Published in final edited form as:

Am J Bioeth. 2018 May ; 18(5): 63–64. doi:10.1080/15265161.2018.1431715.

Facts and Fetishes: When the Miracles of Medicine Fail Us

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In this Open Peer Commentary response to *Responding to Those Who Hope for a Miracle: Practices for Clinical Bioethicists* (Bibler 2018), we reverse the gaze from the patient back onto the physician and explore the medical profession's role in its own type of miracle-wishing. By understanding the parallels between the processes that lead people to make claims about religious and medical miracles we hope to enhance the epistemic humility that Bibler, *et al.* compel us to adopt and recognize that the hopes that physicians place in medical science might not be so different from that of their patients in religion.

In a qualitative interview study conducted by one of the authors (Dzeng et al. 2015) exploring physician attitudes surrounding end-of-life decision-making, this physician respondent recalled how:

“They told [a patient's] wife...there was absolutely no evidence this gentleman would ever recover any cognitive function. She said, ‘well, I still just want to give him a [chance for a] miracle’. We spent weeks watching this gentleman being ventilated with absolutely no chance of recovery. We were at the whim of her wishes...she seemed extremely sharp and understood a great deal what was going on [but] despite that, she clung to what we felt to be irrational hopes.” (C11)

Physicians often have an uncomfortable relationship with miracles. Trained in the medical sciences, those who are not religious sometimes find it difficult to understand the spiritual fortitude necessary to believe that a loved one will be blessed with a miracle. Tensions arise when these beliefs promote continuation of what physicians believe to be futile treatments.

In his book, *On the Modern Cult of the Factish Gods* (Latour 2010), Bruno Latour describes the derision of colonial Westerners who once accused African natives of worshiping fetishes, mocking them for treating stone, clay, and wooden idols as true divinities, when they had crafted them with their own hands. Surely something man-made could not hold sacred powers! So much was obvious to the Westerners. The Africans then questioned why the pious images of the Virgin Mary were any more sacred. There were stronger similarities between the two groups than the Westerners deigned to recognize. And so, as Latour writes,

“we see one group of people covered with amulets scoffing at another group of people covered with amulets.”

Physicians who believe that religious protestation of miracles is fairy-thinking are what Latour describes as “Moderns”. They are “strongly attached to the conviction that there is an essential difference between facts and fetishes”. The trust these Moderns place in medicine allows them to deride those who wish for miracles for ignoring scientific reality. To the Moderns, scientific facts are distinct from fetishes because they involve no fabrication, no human artifice. But the distinction between fetish and fact is not always so clear. What Latour illustrates in his story and throughout his social-theoretical texts (Latour and Woolgar 1986; Latour 1993) is that while fetishes may be partly man-made, facts are too.

To understand Latour, we Moderns must take a closer look at ourselves. Physicians also make statements that can seem to families like unjustified miracle-wishing – medical fetishes in a sense. Many physicians are acutely aware of prognostic uncertainty and yet when it comes to conversations with patients, much of this uncertainty can evaporate as reality is boiled down to facts. How often do physicians tell a patient that, for example, they have an 80% chance of being cured by a particular treatment when they know full well that when a slightly different bundle of realities is taken into account, things *may* look quite different? Yes, this treatment may statistically cure the patient’s illness 80% of the time. But our physician has a feeling that their patient is unlikely to comply with all the conditions needed for the treatment success. Perhaps our physician worries that the patient may have co-morbidities that make them particularly vulnerable to the medication’s toxicities, requiring treatment cessation. They might suspect that the patient’s prior drug sensitivities predisposes them to symptomatic side-effects that make its continuation unbearable.

Looked at one way, the patient may have an 80% chance of being cured, but looked at another, it may be closer to 30%. For the 80% chance of being cured by this treatment to remain fact-like, multiple elements of reality must cooperate. As long as these elements all cooperate, we may not notice that their cooperation was ever necessary. But if these elements break down, they draw attention to themselves so that with hindsight, it becomes obvious to the patient and family that there was only ever a 30% chance of success. Now the physician’s original statement starts to look like miracle-wishing, the product of medical fetishism.

The physician had no intention of ignoring reality. Packaging reality into a fact inevitably involves a process Latour calls “purification”, whereby much of reality’s complexity – its fickleness and fragility, its ability to suddenly surprise us – is pushed out of sight. We need to state facts because doing so allows us to pull together and coordinate our actions in pursuit of a common goal; it enables us to get on the same page as each other. Facts *can* thereby have the virtuous property of bringing the realities whose cooperation they depend on into line: if we state an 80% chance of being cured, we *may* help create healthy optimism that encourages them to comply with all the conditions necessary for treatment success (Latour 2010). But facts necessarily omit much of reality, however we package them. They therefore run the risk of undoing themselves.

Yet can we not say the same about families' miracle-wishing? Yes, their confident statement that there is a chance of a miracle occurring may seem to ignore many of the uncertainties of religious belief (Does god really exist? Is there any mechanism through which miracles occur?). We cannot necessarily conclude from this, however, that families are unaware of these uncertainties, or that they are wrong to have left them out of their "fact" – just as we cannot necessarily conclude that physicians are unaware of uncertainties that do not appear in their prognoses, or that they are wrong to have omitted them. In both cases the facts presented have undergone purification. Like medical facts, religious facts *can* even help produce the realities they describe; just as the doctor's "80%" may make the patient optimistic enough to fully comply, the family's faith may inspire the doctors and patient to rally and reward such inspiring human hope. In either case reality might cooperate to ensure that the fact continues to look like a fact: the patient may miraculously recover in a way that physicians find difficult to explain (a gift from god!); or they may recover because of the 80%-effective treatment (a gift from science!). Or reality may conspire to make the alleged "fact" look like a fetish.

One physician respondent in the same study reflects upon the magical thinking of doctors and the conflict that occurs when medical facts become fetish:

"We believe in our miracles and we get families to believe in our miracles... There is a lot of magical thinking...doctors want success. So there's, 'we did it last time', or 'we did it for that patient', or 'my colleagues did it for that patient and now I want to do it for my patient'...The question is, when do you stop pursuing the miracle? [Our ethicist] said 'For the last thirteen months, you have [the mother] orientated towards the miracle...you told her you were pursuing a miracle but now at month eleven you suddenly say you can't...She's going to take time to come to that conclusion.'" (B2)

The physicians' faith in medical facts over eleven months, shored up by purified accounts of success seen in previous patients, morphs into medical fetishism as the fragile arrangement of reality required for success breaks down. The patient's family had been presented with the possibility of a medical miracle, supported by purified medical facts. Months later, the physician's belief in medical miracles that brought the family so much hope now seems to them like a medical fetish.

For some hospitals, purified medical facts literally become medical miracles in the very way they present themselves to the public through advertising. City of Hope, a comprehensive cancer center, recently had an advertising campaign centered on the message: "The MIRACLE of SCIENCE with SOUL" (London 2016; Kutscher 2015). Advertisements proclaimed that "We don't just treat cancer, we cure it" and "When You Have Cancer, You Want a Miracle". One can imagine the disillusionment of someone with pancreatic cancer who believed that they would be cured only for this fact to later dissolve into a medical fetish.

Latour emphasizes that the purpose of all this is not to "drag them all down, [but pull] them all up" and pay "equal respect to facts and fetishes (Latour 2010)". The goal of this commentary is not to downgrade the extraordinary achievements of modern medicine but to

make a plea for greater mutual understanding between physicians and patients and of the permeable boundary between medical fact and fetish. By doing so, we might achieve greater empathy for those who pursue medical and religious miracles alike.

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