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Update - June 2011

Loma Linda University Center for Christian Bioethics

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Recommended Citation

Loma Linda University Center for Christian Bioethics, "Update - June 2011" (2011). *Update*.
<http://scholarsrepository.llu.edu/update/86>

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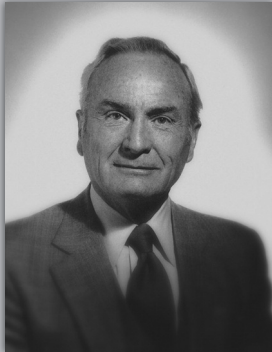


LOMA LINDA UNIVERSITY

Center for Christian Bioethics

UPDATE

JUNE 2011



2012 Jack W. Provonsha Lecture opens the Alumni Postgraduate Convention

Mark your calendar for Friday, March 2, 2012, when the Center for Christian Bioethics presents the Jack W. Provonsha Lecture, "International Medicine and Human Rights." Dr. Gilbert Burnham, co-director of the Center for Refugee and Disaster Response at Johns Hopkins, will deliver the lecture.

Dr. Burnham has an extensive background and experience in both national and international emergency preparedness and response, particularly as it pertains to humanitarian needs assessment, program planning and needs evaluation of vulnerable populations, and the development and implementation of training programs. One of his current activities is the reconstruction of health services in Afghanistan.

All are invited to attend the lecture and the panel discussion that will follow. Continuing medical education (CME) credit will be offered for the lecture. More information will be coming, or you can contact the Center for Christian Bioethics at bioethics@llu.edu.

CLINICAL BIOETHICS AND RELIGION:

ROBERT ORR'S *MEDICAL ETHICS AND THE FAITH FACTOR*

Review

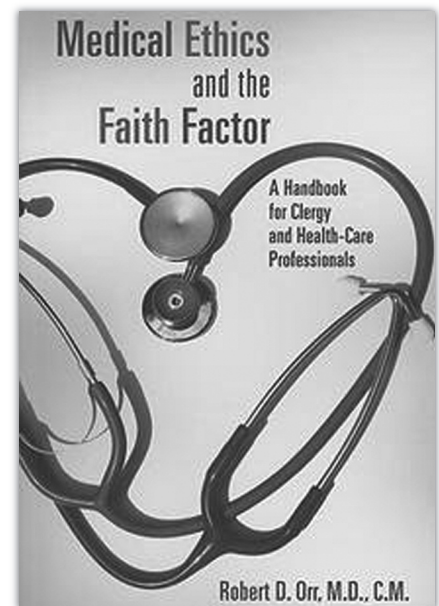
FORGING A PATH FOR CHRISTIAN ETHICS

Daniel P. Sulmasy, MD, PhD

Clinicians and clergy alike deal with concrete cases. Theological erudition can contribute to an understanding of cases, and important cases can provide important feedback for theological theory. Nonetheless, when the rubber of ethics meets the road, it is always traversing the cobblestone of cases.

Robert Orr has assembled an impressive array of concrete cases in this book. Unlike most casebooks that are assembled by theorists and are designed to evoke controversy and provoke debate, Dr. Orr's cases are moral quandaries, not dilemmas. The book provides a compendium of the real cases that clinicians and patients commonly face, and about which clergy are often asked to provide advice, whether as pastors or as chaplains. This collection is thus extremely useful from the perspective of practical pedagogy—because rather than posing intractable and unanswerable problems, Dr. Orr presents cases for which there really are best answers.

I cannot overemphasize how valuable it is that the cases he presents are drawn from real clinical cases. They are not trimmed down to the bare abstract essentials, but full of the uncertainty, the com-



plexity, the drama, and the pathos of real-life clinical ethics. While adhering in each case description to a general need for brevity and employing a uniform structure for ease of reading and cross-reference, Dr. Orr describes the uncertainty regarding diagnosis, treatment and prognosis, the disagreements among consultants, the arguments among family members, the clashing of secular and religious worldviews, and the twists and turns that characterize real cases. So, for instance, in

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EDITORIAL

LET US NOW PRAISE A GOOD MAN

The focus on Robert Orr's work in this issue of **UPDATE** honors both Dr. Orr and clinical bioethics carried out from a religious perspective. Dr. Orr's career is intertwined with bioethics, clinical ethics, religious traditions, and Loma Linda University's early involvement with all three.

In his 1971 book *Bioethics*, the author Van Rensselaer Potter claimed that he had just invented a new word and a new academic discipline. Many of the early writers in the field were theologians, such as Paul Ramsey, Albert Jonson, Richard McCormick, and James Childress. Roman Catholics established the first two principal centers of bioethics in the United States: The Hastings Center, established by Daniel Callahan, and the Kennedy Institute of Ethics, begun by Andre Hellegers. Quickly, philosophers joined the discussions.

As early as 1973, a sub-specialty emerged. Mark Siegler and his mentor, Alvan Feinstein, both at the University of Chicago, developed the term "clinical ethics," to describe moral analysis a) focused on medical cases, and b) based on "the nature and goals of medicine rather than from ethical theory based on philosophy, theology, or law." During 1989-1990, a physician from New England, Robert Orr, joined Dr. Siegler for a year's study of clinical ethics. From there, Dr. Orr, a lifelong churchgoer, went directly,

in 1990, to Loma Linda University, a faith-based health care university.

By the time he came to Loma Linda University, ethics had already become established and highly visible in the medical school. Jack Provonsha, an MD, an ordained minister, and a PhD in ethics, had created ethics courses on campus and held the first Bioethics Grand Rounds in the medical school. With the help of two young PhDs in Christian ethics, David Larson and James Walters, Dr. Provonsha carried on informal consultations on clinical cases, establishing the Center for Christian Bioethics in 1974.

Dr. Orr's arrival at Loma Linda University (LLU) from the University of Chicago brought greater visibility to clinical ethics. He became not only clinical co-director of the Center for Christian Bioethics, but also the first director of clinical ethics at LLU Medical Center. For a decade, Dr. Orr led an expanding number of formal ethics consultations with physicians in the services of the medical center, and he helped clinicians and others earn MA degrees in biomedical and clinical ethics.

