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Loma Linda University Center for Christian Bioethics

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Update

SOCIETY FOR BIOETHICS COUNSULTATION SCHEDULES THREE CONFERENCES

The newly established Society for Bioethics Consultation has scheduled three regional conferences regarding "Ethics Consultation in Health Care" for St. Louis, Missouri (September 13-15, 1987), Danville, California (December 13-15, 1987) and Baltimore, Maryland (March 20-22, 1988). These conferences, which will be identical in format and faculty, will be of assistance to ethicists, attorneys, social workers, clergy, as well as medical professionals who serve as ethics consultants in clinical settings. Participation in each conference is limited to one hundred twenty persons on a first-registered-first-served basis. For further information, please contact The Society for Bioethics Consultation at P.O. Box 10145, Berkeley, CA 94709 (415) 486-0626 or John C. Fletcher, Bioethics Program, National Institutes of Health, Bethesda, MD 20205 (301) 496-2429.

HARVEY COX LAUNCHES ADVENTISM AND ETHICS SERIES

October 24

Harvey G. Cox, Jr., Victor S. Thomas Professor of Divinity at Harvard Divinity School, will launch a series of public discussions entitled: "A Righteous Remnant: Adventist Themes for Personal and Social Ethics" on Sabbath, October 24, 4:00 p.m., at Loma Linda University Church. The series is presented by LLU's Ethics Center and University Church with assistance from the Glendale Seventh-day Adventist Church. The programs, which will result in a book of scholarly essays, is coordinated by Charles Teel, Jr., Chairman of LLU's Department of Christian Ethics.

The purpose of these discussions, which will occur at regular intervals throughout the 1987-1988 school year, is to explore the moral assumptions and implications of Seventh-day Adventism's central convictions. These theological themes include: remnant, creation, covenant, salvation, sanctuary, Sabbath, law, freedom, wholeness and hope. Most sessions will include a presentation by a Seventh-day Adventist ethicist plus two critical responses, one from an Adventist point of view and another from an alternate theological perspective. Presenters and responders will examine the history and development of the theme in Adventist experience and then probe its relevance to contemporary issues in personal and social ethics.

Martin Marty, F. M. Cone Senior Professor at the University of Chicago and Senior Editor of *Christian Century,* will present the final lecture of the series on June 4, 1988. The presentations by Cox and Marty will appear in the published anthology as the book's "foreword" and "afterword." The presentations by the Adventist ethicists will comprise the volume's center chapters.

CONFERENCE PROBES "HUMANITY" OF RESIDENCY PROGRAMS

The June Medicine and Society Conference prompted intense discussion. "Residency programs are totally and dramatically destructive by virtue of their sheer hour demands — destructive in physical, mental, social, emotional and spiritual health," contended Clarence Schilt, LLU campus chaplain, recounting conversations with residents and their spouses.

On the other hand, the only thing worse than residency programs would be no residency programs, stated Bruce Branson, chairman of LLU's Department of Surgery and Ethics Center board member. "Society grants to physicians enormous decision-making powers of life and death which it gives to no other group, and this exacts a price and is very serious business," Branson contended. These audience comments typify the lively conversation that followed the panel discussion and continued in pockets of debate throughout the amphitheater.

The panel consisted of five Loma Linda physicians: Gordon Thompson, Director, Graduate Medical Education; Steven Herber, surgery resident; Robert Spady, internal medicine resident; Ralph Thompson, Surgery Department; and James Couperus, Internal Medicine Department.

Gordon Thompson set the context for discussion by sharing the results of a recent survey of LLU medical residents. "Loma Linda has failed to live

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Active Voluntary Euthanasia: Is It Moral?

YES!

Joseph Fletcher

Ladies and gentlemen, tomorrow I will have my 82nd birthday and, by the Chinese method of calculating human ages, that means I'm entering my 83rd year. I feel I have little time left to waste on the noncontroversial. I would like, maybe greedily, to be at the growing edge of things where we still have not reached anything like a consensus. Our problem is precisely of that sort. It's highly troublesome to patients, their families, physicians, nurses, legislators, courts and churches. I feel not in the least apologetic for bringing this issue before you quite explicitly, with Dr. Conolly's help as a negative examiner of the problem.

