMA Section on Preventive Medicine

[7]These proposals came with a kind of hands-off blessing of the Judicial Council, which simply stated that "the Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion that is performed in accordance with good medical practice and under circumstances that do not violate the laws of the community in which he practices. In the matter of abortions, as of any other medical procedure, the Judicial Council becomes involved whenever there is alleged violation of the Principles of Medical Ethics as established by the House of Delegates" (House of Delegates Proceedings, June 21–25, 1970).

had also made its agreement with the Board's position clear in its 1969 resolution, as well as in one of the five resolutions that had been submitted alongside the Board's report. It is over against this seemingly majority stance within the AMA leadership that the representatives of the CMR, apparently alone, according to the brief summary of testimony, opposed the intent of Report D. Public opposition to the Board on a controversial issue of this magnitude—and one in which the Board had taken a prominent leadership role—was clearly noteworthy as far as the Reference Committee was concerned, and some sort of political fallout perhaps should not have been unexpected.

Though the final resolution recommended by the Reference Committee and eventually adopted by the House ostensibly embody resolutions put forward by the California and Oregon Delegations, it essentially reflects the proposals put forward by the Board in its Report D. Moreover, in finally recommending that the House liberalize AMA abortion policy, despite the evenly divided testimony, the Reference Committee rested its case on essentially legal grounds, appealing to the same reasoning used by the Board. The Committee, like the Board, felt "strongly that physicians who practice in jurisdictions without legal restrictions on abortion should be permitted to institute this medical procedure." The Board and its allies on the issue thus effectively secured the liberalization of abortion policy as a purely legal matter—a reasoning that the House had rejected in 1965. In so doing, they limited further debate, cutting off medico-moral and religious considerations. The move avoided, rather than engaged, the strong emotions that were involved on both sides, and as such, it would have done little to assuage the deeper differences incited by the controversy. Certainly, the feelings over the issue were raw for many in the public, even after the Supreme Court rulings in 1973, which this AMA policy seems to resemble closely in spirit. For the public, abortion grew into an even greater political issue in the mid-1970s, led by powerful Catholic and conservative Protestant voices (Jonsen 1998). Similar tensions no doubt persisted at the AMA, despite appearances to the contrary, following its decision in 1970.

This apparent tension between medicine and religion was no small matter that could be shrugged off as being limited to a particular case; the views involved in the controversy were simply too deeply held by many for that. Opposition to the liberalization of abortion on the national scene had come to be viewed as almost exclusively religious. Religion was coming to be seen by many as the foe of medical and scientific progress, not a friend: even those "who oppose abortion reform who are not religiously oriented," one commentator noted, do so because of the effects of "Christian concepts of morality which so thoroughly permeate our social attitudes" (Wolf 1969, 106). At the same time, religion increasingly looked divided and irrelevant to civic life. The 1960s had seen precipitous declines in religious attendance, and compared to 81% in 1957, just 62% in 1974 believed that religion could answer "today's questions" (Putnam and Campbell 2010, 98). The decade had also produced a climate of opinion that emphasized personal truths, and religious

relativism had begun to set in. For example, in 1969 a retired Supreme Court justice, Tom Clark, identified a recent Christian Medical Society symposium on controlling human reproduction as emblematic of the "chaotic state of thinking" and of the disagreements that prevailed on such key questions as "Is the control of human reproduction against the will and spirit of God?" and "At what stage of the gestation period does the fetus acquire human status?" Exasperated, he asked, "Heaven knows; who can tell? Who shall decide when experts disagree?" Reflecting this challenge, the AMA's CHR in 1967 had also stressed that religions, and even individuals within those religions, held varying positions on abortion, and the CHR did not go beyond summarizing the range of religious positions (House of Delegates Proceedings, June 18–22, 1967). Religion, it seemed to many, was both a powerful enemy of progress and, at the same time, a fragmented entity without a clear authoritative voice.

Within this climate, especially in the wake of the victory achieved by the Board and its formidable allies on the issue, the fact that the CMR—as religion's primary presence at the AMA—had been a barrier to perceived progress may have magnified doubts among physician leaders about religion's status as a partner in medicine's future. By 1972, the record shows that the CMR and related entities were experiencing significant political pressures. In a letter sent to registrants for the upcoming Eighth Annual Interorganizational Consultation in October 1972, DMR Director Arne Larson observed that "it is increasingly evident that more groups are becoming concerned in various or all facets of health care delivery systems. Programs that implemented philosophical positions were being questioned and jeopardized by other institutional and political forces" (Field Services Collection). This was to be the central issue discussed at the meeting. But the consultation was too late for the CMR. Confirming the reality and strength of these pressures, the Board abolished the CMR that very month.

Conclusion

Many within academic medicine today are again seeking to heal the rift between medicine and religion and to engage spiritual and religious resources in addressing the same dehumanizing and depersonalizing forces that led to the AMA's initiative in medicine and religion half a century ago. They testify to the persistence of spiritual or religious needs in the practices of medicine. Much has changed since the 1960s, of course, but modern medicine's more recent interest in religion seems to spring from the same sources. The concept of treating patients as whole persons continues to be revisited, as seen in proposals for what has been termed the "biopsychosocial-spiritual" model of patient care (Sulmasy 2006). Movements for "patient-centered medicine" have embraced the influence of patients' cultures, religions, and spiritualities on their experiences of illness and medical decisions. For physicians, efforts to promote professionalism in medicine have stirred thinking about the virtues in medical practice and about medicine as a spiritual vocation, and

a growing body of research suggests physicians' religious identities and commitments strongly shape their clinical practices, especially in certain domains. Religion encompasses much more than ethics. Despite the establishment of bioethics as a permanent feature of medicine's landscape, patients and practitioners alike seem to express needs that are more spiritual than moral. Ethics, whether secular or religious, cannot address such needs.

In telling the story of organized medicine's experience with religion from 1961 to 1974, we believe that a greater awareness of this history can offer important examples of past successes and failures, which may shape our conceptions of what the intersection of medicine and religion could or should look like in the future. The AMA program engaged patients, physicians, and clergy at the grassroots level and was characterized by transparency, dialogue, and accountability. But these dramatic cooperative efforts quickly collapsed in the face of a divisive moral controversy. At the very least, the abortion debate represents a watershed event, partly causal and partly associated, at the confluence of many factors that led to religion's precipitous fall from the heights of its impressive engagement with modern medicine. Does this history sound a cautionary note? How will medicine navigate the normative aspects inherent in religious belief as it increasingly focuses attention on the religious and spiritual dimensions of its own practices?

Perhaps what is required is a form of détente regarding the normative questions, so that both the secular and the religious camps can join forces to address the spiritual needs of patients. This does not mean that the normative issues are unimportant or that debates about abortion, euthanasia, embryonic stem-cell research, or other divisive issues should not continue. Nor does it suggest that such issues should merely be relegated to the legal realm, as happened with the abortion debate at the AMA in 1970. Rather, it is to suggest that by agreeing to disagree on these issues—by separating them out into a different sphere of debate—all can perhaps move forward to address the ultimate questions of meaning, value, and relationship that have been ignored by a "de-spiritualized" form of medical practice, one that continues to alienate patients and fails to meet their needs as whole persons. This was at the heart of the AMA's initiative over 50 years ago, and the same concerns remain today.

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