During Dr. Orr's first decade at Loma Linda University, and in the years since, he has written and lectured widely. The most recent of his six books, *Medical Ethics and the Faith Factor*, not only draws on the theological resources that nurtured the beginnings of bioethics, but as its subtitle indicates, has been written as *A Handbook for Clergy and Health-Care Professionals*. Appropriately, the appear-

ance of the book coincides with his receiving the Servant of Christ Award from the Christian Medical & Dental Associations.

During the last two years, Dr. Orr has again led clinical ethics at the Loma Linda University Medical Center and helped direct the Center for Christian Bioethics. It has been a joy to know Bob both as a colleague and friend. This July, he completes his second tour of service at the center and moves to new responsibilities.

The center is delighted to devote this issue of its publication, **UPDATE**, to the work of our distinguished colleague. We are honored to include a review of his latest book by one of the founders of both medical humanities and bioethics, Edmund Pellegrino, MD, director of the Center for Clinical Bioethics and a former director of the Kennedy Institute of Ethics, both at Georgetown University, and a former president of the Catholic University of America. Dr. Pellegrino is joined as a reviewer by Daniel P. Sulmasy, MD, PhD, the present associate director of the MacLean Center for Clinical Medical Ethics at the University of Chicago, one of Dr. Orr's alma maters.

Dr. Robert Orr has enriched Loma Linda University and the field of bioethics by combining clinical and religious perspectives.

Roy Branson, PhD
Director, Center for Christian Bioethics
Loma Linda University

describing an agonizing case of a patient with schizophrenia whose family wants to make him an organ donor, and who appears to meet all the criteria for brain death save for the fact that he might still have sedatives in his system—but knowing that the time necessary for the effective retrieval of organs would not permit waiting for the drugs to clear from his system—Dr. Orr argues that, in this case, since test-

ing shows no blood flow to the brain, it would be permissible to declare him brain dead and proceed to retrieve the organs even though he does not fit the letter of the law's definition for brain death. After this decision is made, however, we then find that the deceased man is precluded from donating his organs because the transplant team uncovers evidence that he might be harboring asymptomatic tuberculosis.

Ethicists might call this high casuistry. Anthropologists might call it "think description." I would characterize it the *cinéma vérité* of bioethics.

The book is divided into 15 chapters. Chapters 1 and 2 describe the moral and theological framework that Dr. Orr brings to the work of clinical ethics. In Chapter 15 he describes his view of the theological

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notion of the priesthood of believers and how this relates to his own work as a clinical ethicist. The bulk of the book, consisting of Chapters 3-14, presents an astounding array of medico-moral quandaries—134 cases in total. They run the complete gamut of topics, from artificial reproduction to pregnancy, neonatology, pediatrics, psychiatry, neurological disease, end-of-life care, and organ transplantation. They also cover a wide range of technologies, from ventilators to dialysis to feeding tubes.

As he states, only a reviewer will be inclined to read this book cover to cover. It is meant to serve more as a reference book to be used to explore cases that might be similar to a situation the reader is currently facing in clinical or pastoral practice.

The writing is clear and remarkably free of jargon. Where necessary, he supplies superb explanations of medical terms for pastors and of ethical terms for clinicians. The six-page glossary is an excellent resource. And the case-index cross reference appendix will be key to the fruitful, practical use of the book.

One must be impressed by the

remarkably sensible approach the author takes to these cases. Assembled in these pages one finds a career's worth of clinical ethics consults, drawn from the experience of one of the masters of the practice. The man himself comes through—subtly but clearly—in his compassion, his humility, his integrity, his piety, and above all, his wisdom. Dr. Orr is truly what Aristotle would call a *phronimos*—a man of great practical wisdom in the world of clinical ethics. The only disappointment for most readers will be that they will have to rely on his book when they would rather have the man himself at their sides as a consultant.

The answers he provides are sound. He forges a path for Christian bioethics in the secular world of U.S. medicine and law. He and I might have a few very minor disagreements in the actual decisions he makes. For example, Dr. Orr seems a bit more tolerant than I would be of assisting terminally ill patients who are still able to eat in voluntarily stopping eating and drinking; he worries, but does not see the problems I see in surrogate motherhood; and I would be a tiny bit more liberal in the

scope of what I would call “biomedical” rather than what he calls “physiological” futility even though we both reject the qualitative or subjective standard of futility. But these are really quibbles around the edges, affecting perhaps three or four of the 134 cases he presents. That's not bad for convergent validity!

Dr. Orr's book should prove extremely useful to the audiences he sets out to serve—clinicians and clergy. But it might also prove useful to family members and patients as well, struggling to make the right decision when asking the “Should we?” question. As medical progress provides an ever-growing list of “we could,” the question of whether we should will loom even larger in the future. This book provides sound guidance for navigating that future.



Daniel P. Sulmasy, MD, PhD, is the Kilbride-Clinton Professor of Medicine and Ethics and associate director of the MacLean Center for Clinical Medical Ethics at the University of Chicago.

Review

A PASSIONATE, FAITH-INSPIRED PHYSICIAN – ETHICIST

Edmund Pellegrino, MD

This is a handbook dedicated to assisting physicians, health professionals, and the general public—to all who must make ethical decisions associated with medical and health care. The author's expressed hope is “... to assist people of faith as they seek satisfactory resolution of difficult ethical dilemmas.”

The first two parts of the book provide synopses of the ethical and theological foundations on which the author grounds his ethical analyses of the cases he presents. These two introductory sections occupy 29 of the book's 483 pages, making this a casebook derived principally from the author's vast clinical and ethical experience.

The author is more than amply qualified for the task he has set himself. He has been a respected contributor to the field of Christian bioethics as teacher, practitioner, and author for many years.

The author has chosen a wide variety of cases illustrating the major ethical challenges presented by serious illness in every major organ system of the body, as well as the neonatal period, children, pregnancy, reproductive technology, organ transplantation, and cultural and religious beliefs. Each case is presented in clear, reader-friendly language, and analyzed in an unusually orderly manner. Thus, each case is discussed under six headings: 1) posing a

central question; 2) a case history; 3) a discussion of the issues; 4) the author's recommendations; 5) a follow-up of the clinical course; and 6) a closing comment. Crucial points are often printed in bold-faced type.