An editorial in the *Journal of the American Geriatric Society* recently caught my attention. (I suppose that at 82 I am somewhat geriatric myself.) The editor, Dr. Gene H. Stollerman, was calling upon physicians to try to be, as he put it, "stewards" of their dying patients when the battle for life has been fought and either lost or conceded. Well, more than that, Dr. Stollerman asked physicians to make their decisions *loving* decisions — not just accurate or correct, not even just sympathetic or empathetic decisions.

"I feel I have little time left to waste on the noncontroversial."

In *Roget's Thesaurus* we find a lot of synonyms for "loving" — terms such as goodwill, benevolence, charity, mercy, caring, and humaneness. The term in this list that I want to stress is "to smooth the bed of death." Think for a moment what it means to smooth the bed of death lovingly. When doctors and nurses truly love their patients, they respect their rights not just because rights may happen to be legally reinforced, but because rights — morally valid claims — are surely an essential part of loving concern. One of these rights is the right to die, the right to choose to die.

Our discussion concerns the question: What is the right to die? Is it, for example, only the right to be allowed to die by stopping treatment or through some such maneuver? Or is it the right, more positively, to be helped to die when one has freely chosen to die?

I want to contend that the right to die, if we look at it lovingly and not just legalistically, ideologically or selfishly, entails helping as well as allowing. If, for example, a patient makes it clear that he or she does not want to go on living — for example, one who may have fallen into an irreversible coma, an incurably nonsapient, vegetative state — then I contend that his family, his physicians, and his nurses should end his life. They should not simply look on passively and provide comfort and care and cease treatment. Rather they should use some active means such as withdrawing nutrition and hydration. These need not be artificially provided in such a case. Starvation and inanition or some quicker means such as a lethal injection could be employed. There is, I contend, nothing loving about dragging out dying for hours and even days.

"The right to die entails helping as well as allowing."

Newspapers and magazines, court and congressional records, and medical and philosophical journals discuss this problem more and more. Opinion polls show a significantly increasing approval not only of passive euthanasia but also of active euthanasia — *helping* to die, not only *allowing* to die. With the enormous advances of resuscitative medicine, families are confronted every day with the heartbreaking, headache-making question: At what point can we say we have passed from prolonging living to prolonging dying? The distinction between letting a patient die and helping or causing a patient to die is, I would like to say, empty — rationally vacuous — when it is morally examined. Whether the physi-

**Joseph F. Fletcher, Ph.D., and Matthew E. Conolly, M.D., debated active voluntary euthanasia in a gentlemanly fashion at LLU on the evening of April 8. James Walters served as moderator. A condensation of the addresses and interchange follows; space limitation does not allow inclusion of audience participation. A booklet of the evening's full proceedings is planned. Videotapes of both the euthanasia debate and a lecture delivered earlier in the day by Fletcher, "Management of Terminal Illness," are available from Media Services, LLU Libraries. for $25.00 each. Joseph Fletcher, educator, clergyman and ethicist, served for many years as Professor of Pastoral Theology and Christia Ethics, Episcopal Theological School, Cambridge, Massachusetts, and later, as Visiting Professor of Medical Ethics, University of Virginia. Professor Fletcher's many books include* Morals and Medicine *(1954),* Situation Ethics *(1966), and* Humandhood: Essays in Biomedical Ethics *(1979). Matthew Conolly is Professor of Medicine and Pharmacology, School of Medicine, University of California at Los Angeles. After receiving his medical training in London, Dr. Conolly served as Advisor to the House of Lords' Committee Against Euthanasia.*

cian simply stops treatment or whether he actually ends the patient's life by direct means, in either case the purpose is precisely the same — to bring the patient's life to an end.

Active euthanasia is addressed in a recent guideline from the judicial council of the American Medical Association. This guideline (not a law) allows physicians not only to stop treatment but to suspend food and liquids to make sure the patient dies, even though death from so-called natural causes might not be expected to ensue for another twenty years. The language of the judicial council's report on this question is: "Whether death is imminent or not." This clearly moves beyond passive euthanasia, conceived to be "letting" a patient die without further medical intervention. The purpose is the same in either passive escape from unendurable life or an active release from it — the ending of a life that is no longer wanted by the patient.