The author's opinions are personal and open to further discussion. They clearly reflect the author's long and broad experience as a compassionate, faith-inspired physician-ethicist. He often expressed his opinions informally in such terms as “ethically appropriate,” “ethically problematic,” “morally obligatory,” “a morally valid decision,” “ethically troublesome,” etc.

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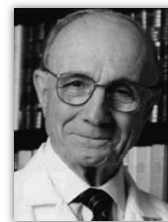
The author's faith commitment as a Protestant is set forth from the beginning. There is little formal argumentation, however. Reference to his particular Christian perspective is intermittent and more by indirection than formal argument. The book can be approached for its impressive clinical wisdom and responsible ethical analyses, as well as its faith centered orientation.

This reviewer will make no attempt to subject the author's case analyses nor his ethical opinions to criticism. Many of his opinions would be congenial to this reviewer; others might not, particularly in the sections relating to pregnancy, reproductive technologies, or organ transplanta-

tion. These differences do not in any way depreciate the value of a volume dedicated to careful clinical and ethical analysis, one which could be read with profit by anyone interested in careful ethical reasoning.

A few suggestions for making this book more useful seem to be in order: 1) an index would make this case book more accessible as a ready reference for clinicians; and 2) closer connection between a particular resolution and a particular case would assist in clarifying the author's reasons for his recommendations. These reasons could advance his aim of assisting people of faith to appreciate the way the author's faith commitment shapes his recommendations.

This book will be valuable to clinicians as well as bioethicists. The combination of careful ethical analysis, and unusually orderly discussion, with a foundation in extensive clinical experience, should be a valuable reference for all who confront ethical issues in medical and health care.



Edmund Pellegrino, MD, is professor emeritus of medicine and medical ethics at the Kennedy Institute of Ethics and interim director, Center for Clinical Bioethics, at Georgetown University.

Excerpts

MEDICAL ETHICS AND THE FAITH FACTOR

A Handbook for Clergy and Health-Care Professionals

Preface

Chaplains, pastors, priests, rabbis, and other people of faith frequently interact with individuals and families who are facing life-threatening illness, chronic illness, or disability. The conversations stimulated by such life events and conditions may include crucial questions of faith, God's will, the meaning of life and death, and eternity. Many believers are prepared for and comfortable with such discussions.

However, these conversations often include questions that make clergy and other people of faith distinctly uncomfortable—questions they are not typically prepared to answer, such as: “Should we use a feeding tube for Mom?” “Is it OK if I stop dialysis and die?” “What should we do for our baby who is about to be born with life-threatening anomalies?” “Dear God, what should we do?”

These questions of ethics are usually first posed to physicians and other health care professionals. Physicians are usually able to address the “Can we?” questions, which are generally questions of fact, laced significantly with matters of experience and

training, often focused on the fine art of prognosis. But the “Can we?” questions are often insufficient, and answers to these questions are often inadequate.

Increasingly we must address the “Should we?” questions. Just because we *can* use a ventilator to postpone death for a few more hours or days in a man dying of lung cancer, *should* we? Are there other considerations—patient comfort, social interactions, spiritual matters—that might help to answer the various questions? Not infrequently different individuals answer the “Should we?” questions differently, based on their own experience or values. Health care professionals are increasingly encouraging patients and families to discuss these “Should we?” questions with an ethics committee or a specialist in clinical ethics, who is often referred to as an ethics consultant, a clinical ethicist, or simply an ethicist.

Clinical ethics is a relatively new discipline within medicine, generated primarily by such “Should we?” questions. Those who serve as ethics consultants may be clinicians (physicians, nurses, social workers) with additional training in ethics. Or they may

be individuals whose primary training is in another field (philosophy, law, theology) who have, in addition, some experience in or exposure to clinical medicine.

The ethicist, in an attempt to resolve conflict or bring clarity to the ambiguous questions, will often inquire about the personal and religious beliefs of the patient. This often leads to a recommendation to discuss the difficult value-laden question with the patient's clergyperson or other spiritual advisor. Many clergy are not fully informed on such ethical questions. Indeed, health care professionals themselves cannot be expected to keep abreast on all the ethical nuances relevant to such value-laden decisions. Their devotion, after all, is primarily to the “Can we?” questions.

This book is intended to help fill the information gap so clergy and health care professionals can become more comfortable with these questions in clinical ethics. The core message of the book is that questions in clinical ethics are not beyond the purview of religious leaders or health care personnel. In fact, they are manageable if you know the

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medical facts; if you know the principles of Scripture and of clinical ethics; if you know the values of the patient and his or her family; and in the Christian tradition, if you rely on the leading of the Holy Spirit.

It is not my intention that each reader will serve as an ethics consultant. Rather, my hope is that the reader will become somewhat familiar with the clinical issues, will recognize the moral questions raised by those issues, and will then be able to apply religious or spiritual tenets from his or her own tradition to the pertinent questions. If this is accomplished, I believe the reader will then be of great assistance to patients, families, and clinicians.

I am a Christian, and my faith is important to me. Some of the patients and families I have interacted with share my faith and beliefs. Some, however, are Christians whose teaching or beliefs are somewhat different from my own. And a significant percentage of the situations where I have been involved in ethics discussions, including many of the cases reported in this book, involve people from different faith traditions or different cultures.

I believe the clinical information, the principles, and precepts of clinical ethics presented here are equally applicable in all these situations. I do not expect the reader to agree with each recommendation made in every case discussed. But I hope that the discussion that ensues will help clergy and chaplains, students and clinicians, professionals and laypersons, as they delve into dilemmas in clinical ethics.

The introduction tells a personal story about treatment decisions for a dear friend—decisions that were exceedingly difficult, but at the same time remarkably easy.

Part I will look at the foundations of contemporary clinical ethics. Chapter 1, titled “An Ethical Foundation,” gives a brief overview of treatment decision-making, including the role of ethics consultations. Principles, precepts, and precedents of clinical ethics are described including patient autonomy; surrogate decision-making for

patients who have lost the capacity to do so; the use of advance directives; do-not-resuscitate orders; dealing with uncertainty; the understanding that there is no difference between withholding and withdrawing treatment; conflict resolution; and more. Chapter 2, “A Theological Foundation,” outlines an approach to decision-making in clinical ethics that is consistent with teaching in the three monotheistic faith traditions, including discussion of God’s creation and sovereignty; the sanctity of human life; quality of life; free will; dominion and stewardship; boundaries; caring for others; miracles; and more.

Part II will look at some of the more common issues encountered when a patient’s life is threatened by failure of one or more organ systems. Chapters 3 through 8 focus on different clinical issues that raise questions about what should be done when a patient encounters failure of his or her heart, lungs, kidneys, gastrointestinal tract, brain, or mind. Of course, not all dilemmas in clinical ethics are about life-threatening issues. Woven into these chapters are also cases of nonlethal conditions in these organ systems that often lead to ethics consultation.

Each of these chapters includes background information about the condition or treatment modality that will increase a non-professional’s understanding of the issues. In addition, each includes some discussion of how personal values, professional standards, legal precedents, and biblical perspectives may influence decisions in these cases. The bulk of each chapter consists of several case discussions, each with a story, discussion (ethical analysis), recommendations, follow-up, and comments.

Part III (chapter 9) is about specific ethical dilemmas that arise because of differing cultural or religious beliefs. An attempt is made in each case to understand the values and beliefs of the various individuals involved, and to identify common ground that might allow resolution of the dilemma or conflict. When compromise is not possible, the patient’s values and beliefs

are generally given top priority.

Part IV includes five chapters that focus on ethical issues encountered in patients of a specific age or condition (neonatal issues, other pediatric issues, pregnancy), or patients faced with decisions about the use of specific technologies (assisted reproductive technology, transplantation).

In Part V, the chapter titled “The Priesthood of Believers” explores ways that family members, clergy, counselors, and friends can assist patients and families as

“The ethicist, in an attempt to resolve conflict or bring clarity to the ambiguous questions, will often inquire about the personal and religious beliefs of the patient.”

they struggle with these difficult decisions, emphasizing the priesthood of believers and the importance of prayer for God’s wisdom and peace.

The story in the introduction is true. Dave’s family has given me permission to share the story with pastors, students, and other people of faith in an effort to make a bit easier the journey through complicated dilemmas in clinical ethics. The other stories in this book are also true, or they are based on actual cases, sometimes representing a synthesis of two or more stories. However, names and some of the nonpertinent details have been changed to protect the identity of those involved.

It may be tempting for some readers to think that the resolution of these cases represents “the answer,” since the reports are written by a person of faith. Let me refute that notion right at the outset. I do not claim any particular wisdom in these cases. I do believe that most were resolved in a

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manner consistent with religious principles as understood by the individuals involved at the time. Some readers may disagree with the recommendations or with the resolution of the issue. In fact, I personally disagree with the choices made by some of the patients, families, and professionals; I try to point these out in the “Follow-up” or “Comment” sections of the case reports. My purpose in offering these examples is to show that biblical principles, personal values, and denominational tenets play a vitally important role in the resolution of difficult ethical dilemmas at the bedside.

Most of these consultations were done in secular hospitals. Some of the patients were people of faith, some said they were not. Some of the health care professionals involved in their care were also people of faith, but some were not. These reports were written for the benefit of professionals, patients, and families, regardless of their

“It was one of those life-defining events that becomes indelible in your memory.”

faith traditions. You will find few, if any, theological terms or scriptural references in the text of the consultations. But the discussions and recommendations are designed to fit within professional and personal boundaries of acceptable practice.

At the end of most chapters, I have listed other cases in the book that address similar conditions or treatment modalities. These may be reviewed to expand the discussion of that chapter. I have also included a few references at the end of most chapters that might be of value for readers particularly interested in that subject. Most of the references come from the secular literature without specific focus on the faith factor.

Most of the information in these references is of high quality and representative of contemporary secular clinical ethics. Some of the information or opinions, however, are not consistent with the theological foundations addressed in chapter 2 of this book, and some may even be in direct opposition. Such references are included to give the reader a better understanding of the depth and scope of modern clinical ethics.

The glossary in appendix 1 is intended to define terms used in the text that may not be familiar to readers. The first time that terms, defined in the glossary, or their cognates, are used in a chapter or case study, they are printed in the text in boldface type. Some unusual terms that are used only once or only in one chapter may not appear in the glossary but are instead defined in the text or in a footnote.

The case index in appendix 2 is a cross-reference tool to help readers find cases with similar issues in various chapters. For example, while all cases in chapter 6 will be about the use or non-use of artificially administered fluids and nutrition, the issue in a particular feeding tube case may be the interpretation of a written advance directive, or resolution of conflict between family members, or a question of futility, or caring for someone with severe cognitive impairment, or a host of other issues. The case index will allow the reader to find similar discussions and analyses in cases involving differing diagnoses or treatment modalities, thus offering broader assistance.

This book is intended to be a reference book. While I would not discourage a goal of reading it from cover to cover, my expectation is that people using this book will read chapters 1, 2, and 15 for a foundation, and thereafter peruse or read chapters that are focused on specific clinical issues. Alternatively or in addition, the reader may find cases listed in the case index focused on a specific problem. For this reason, many of the discussions in the case studies will be repetitive or redundant, since a reader may be reading only that one case.

It is my hope that the content and format of these discussions will assist people of faith as they seek satisfactory resolution of difficult ethical dilemmas. Perhaps they will gain a better understanding of the clinical situation. Even more important, I hope they will gain an understanding of the moral dilemma in light of the personal and religious beliefs of the patient, family, and professional. Most important of all, I hope the reader will come to a greater reliance on the leading of the Divine in the given situation.

God bless.

Introduction

It was one of those life-defining events that becomes indelible in your memory. I had just returned from a Saturday morning council meeting of the Vermont Medical Society and my wife, Joyce, met me at the door. I could tell from the look on her face that she had terribly bad news: “Dave Pollock is critically ill in Vienna.”

Dave and I had been friends since college, more than forty years earlier. Our families had been very close for many years. I was his family physician and racquetball competitor for eight years when our families lived in the same community. Joyce worked as his office manager for those eight years. He had been involved in international ministry with missionary families for 25 years and was in Vienna to speak at a conference of Christian educators. The news was now fourth-hand, so I had to hope some of the details were wrong: sudden abdominal pain; hospitalized; gallstone blocking his bile duct causing pancreatitis; stone successfully removed; unexplained cardiac arrest 36 hours later; successful resuscitation, but now, another 12 hours later, Dave was unconscious, in the intensive care unit (ICU), on life support.