Euthanasia is only morally and ethically acceptable if it is voluntary, if it is desired by the essential decision-maker in

"The distinction between letting a patient die and helping or causing a patient to die is empty — rationally vacuous."

the medical situation. This decision-maker is the patient, as the courts have made abundantly clear. Physicians who resist or drag their feet are guilty of medical paternalism. That is to say, they ignore the patient's autonomy, the patient's moral and legal right to refuse treatment. Now the sad truth is that physicians commonly obstruct the right to die. I say this knowledgeably from within the medical community. The feelings of physicians, their visceral perceptions and insights, attitudes and sentiments have not kept up with their skills, capabilities and advanced competencies.

It's no longer true that death is the enemy. Now the enemy is often a subhuman existence brought about by resuscitative medicine such that death is to be preferred to life. There is a long list of cases in which the courts, mostly appellate or supreme courts, not primarily trial courts, have found it necessary to rule explicitly against physicians and hospitals that

"Euthanasia is only morally and ethically acceptable if it is voluntary."

have tried to keep patients alive against their will. The list includes the Barber, Bartling, and Bouvia cases here in California. In the Bouvia case, one of the justices at the appellate level in the second division added to the decision that physicians and/or others besides physicians (i.e., a friend or some member of the family) should help to make such deaths as painless and quick as possible. This justice added that, of course, this recommendation knowingly violates a section of the state penal code which forbids anybody to aid and abet suicide.

This is exactly the word for it — "suicide." Suicide is choosing to die rather than to go on living. All over the civilized world, suicide, at last, quite effectively has been decriminalized. But it has taken roughly a half-century to get it done because of the reluctance of the conventional wisdom to adjust to new technical and scientific realities. It may take another half-century to decriminalize assistance in suicide. The tension between taboo and rational decision-making is a constant problem, inevitably and understandably so, for thoughtful and loving human beings. But, I am personally convinced that in that tension reason will win out, both as public policy and conventional wisdom. The fundamental conflict at

"The fundamental conflict is between those who are concerned about the quality of life and those who believe in the sanctity of life."

work in all of these questions about death and dying is between those who are concerned about the quality of life and those who believe in the sanctity of life or even, in the case of some religiously motivated persons, the sacrosanctity of human life. To say it bluntly, we all must decide whether mere biological function is worth enduring at the cost of constant and inescapable suffering, vegetative and nonsapient states, or the personality regression and degradation that goes with the diminution of vital signs and the loss of normal function. What good is achieved by forcing such patients to go on breathing against their will?

It seems to me that our problem is ethically searching and emotionally uncomfortable, and particularly so for professionals whose basic commitment is to healthy life and its defense

"Euthanasia is beginning to be trotted out as a bumper-sticker solution."

and protection. This is, of course, the essence of the commitment of people in the health professions and the healing professions in general. Yet it is medicine itself, especially in its resuscitative capabilities, which has posed the question in our time and will increasingly do so in the future: Where, when and why should we stop prolonging life, and should we help people with their dying as well as help them with their living? I'm told that Dr. Conolly, bless his heart, has another view; and I hope I've stopped soon enough to allow him time to expound it. Thank you.

NO!

Matthew Conolly

I must congratulate you, sir, on looking so well at 82. I shall be exceedingly pleased if at 82 I look and think as well as you do now. Having just been treated to such a philosophical tour de force, I apologize for immediately reducing this discussion to the level of bumper stickers.

In confronting the awfulness that terminal illness can represent, I'm afraid that euthanasia is beginning to be trotted out as a bumper-sticker solution to this problem. It's my belief that, far from being a solution worth having, it's a Pandora's box of woes that's worse than no solution at all. Now let me make it quite clear because of the thrust of the points which

Professor Fletcher so eloquently made, that I am not arguing for staving off inevitable death at the cost of extra pain. Rather, I see us needing to raise the level of the care we offer the terminally ill so that euthanasia no longer becomes an issue. I'd like to give eleven of the more obvious reasons why we shouldn't even contemplate active voluntary euthanasia:

1. Such legislation will open doors that we will never be able to close again. We've seen in the context of abortion that once the principle of the inviolability of the fetus is compromised, exception after exception is demanded. Step by step the indications were expanded until between one and two million viable fetuses are destroyed each year in this country alone. Since we are dealing with an issue of the life and death of mankind, I think it's fair to draw this parallel. If euthanasia is available for one, it has to be available for all; and in the light of what happened to abortion, I have no confidence in any so-called safeguards that might be built in.