What a mixture of responses. The optimistic doctor in me said, “Well, since he is on a ventilator, the doctors have probably given him heavy sedation and he’ll awaken

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when it wears off.” The cautious clinical ethicist in me said, “This does not sound good. Betty Lou and their three children will probably have some difficult decisions to make in the next few days.” The friend in me said, “I’ve got to get to Vienna.”

It took about 48 hours for me to rearrange my schedule and get to Dave’s bedside. I cried as I hugged his family and especially as I held Dave’s flaccid hand. We spent the next six days praying, talking with doctors and nurses, waiting for test results. The five of us talked, reminisced, laughed, and cried. We vacillated between hope and despair. “Our God is a great God. He can do what is humanly unexplainable.” “Dear God, what should we do?” “It is very, very rare for someone with this amount of brain damage after a cardiac arrest to have any meaningful recovery.” “We can always hope.” I shared with them Vaclav Havel’s concept of hope: “Hope is not the conviction that things will turn out well, but the certainty that things make sense, regardless of how they turn out.”¹ We began our grief process.

What was my role in this situation? As a physician, I explained to Dave’s family the mechanism of brain injury from lack of oxygen, and how this has a much worse outlook than brain injury from trauma. I was intermediary and spokesperson between the family and the intensive care team and neurologist. As a clinical ethicist, I talked with the family about Dave’s personal values and previous conversations about his wishes in the event of overwhelming illness. He had clearly and repeatedly said he did not want to survive with the aid of machines or tubes if he would be permanently unable to interact with his loved ones. I also helped them understand how medical decision-making was somewhat different in Europe than in the United States. As a friend, I kept denying this was really happening, hoping I would awaken from this horrible dream at any moment.

Of the nearly 1,500 ethics consultations I have been involved with in my second career as a clinical ethicist, this was the

most difficult. I had alerted my closest professional colleague before I left Vermont that I would probably be on the phone asking for his help.

At the same time, this was one of the easiest ethics consultations I have done. The medical facts were clear and unambiguous—there was virtually no possibility that Dave would recover to a level of function he would find acceptable. He had made his personal preferences known, both in writing and in conversation with his wife and each of his three children. The standards of medical ethics, though somewhat different in Austria, had fairly clear boundaries of permissible options. And the five of us standing around Dave’s bed were united in one Spirit, knowing he was poised to enter God’s presence.

Nine days after his cardiac arrest, he did just that. His condition deteriorated suddenly, and God made the decision the five of us were dreading. God took Dave home on Resurrection Sunday 2004.

A Theological Foundation

Writing this chapter seems like an exercise of hubris—a nontheologian trying to demonstrate to readers, many of whom may have far more theological training and expertise than he, that contemporary clinical ethics has a unifying theological foundation. Certainly there are many books written on this topic already, some of which are listed at the end of this chapter. I would encourage you, the reader, to explore those that come from your own theological tradition.

But I am going to try to do more than that. I hope to show that the three monotheistic faith traditions—Judaism, Christianity, and Islam—share some basic theological beliefs that are foundational for our thinking about these clinical issues. This should help to focus our understanding of how this basic theological approach differs from the nontheistic worldview that is so common in contemporary clinical ethics. This is perhaps an example of

extreme hubris.

I got the idea and the courage to undertake this daunting task while speaking at a conference at West Virginia

“There are many opportunities for conflict of interest...Academic medical centers are increasingly dependent on industry support for education.”

University in 1994. The title of the conference was “The Spiritual Dimension of Illness, Suffering, & Dying.” Leaders in medical ethics from these three monotheistic faith traditions were invited to share their perspectives on issues at the end of life. I left the conference exhilarated because I came to realize that more foundational elements unite us than divide us. What a breath of fresh air!

I suspect that my own Christian tradition will be visible between the lines here, but my intent is not to be a Christian apologist or an evangelist. Rather, I hope to show that, in spite of significant differences in our understanding of our relationship with and obligations to the Divine, we share some fundamental beliefs about who we are and how we should care for each other.

I have patterned the outline for this chapter and borrowed some of the content for it from the small book that came out of a 2004 Lausanne Forum in Thailand: *Bioethics: Obstacle or Opportunity for the Gospel?*² While this small treatise comes from a Christian perspective, the points I have chosen to underline here are generally consistent with my understanding of Judaism and Islam in many regards.

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What does it mean to be human?

People of faith believe that a divine Being—Yaweh, God, or Allah—created the heavens and the earth, and specifically that He created humankind in His own image, the *imago Dei*. We may differ on our understanding of that concept, and I don't pretend to know exactly what it means. But it does seem clear that God views created humans as different from the rest of creation. We have been given stewardship over the rest of His creation, and we are able to be in relationship with Him.

“Occasionally suffering is corrective, that is, as C.S. Lewis says, pain is God’s megaphone, a way to get our attention.”

A secular worldview does not, of course, consider the *imago Dei*, but rather focuses on personhood. Proposed criteria for personhood have varied over the past few decades, from the 14 characteristics of neocortical function proposed by Joseph Fletcher² to the single concept of self-awareness espoused by Michael Tooley.³ This leads to the difficulty of defining which humans are persons and which are not, which deserve protection and care, and which do not. It may even allow some non-humans to be considered persons.

The sanctity of human life

The *imago Dei* present in each human is a gift from a loving Divine Creator. He considers human life to be set apart from the remainder of creation, to be sacred. And because of this, He has enjoined us from shedding the blood of innocent human beings. Further, his love is extended especially to the weak and vulnerable, implying that we, too, as bearers of His

image, should offer protection and care to the sick, the disabled, the very young, and the aged.

It is interesting and noteworthy that the concept of the sanctity of human life is not absent from a secular worldview. The term is often used in a nontheistic context to indicate the value of human life. In my way of thinking, it is difficult to explain the genesis of this understanding without invoking the creation narrative. In fact, some discussants of medical ethics from an atheistic perspective recognize this difficulty. For example, Peter Singer calls the unwavering protection of human life “speciesism,” and he asserts that “progress” will not be made in the public policy arena (e.g., on issues like euthanasia) until the notion of the sanctity of human life is eliminated.⁴

The fall, suffering, and death

For centuries, philosophers and theologians have struggled to explain the presence of evil, suffering, and death in a world created by a loving and merciful God. My simple understanding is that it was not intended, but was permitted by God.