"I see us needing to raise the level of care we offer the terminally ill."

I do not disdain the slippery-slope argument against euthanasia. But whether it be a slope or a precipice we're being asked to walk over, I'm a devout believer in gravity. There's only one place we'll end up — right at the bottom. We need to remind ourselves that the obscenities of the Third Reich did not begin with the gas chambers of Dachau and Auschwitz. Somebody has said of that episode of human history that the infinitely small lever from which this entire trend received its impetus was the Nazis' attitude toward the incurably ill.

2. My second reason for opposing euthanasia concerns the appalling price of medical care in this country and the very inadequate means some people have of meeting these costs. This more or less guarantees that if the option of legalized active euthanasia existed, many would be obliged to take that route. I think that the people most vulnerable to this artificial necessity would include the old, the unwanted, the poor and numerous ethnic groups — people on the lower economic rungs of our social ladder. I'm afraid that current health planning, based as it is on rational principles and economy and not on human compassion and respect for human life, is pushing us inexorably in that direction.

"The obscenities of the Third Reich did not begin with the gas chambers of Dachau and Auschwitz."

3. There are many very special people who throughout their lives and even in their terminal weeks and months are thinking of other people before they think of themselves. Once euthanasia has been unleashed, a terrible burden will be placed on them. They will feel that to save their relatives emotional trauma, expense and trouble, maybe they ought to do away with themselves.

4. There's a matter of trust which at present undergirds the doctor-patient relationship. I think this will necessarily be eroded if in any way the doctor has the power to administer some kind of legalized coup de grace.

5. The fifth argument is that patients are rarely isolated persons. Like all of us, they're a part of a web of human relationships. If the patient's family situation is anything like mine, within that web there are all sorts of quarrels that need settling, sins that need forgiving, reconciliations that need to be made. Experience has shown that the last weeks or months of a patient's life can be a time of enormous healing, crucial to the peace of mind of the dying patient and absolutely essential for the relatives who must cope with the bereavement process. To cut this short by euthanasia, say those who work in terminal care, would do great harm.

6. Those who counsel the relatives of the more conventional suicide victims all attest to the feelings of guilt which haunt surviving relatives. It's hard to see how this would be any less the case with euthanasia. The feeling that if only they'd been more loving, if only they'd been more supportive, if only . . . if only . . . if only. . . .

7. History is littered with diseases that we once thought incurable. To adopt euthanasia will take much of the urgency out of the research community. Do you think we would have made so much progress so quickly in learning about AIDS if this disease, once having been recognized as incurable, had been managed by a program of compassionate slaughter?

8. My eighth argument against euthanasia springs from my recollection of what the legalization of abortion did to many of my contemporaries who had set their hearts on a career in obstetrics but who had moral objections to abortion. Regardless of the lip service paid to the conscience clauses built into those laws, for them the field of obstetrics was forever closed. If euthanasia is to be legalized, it inevitably will require medical participation. Then I feel large areas of medicine are going to be closed to people who feel, on grounds of conscience, that they cannot take part in these activities.

"Many will feel that to save their relatives emotional trauma, expense and trouble, maybe they ought to do away with themselves."

9. Contrary to what I'd been led to believe as a medical student, "M.D." stands only for Doctor of Medicine, not for Mind of the Deity. I prefer not to overly talk about it, but doctors do sometimes make mistakes. Not a few patients at autopsy have been found to have died from some entirely treatable condition. What a tragedy if we actually performed an act of euthanasia because of some mistaken diagnosis!

10. For the theists there's another problem. For them life is a gift from God to be held in trust until taken back by the Giver. To choose death as an end in itself is to throw the gift back into the face of the Giver. If, as the Bible teaches, death is the last enemy, then to choose death for its own sake turns our last conscious act into one of desertion to the enemy, an explicit profession of distrust in the Lord of life.

11. And finally my last reason. The call for euthanasia is based on the notion that the terminally ill are bound to suffer horribly and that this suffering can only be relieved by death. Like all the lies and half-truths of Dr. Goebbels, this is in danger of being believed if only because it is trumpeted so

loudly and so often by the well-meaning souls of the Hemlock Society and their kindred spirits. But it is, nonetheless, a false premise. At least it is false in the sense that it does not have to be so.

Pain looms large in the thoughts of most people and larger in the arguments of those who would have us adopt euthanasia. In fact, pain is *not* the most common symptom in patients dying of cancer. Fully one-third of those people never have any pain at all. Dr. Cicely Saunders, founder of the modern hospice movement, talks about total pain and she describes four components: social, spiritual, mental and physical pain.

"To adopt euthanasia will take much of the urgency out of the research community."

Social pain can arise as a patient contemplates the world as it will be when he is no longer there. If he is the provider of his family, has he done enough? Will his family have to live in reduced circumstances? Here, I think, we have to help our patients put their affairs in order. If there are social services, get them mobilized.

"Doctors do sometimes make mistakes."

Spiritual pain speaks for itself. Ours is not an age that will be remembered for the depth of its spiritual insights. Most people nowadays do not consider the eternal order of things until it becomes clear that their immediate future is bound up in it. And I do not suggest that terminal care is a field for aggressively proselytizing people. I think our attitude has to be one of complete tolerance for the religious and irreligious alike. Nonetheless, there is great comfort in life's darkest hours in the Psalmist's affirmation: "Yea, though I walk through the valley of the shadow of death, I will fear no evil, for Thou art with me." If we can share this with our patients, well and good. If not, we need at least to be positioned to direct them to a priest, pastor, or rabbi of their own choosing.

"Life is a gift from God to be held in trust until taken back by the Giver."

Mental pain must arise especially in the minds of those who die young. A man I recently treated was deeply and understandably distressed at the thought of the two young children he was leaving behind. To be sure, there is little we can do about the fact of the patient's impending death. But standing by them means more than we often realize.

Concerning the control of physical pain, there's a lot we can offer. We have to begin by determining the origin of the patient's pain. Maybe one patient in five has only one cause for pain. There's a skill to be learned in managing these patients. Surveys in places like St. Christopher's Hospice, where patients are admitted because they have particularly severe distress from pain, show that of those selected, fully 95 percent of them can, given time, get virtually total control of their pain. That leaves a residue of five percent, and even they will get some relief.

I will conclude by quoting from Cicely Saunders. She writes: "When I took the former chairman of the Euthanasia Society around St. Joseph's Hospice, he came away saying, 'I'd like to come and die in your home.'" Dr. Saunders continues: "I do not believe in taking a deliberate step to end a patient's life, nor am I ever asked to do so. If you relieve a patient's pain and if you make him feel a wanted person, which he is, then you are not going to be asked about euthanasia."

"Ours is not an age that will be remembered for the depth of its spiritual insights."

I think euthanasia is an admission of defeat and a totally negative approach. One should be working to see that it is not needed. And that, ladies and gentlemen, I think is one of the big ethical challenges of the next decade. If we fail, God forgive us; for history will find it very hard to forgive. Thank you.

DISCUSSION

James Walters: Gentlemen, thank you for delivering your insightful and persuasive points of view. First, Professor Fletcher, would you like to respond to Dr. Conolly's arguments?

Joseph Fletcher: Mr. Chairman, one of the questions I would dearly love to hear Dr. Conolly explore is whether I am right in my feeling — my perceptions — that although most of his time was devoted to what he regards as truly pragmatic objections to active euthanasia, fundamentally, he is opposed to euthanasia for the same reason he opposes abortion.

"For me the primary good is human well-being."

That is to say, Dr. Conolly, you believe suicide — an important element in the euthanasia case — is wrong and abortion is wrong, because they are against the divine and the natural law. Fundamentally, the issue between us may not be which ones of your pragmatic arguments are sound enough and which ones of mine are sound enough, but whether we aren't both coming from a totally different world view to start with. For me the primary good and primary value is human well-being. This includes not only negatively expressed avoidance of physical suffering but also avoidance of all the other kinds of suffering that often afflict people in *extremus*. I think you are primarily moved by your church's teachings, but that may not be an acceptable kind of question. I'm being greedy about this. I want to pick your brains and your mind, and hear how you would respond to that. That may be the most significant question.

Also, under the heading of the pragmatic objections to voluntary euthanasia in your list, you highlighted "slippery-slope" objections. I would say that slippery-slope argumentation is

really not argumentation. It's not reasoning, and it's often quite irrational. It's just an expression of a sentiment and an attitude. It may be a genuine attitude and not without some kind of authentic history to justify it, but in moral theology — in your own church, for example — for centuries it's been an important guiding principle that the abuse of a thing does not bar its proper use. I contend that "crying wolf" when new problems seem to call for new positions is simply not good enough.