God created humans in His own image, placed them in an idyllic setting, and gave them dominion over His creation. But the prospect of being like God proved to be too tantalizing; temptation gave way to sin. Adam and Eve disobeyed God. This resulted in punishment from God—the necessity to work by the sweat of one's brow, the pain of childbirth, and the prospect of sickness, suffering, and death. Thus the theistic worldview includes not only the sanctity of human life, but the finitude of human life as well.

Suffering is allowed by God. It is not without purpose, however. Even though some suffer in vain, that is not God's purpose. Occasionally suffering is corrective—that is, as C.S. Lewis says, pain is God's megaphone, a way to get our attention. Suffering may be developmental, to help us grow toward maturity, to make us more like Christ, or to draw us closer to Him. He

may allow suffering to bring glory to Himself. People of faith may be able to intellectually accept these statements of purpose in suffering, but let's face it, no one likes to suffer.

In contrast, the secular worldview almost always sees suffering as bad—and it is. Though some may see some benefit in suffering (“no pain, no gain”), the majority of secularists seek to eliminate all suffering. I believe the relief of suffering is noble, and in fact is part of the calling of the ministry of healing. At the same time, we must recognize that sometimes our efforts will be inadequate. Most people of faith believe there is a limit here. In the process of relieving suffering, we are not allowed to destroy human life.

The quality of life

The concept of the sanctity of human life is inviolable from a theistic perspective. But what's all this talk about quality of life? Many people of faith get hives whenever the phrase is mentioned. But because the fall of humankind brought suffering and death into the world, we must admit that individual human lives have varying quality. Some have limited functional or intellectual capacities. Some have chronic pain or suffering. In spite of this, each individual human life is of inestimable worth because each bears the image of God.

It is very appropriate to be wary of discussions about quality of life. Secular ethicists often use quality of life as the yardstick to determine whether an individual's life should be preserved. They may espouse that someone who is severely demented, or severely developmentally delayed, or has sustained severe brain damage, has such a poor quality of life that society has no obligation to protect or even preserve that life.

One thing I think we can all agree on, however, is that an individual's quality of life is a subjective determination that only he or she can make. Repeated studies have shown that both professional and personal care-

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givers underestimate the quality of life perceived by the patient.

For some theists, sanctity of life always trumps quality of life. This leads to what is called a vitalist stance—if it is possible to preserve life, it must be done, regardless of its quality. However, we must first recognize that human life is finite. In addition, human lives have varying quality. One of the pressing questions before us as we contemplate dilemmas in clinical ethics is to try to determine when the quality of life is so low that there is no moral obligation to preserve that finite life. I suspect we will not all agree on where that line should be drawn, but let us at least accept that we must try to draw the line.

The ministry of health care and the hope of eternity

Divine love, mercy, and compassion dictate that we, the bearers of God's image, should reach out to care for those who are ill and suffering. We should try to prevent and alleviate the ills of the fallen world. At the same time, we must realize the limits of our current situation. We will not be able to eliminate suffering and death. We still have to deal with terminal illness and death, and do it as compassionately as we can. But almost all theistic faith traditions believe in an eternity with the Divine, free from suffering and death. The pathway and requirements vary, but the faithful can joyously look forward to paradise.

Many people in health care and clinical ethics—even those who do not personally hold a theistic worldview—respect these beliefs when expressed by patients or families. Not infrequently, however, differences of belief system will lead to conflicts, often dealing with moral obligations or with hoped-for supernatural intervention in natural events.

Miracles

All three of the monotheistic faith traditions support a belief in Divine supernatural intervention in the course of human lives. Specific instances of miracles

are recorded in their respective sacred scriptures. But do miracles still occur today? Some say yes, and some say no.

Unfortunately, the words “miracle” or “miraculous” are often trivialized so that phenomenal recovery from a serious illness or injury or the use of a powerful new drug is often incorrectly made to sound like a supernatural intervention. Such occurrences may be the wonderful application of medical knowledge, brought about by the diligent use of human intelligence, and allowed by Providential grace, but they do not qualify as miraculous unless they truly defy human logic. Even this qualifier is suspect since human logic is admittedly limited and imperfect.

How does the health care professional respond when a patient, or more often a family member, requests that treatment be continued—treatment felt to be inappropriate by the professional—because the family is praying for and expecting a miracle? Should the response be different if the professional is also a person of faith?

A belief in miracles need not cripple the practice of medicine, nor even have a major impact on our decisions. A colleague once said to me, “God is not ventilator dependent.” The implication is that the patient's life may be dependent on the use of external support, but God's omnipotence and sovereignty are greater than that. If He decides that an individual should go on living, in spite of life-threatening illness and dependence on human technology, then He is able to intervene in a supernatural way—without our help. This line of reasoning may or may not give some solace to family members. It does not, however, satisfy those few who believe that God will not perform a miracle unless that praying individual has sufficient faith to continue human efforts awaiting God's intervention.

God is sovereign, but humans have dominion and are stewards

Most individuals coming from a theistic worldview believe that God is

omniscient and omnipotent. Translated into the realm of clinical ethics, this would mean that He ultimately determines whether an individual lives or dies. Different traditions vary on the human component here. This raises the issues of dominion and stewardship.

The fact that God gave dominion to humankind implies His sanction of the scientific enterprise including medical care,

“How does the health care professional respond when a patient, or more often a family member, requests that treatment be continued ... because the family is praying for and expecting a miracle?”

research, and the development of medical technology. But the balancing tenet of stewardship implies that we are responsible and accountable for how we use our knowledge and technology. We have liberty, but only within the moral boundaries established by the Divine.

Even those in medical ethics who do not seek the will of God recognize boundaries. They often say, “The ability to act does not justify the action.” And they seek other guidance to determine where those boundaries are or should be—for example, the accepted principles of beneficence (doing good), non-maleficence (doing no harm), and justice (treating people without discrimination). But far and away, the dominant principle in secular medical ethics today is autonomy—the patient's right to self-determination. Deferring to the will of the individual rather than to the will of God allows the acceptance of some decisions/procedures that are disallowed by consideration of the other theological concepts and precepts outlined above. For

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example, relying on parental autonomy might be seen by some to justify termination of a pregnancy because it has been discovered that the developing fetus has Down syndrome, whereas relying on the theological concept of the *imago Dei* would be seen by most to preclude such a decision.