"Slippery-slope argumentation is just an expression of a sentiment."

I would also want to say that the Nazis were not interested in euthanasia in the sense we're discussing. They cared nothing about our strong principle that euthanasia should be a voluntary act. They were not interested in voluntary acts. They imposed death on masses of people. It's a horrible tale, but it has no relevance to what we're talking about, as most of the historians of the Holocaust themselves are careful to point out.

Another pragmatic objection: You expressed a belief, not just a fear, that if voluntary active euthanasia were ever practiced, however infrequently, medical research would end. I honestly don't see why you think that. I would say that's a psychological feeling. Time after time medicine has learned, but never satisfactorily enough, to develop capabilities for

"The Nazis were not interested in euthanasia in the sense we're discussing. They were not interested in voluntary acts."

dealing with problems. The work for research is, if possible, to obviate the problem altogether. It would be tremendous if we could obviate the question, "Is this patient in such a state that the more humane and loving thing to do would be to end his life or let him go?" Let's hope that, more and more, medical science will be able to narrow down the range of situations in which such a terrible decision has to be made. The question of whether scientists will stop trying to obviate these problems suggests to me just the opposite. I think that if we find many cases where this is still an appropriate question, medical science will be determined to reduce the number even more.

James Walters: Dr. Conolly, do you care to comment on Professor Fletcher's response before we enter into more informal dialogue?

Matthew Conolly: First, I will respond to your objection, Dr. Fletcher, that I am only saying the things I'm saying because I have a certain theological stance.

As best I understand my own heart and mind, that is not the case. I don't deny that a certain set of religious beliefs is important. Incidentally, despite my Irish name I'm not a Catholic. Like you, I'm Episcopalian by upbringing. But I think, if one can set such a momentous and fundamental thing aside, I would be persuaded by at least some of those other reasons I advanced.

I agree, as you politely pointed out, that some of my reasons are weaker than others. However, I would certainly be persuaded by some of those reasons that euthanasia is not a path that I want to follow. I take your point that in some respects the way in which the Nazis applied their philosophy was rather different from what you're proposing. But I think we must not overestimate our own moral purity, and I think our capacity for following the same kind of path is there. We need checks and balances in everything we do. Santayana is credited with saying that those who refuse to learn the lessons of history condemn themselves to repeat it. So I like to have my feet on level ground.

As to the frequency with which this would come to be applied, I'm not sure it is that infrequent. I find it very sad to look at Holland now. During the Nazi ravages of Western Europe the Dutch were heroic in the extreme as they resisted Nazi attempts to make them collaborate in various attacks on

"Despite my Irish name I'm not a Catholic. Like you, I'm Episcopalian by upbringing."

human life. Some even laid down their own lives rather than collaborate. Now I find it very sad that that same nation should be the vanguard of the euthanasia fleet in Western Europe. The number of patients who have been "put down" — or whatever word one uses for euthanasia — in the last few years in Holland already runs into the thousands. We're not talking about the odd dozen cases. So it is a product for which there is a ready market. I'm afraid we may be surprised, just as we were surprised by the number of abortions done.

Who would have thought that millions of abortions would be legalized? I don't think it was ever in the minds of the Supreme Court justices who handed down the decision *Roe v. Wade,* and I know it was not the intention of the people who enacted legislation permitting abortion in England in 1967. Abortion was very much argued for cases of pregnancy arising out of incest and rape, both of them exceedingly rare causes of pregnancy. Abortion is now used to modulate the effect of promiscuity in the social scene at large.

You use two phrases as though they meant the same thing. You talked about helping a patient end his life, and you talked about letting the patient go. I do not think these are the same thing. This gets us into the discussion of the term you used earlier — passive euthanasia — a term which, to me, is an oxymoron if ever I heard one. It's like a "thunderous silence" — a contradiction of terms. I think there's a great deal of difference, morally and medically, between devising a therapeutic, life-saving, life-prolonging strategy which will improve the patient's symptomatic comfort, and deliberately ending the patient's life. I do not believe attending to a patient's symptomatic comfort can be equated with a deliberate step to end the patient's life in order to relieve his discomfort.

In the end the patient will die; we'll all die sooner or later. But I think that if we say it's inappropriate to continue giving this patient chemotherapy because he is not responding and the side effects are unacceptable, then our treatment should be to give him morphine to relieve his pain. I do not see this as being the same thing as deliberately taking a syringe, loading it with who knows what, and injecting it in order to kill him. I think the intended ends are morally different.

Joseph Fletcher: When we do something with a given object in mind, we may use different methods of contriving success, and they may be direct or indirect methods. But the same end is being sought in both courses of action. I would say, therefore, there is, ethically speaking, no difference between them.

Matthew Conolly: This is where I disagree with you. I don't think the same end is being sought. If I relieve your pain, you may die. Actually, you won't die sooner because I give you morphine to relieve your pain. You'll probably live a little longer because the physiological stress of unrelieved pain is definitely, as the Surgeon General would say, harmful to your health. But my object is to relieve your pain, not to kill you, whereas the contents of that other bottle are intended only for one thing — to kill you. I feel there's an essential difference.

"We must not overestimate our own moral purity."

Joseph Fletcher: You're adverting to the problem of double effect in ethical analysis. I understand what the rule of double effect is, and it certainly has its bearing here. All I'm saying is that a physician who wants to help a patient with a terminal illness or one who is permanently nonsapient — vegetative — to end it all because he's got reason to believe that's what the patient wants, should be empowered to do so. The courts are clear in these cases; if there is no evidence that the patient wants it, you can't impose it on him, and I would certainly agree. We're talking about voluntary, active euthanasia. In such a hypothetical case, whether you decide to bring an end to that patient's life by indirect means or direct means makes no difference. You're going after the same thing; you're trying to achieve the same result: you want the patient dead. Why do you want the patient dead? In the case of active voluntary euthanasia, you want the patient dead because the patient thinks that is preferable to going on living under these conditions. Immanuel Kant's true and somewhat witty observation is that if you will the end, you will the means. But there are those who insist there is an ethics of means as well as an ethics of death, and I disagree with that.

"The number of patients who have been 'put down' in Holland already runs into the thousands."

Matthew Conolly: If it were my objective to terminate the patient's existence, I think I would agree with you. I maintain that the end I seek is different. There may come a time when I can no longer stave off the patient's disease, and by my standing back death occurs. It would occur anyway even if I stayed in there with chemotherapy. I'm not seeking that end. That end has come. The patient has lived his life, and it is time for him to depart. All I'm seeking to do is to make that terminal phase comfortable and, if possible, useful to him. In the case of the comatose patient, of course, I have no means of knowing what he thinks or if he thinks.

Joseph Fletcher: You might have, as in the Brophy case.

Matthew Conolly: Well, as I understand the Brophy case — and I have not read deeply into it — there was a lot of controversy about whether he was conscious and unable to communicate or whether he was unconscious.

Joseph Fletcher: Oh, no. I think there was agreement in the minds of the jurists and the minds of Mr. Brophy's family that the record — his constantly repeated statements before this ever happened to him — showed that in no way did he want to go on living in a nonsapient condition. He wanted it ended. The courts, up to this point, would never reverse a lower trial court on these cases unless they were quite convinced that the patient wanted this to happen. They are very clear about that. They are rigorous in demanding that termination of life must be voluntary.

James Walters: Dr. Conolly, since Professor Fletcher began this friendly debate, it is fair that you have the final word.

Matthew Conolly: I'm not used to having the last word in such distinguished company. I think all I would say in defense of my own profession is that, as Dr. Fletcher pointed out, our wisdom in action has been left way behind by the advance in our skills. We're not alone in this, of course. The politicians are faced with exactly the same dilemma regarding nuclear weapons. Also, where we have human agencies involved — M.D.s or not — there are going to be mistakes. I think that no matter how carefully we balance our judgments, no matter how hard we listen to our consciences, there will be times when we will later realize that we did the wrong thing.

"Passive euthanasia is an oxymoron if ever I heard one."

I am grieved by the thought that the medical profession is exerting a kind of paternalism: "I'm a doctor and I've got a stethoscope, and I will decide what's best for you with the aid of my guessing tubes." I think we really don't intend this, if I can speak for the medical profession. Increasingly over the last two or three decades the medical profession has realized the rightness of involving patients in their own therapeutic decisions, not just in the terminal phases. If a man's got hypertension, I want him to get his own blood pressure machine, or, if he's a diabetic, I like him to measure his own blood sugar and monitor his therapy.