Justice

Justice is a complicated issue with many perspectives and nuances. But for the sake of this discussion, let us define justice as getting what we deserve. Many faith traditions include a concept of deserved punishment for those who do not seek God's will or follow His commands. In the Christian tradition, we look beyond justice to God's mercy (not getting what we deserve) and His grace (getting what we do not deserve) for those who have sought and found personal redemption.

From a secular worldview, justice means treating equals equally, without discrimination. This is certainly consistent with theistic teaching. But this view of jus-

tice often goes on to focus on the protection of personal autonomy, and as we have discussed above, the predominance of autonomy is antithetical to a theistic worldview.

With these fundamental theistic precepts in mind, let's begin the walk through muddy water. Let's look at some ethical dilemmas encountered by patients, families and health care professionals, and try to apply some of the foundational principles of clinical ethics and theology.

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Robert Orr, MD, CM, is associate director at the Center for Christian Bioethics at Loma Linda University and director of clinical ethics at Loma Linda

University Medical Center. Dr. Orr served as clinical co-director of the Center from 1990–2000. He returned to Loma Linda in 2009, again as director of clinical ethics and to direct a clinical ethics fellowship. Other books Dr. Orr has been involved with include: *Aging, Death, and the Quest for Immortality* (Grand Rapids, MI, and Cambridge, UK: William B. Eerdmans Publishing Company, 2004); *Basic Questions on Healthcare: What Should Good Care Include?* (Kregel Publications; Grand Rapids, MI; 2004); *The Changing Face of Health Care* (Grand Rapids, MI: William B. Eerdmans Publishing Company, 1998); and *Life and Death Decisions* (NavPress, 1990, Colorado Springs). A revised edition was also released in two volumes: *Life and Death Decisions* (1996) and *More Life and Death Decisions* (1997) by Baker Book House, Grand Rapids, MI.

CENTER VIDEOS ONLINE

The Center for Christian Bioethics records all of its programs, in an attempt to provide them to as many people as possible, whether they are on campus or not.

Here is a short list of some of the most recent programs ... enjoy.

Is San Bernardino Going Up In Smoke: A Case Study in Environmental Justice
www.vimeo.com/16841068

Adventist Advocates
www.vimeo.com/12112281

Quid Pro Quo Vadis Relationships Between Academia and Industry—A Journey
www.vimeo.com/9091591

First-place 2010 essay winner

WHITE COATS: PURPLE PENS

Gregory A. Lammert, School of Medicine, Loma Linda University

As developing health care professionals, we are constantly under pressure to simultaneously be a “good student,” as well as a “good doctor.” Those expectations can be daunting at times, but we do our best to succeed and to impress those that we train with. Medical students can be subjected to particularly intense pressure from attending physicians that act more like dragons controlling troops than benevolent teachers of medicine. Thus, medical students are at risk of facing situations where we must act as “good students” but forget that we must fulfill a duty to be “good doctors.” This occurs when our own professional standards of integrity, honesty, and moral character somehow come into conflict with our daily duties.

When most people think about “claims of conscience” the most poignant issue that comes to mind is that of abortion. Several fellow students that I know have stated quite clearly that they do not wish to ever be part of training or even observe such a procedure. However, this a topic that has such a plethora of emotion attached to it that a discussion here would last for numerous pages. I would argue that while the abortion debate is the classic discussion of opting out due to a claim of conscience, I find it to be a rather rare occurrence, even in the life of a medical student. I will share an experience that was related to me this past summer that prompted me to address issues of obligations and rights, and when medical students should hold onto their integrity and not do something that they find to be objectionable.

The story begins with a student that was rotating through the surgery department at the VA hospital. The adopted national patient safety goals state that it is standard procedure for the operating sur-

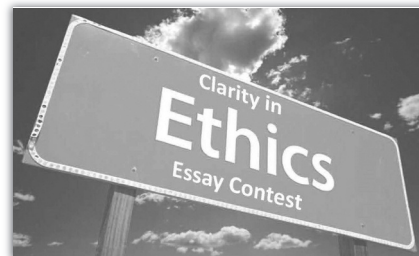
geon to use a small purple permanent marker to identify the site on the patient’s body where he or she plans to operate, prior to entering the surgical suite. While this is principally done to ensure the proper operating site, it also serves as a way to provide discussion between the patient and the physician for any final concerns, questions, or comments. This is a practice that has greatly reduced the number of improper operations and has markedly improved patient safety. A portion of the guidelines state that this marking must be done by the operating surgeon or, at the very least, the senior resident on the team. In the busy department of surgery, time is of the essence for surgeons, residents, and students. In an effort to save time, the student in this example was asked to go locate the upcoming patient in pre-op holding and mark the surgical site.

On the surface, this student should be jumping at the opportunity to aid the team,

“The most important set of rights in this example is the rights of the patient.”

meet the patient, and help the surgery schedule run smoothly. All of these things make a “good student.” However, the student relayed to me that he felt uncomfortable going to mark the site, as he knew that it was against the national patient safety goals, even though the resident told him that it was okay. Due to the power differential that exists between residents and students, the student complied. In this situation, it is possible that the student felt

CLARITÁS



ESSAY CONTEST

undue pressure to go and mark the site as asked. What makes this situation interesting is that it violated the student’s conscience; it was not his responsibility to mark the patient for surgery. Students are asked all the time to do things that might not seem like situations that warrant discussion in a bioethics context, but it is important to understand potential issues that face medical students on a daily basis.

This is a situation that violated both the integrity of the senior resident and attending who asked the student to mark the site, as well as the student’s integrity to follow through with such a request. Beauchamp and Childress suggest that “integrity is the primary virtue in health care” (Beauchamp, 41). The policing of our individual integrity is manifested externally and internally as what we define as our conscience. This would suggest that, if the operating surgeon did not feel the need to be present to mark the site, despite it being required, the conscience should have been alerted that something was amiss.