I think we find ourselves caught in a vice of society's making. For a long time now, the lawyers have regarded the medical profession as a kind of milk cow that can be gone to time and time again for endless dollars, and it's not surprising if the medical profession is wary. If people feel that physicians are refusing to give up in the face of all reason but flogging on to the bitter end, to some extent society has only itself to blame. I hope that any arrogance and stupidity in me and my professional peers will be explained to us and we will be helped to deal with it. But when this happens, please have pity on us; we're not solely responsible for it.

James Walters: Thank you, Drs. Conolly and Fletcher. I am impressed by the civility of the debate of gentlemen from the Anglican tradition. Some of us from other traditions might learn from what has gone on here this evening.

Update

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CONFERENCE *continued from page 1*

up to its most basic goals. It teaches residents to put family, friends and God on hold until the residency is completed. Some learn so well, they keep right on doing it," responded one resident. Thompson's survey showed attitudes at LLU similar to those revealed in national studies. One recently published study of stress in medical residencies stated that over 40 percent of respondents experienced serious problems with their spouses or partners during their residency programs.

Herber and Spady shared from their current experiences. Herber was thankful for good social support but confessed that his program left little time and no energy to address non-medical concerns. One of Herber's colleagues felt imprisoned when confined by one hundred continuous days of house staff service. Another lamented to Herber the throes of working for four days without sleep. Spady stated that his first priority is personal health and family. He copes with inadequate time by spending less time with "difficult" patients, giving less time to patient education and limiting professional advancement activities.

Ralph Thompson put contemporary residency programs into historical perspective. At Johns Hopkins in the 30s, medical residents lived in the hospital, and marriage for house officers was discouraged. Thompson acknowledged the need for further reform, but he emphasized the need for serious commitment to patient health.

A "former burned-out resident," was Couperus' self-description. "Are residencies stressful? They are intended to be! Residencies involve the compression of important learning experiences into a short time. Never will so many kinds of illness be seen by a physician. This is the pathophysiology of a resident's stress." Ideally only students who can handle stress will study medicine, he suggested. Second best, those students with low stress thresholds can be identified and successfully persuaded to take less stressful specialties, Couperus argued.

Although the panelists agreed that some changes are necessary, no one questioned the need for residency programs or offered concrete suggestions for improvement. New York state is currently considering legislation to limit the number of continuous hours which a resident may legally work. Such legislation, if passed, could result in residents having an easier lot than some attending physicians. Ralph Thompson suggested that the life of a post-residency physician is the real challenge. Spady confessed that his attending physicians are equally busy.

Although financial problems and personal health are important, the topic receiving primary attention in audience discussion was the resident/spouse relationship. Comments ranged from the need of a spouse to make a co-commitment to the physician's calling and strenuous life to a decrying of the inhumanity of the total program. Couperus was likely speaking for a majority of physicians present when he stated that the difficult regimen surely leaves some physicians impaired for life, but that stress is intrinsic to the practice of medicine. Better coping mechanisms must be taught as further modifications are made in residencies themselves.

A RIGHTEOUS REMNANT
ADVENTIST THEMES FOR PERSONAL AND SOCIAL ETHICS

Matheson Chapel/12:00 Noon
Loma Linda University Church/7:30 PM

October 24, 1987
FOREWORD
Harvey Cox
Harvard Divinity School

October 30, 1987
REMNANT
Charles Teel, Jr.
Loma Linda University

November 20, 1987
CREATION
Jack Provonsha
Loma Linda University

January 8, 1988
COVENANT
Michael Pearson
Newbold College

February 12, 1988
SANCTUARY
David Larson
Loma Linda University

March 11, 1988
SABBATH
Miroslav Kis
Andrews University

April 1, 1988
LAW
James Walters
Loma Linda University

April 15, 1988
SALVATION
Charles Scriven
Sligo Seventh-day Adventist Church

April 29, 1988
WHOLENESS
Ginger Harwood
Iliff School of Theology

May 13, 1988
MILLENNIUM
Gerald Winslow
Loma Linda University

June 3, 1988
COMING
Roy Branson
Kennedy Institute of Ethics

June 4, 1988
AFTERWORD
Martin Marty
University of Chicago

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