I find this lack of conscious objection to reflect negatively on the surgeon’s integrity. Furthermore, this suggests that the student violated his own integrity. By agreeing to perform such a task, the student has outwardly expressed that he does not have a conscious objection to marking a surgical site, when he knew it was wrong to do so. This erodes his integrity at a very early level of professional development. This event is a perfect demonstration of the battle between being a “good student” and a “good doctor.” On one hand, the stu-

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dent wanted to be helpful, while on the other, was feeling pressure from the surgical team to be a “team player.” This desire to be a team player can at times be in conflict with what is truly best for patient. In this situation, I believe that the patient would be best served by the operating surgeon marking the surgical site, not a medical student.

Medical students are often pulled between wanting to be a “good student” and being a “good doctor.” This is a unique situation that does not fit into a positive/negative rights framework, but it does fit into the frame of obligations. We are told as medical students (usually from residents) that one of our main duties is to work hard so the resident is able to go home more quickly. We try to do things that make the resident’s day easier, and if good patient care happens simultaneously, it is usually by some miraculous accident. On one hand, we are obligated to provide high-quality, safe, effective care; on the other we are obligated by the physician’s oath to respect our teachers and those that came before us. This situation puts the two

directly against each other.

The most important set of rights in this example is the right of the patient. It is the patient’s right to understand his or her care, to understand the surgery, and to understand and trust that the surgeon will provide the best care. This begins with marking the surgical site. To have anyone else mark the site is doing a disservice to the patient. I recognize that a great majority of the time, there would be no problem with the practice of having a medical student mark the site, is it worth the risk of a “sentinel event,” of a wrong site/side surgery, for the attending surgeon to save an extra few minutes to mark the site?

Patients have come to expect high-quality health care, and we are in the business of providing a high-quality service. Marking an individual for surgery is a minor example in the vast array of claims of conscience cases, but it is important to realize that claims of conscience do not have to involve decisions of life and death, abortion, or withdrawing care. Conscious

objections occur every day, and many of us are conditioned to ignore them. For if we mention them, we fear we are at the risk of being a “bad” or “annoying” student who is not a team player. If you are labeled as not being a “team player” on any medical service, life becomes quite difficult and you fear that your end-of-rotation evaluation might be at risk.

In a field that is as competitive as medicine, we are pulled between two ideals: being a “good student” and being a “good doctor.” In an ideal world, these two should never be in conflict. Thus, should we just be a “good student” and mark the site as asked without question, or should we be a “good doctor” and openly express that the attending surgeon fulfill his or her obligations and the rights of the patient?



Gregory Lammert is a student in the School of Medicine at Loma Linda University.

DENTAL ETHICS AT LOMA LINDA UNIVERSITY

The Center for Christian Bioethics has been involved with the American Society for Dental Ethics (ASDE) since 2004. ASDE is dedicated to promoting ethical responsibility and conduct for dental health care professionals.

The executive director for ASDE is Anika Ball, MA, RDH, who received her master’s degree in bioethics at Loma Linda University and regularly teaches ethics courses for the LLU School of Religion. She administers the ASDE from the Center for Christian Bioethics, LLU, including continuing education courses in dental ethics.



Anika Ball, MA, RDH

U p c o m i n g American Society for Dental Ethics events

include a continuing education course, “Culture and Dental Ethics,” that was offered at A. Dugoni School, San Francisco, August 12, 2011.

ASDE will present its next course in the individuals program of the professional ethics initiative at the America College of Dentists annual session in Las Vegas, in October 2011.

Also in October, the clubs of students studying dental ethics at universities across the nation (i.e., Marquette, Indiana, Buffalo, and Oregon Health & Science University) will become the Student Professionalism and Ethics Association.

Finally, an ethics faculty development workshop is proposed for the American Dental Education Association annual meeting March 2012 in Orlando, Florida.

Titled “Engaging Students in Professional Identity Formation,” it has been proposed by Muriel Bebeau, PhD, University of Minnesota, School of Dentistry, and Marilyn Lantz, DDS, University of Michigan. They will be joined in making presentations by medical colleague Kathy Faber-Landendoen, MD, Upstate Medical University.

For more information visit <www.societyfordentaethics.org>.



USC chapter of Student Professionalism and Ethics Association

NON-VIOLENT REVOLUTION: BLESSED ARE THE PEACEMAKERS

Roundtable discussion at Loma Linda explores ethical paradigms for peace and war

More than 200 people in were in attendance for the roundtable presentation, “Non-Violent Revolutions: Blessed are the Peacemakers,” led by Roy Branson, PhD, director of the Center for Christian Bioethics.

The roundtable began with Glen Stassen, PhD, the Lewis B. Smede Professor of Christian Ethics at Fuller Theological Seminary. He outlined the 10 practical steps for “Just Peacemaking: The New Paradigm for the Ethics of Peace and War.” The two standard ethical paradigms for the ethics of peace and war are pacifism and just-war theory. They focus on debating whether or not a war is just. Every one of the 10 practical steps of just peacemaking, Dr. Stassen argued, have proven effective at preventing wars and making peace.



Glen Stassen, PhD

With the groundwork of just peacemaking laid, the panelists discussed its involvement in peacemaking, starting with the most recent occurrence of struggling peace, Egypt. As a member of the Coptic Orthodox Church, Ayman Ibrahim (a PhD candidate at Fuller Theological Seminary), spoke with passion about the February 2011 “Twitter revolution” where the citizens of Egypt let the world know they were tired of decades of authoritarian rule.

Despite reports of military overreaction, the “revolutionaries” manned their phones, computers, and tablets to advance democracy, human rights, and religious liberty via non-violent action, enacting two of the principles of just peacemaking.

Najeeba Sayeed-Miller, JD, assistant professor in interreligious studies, and senior advisor for Muslim relations at Claremont School of Theology, spoke on the tradition of peacemaking in the Muslim religion. Ms. Sayeed-Miller’s work has been both international and local. She



Left to right: Ayman Ibrahim, PhD candidate; Najeeba Sayeed-Miller, JD; Roy Branson, PhD; Glen Stassen, PhD; Mumtaz Fargo, PhD; and David Augsberger, PhD

is founder and director of the Center for Global Peacebuilding at Claremont School of Theology. She has also seen firsthand the results of just peacemaking in her international experiences at The Hague, in the Netherlands, and locally between gangs in the streets of Pasadena.

Ms. Sayeed-Miller said that according



Ayman Ibrahim, PhD candidate (left); Najeeba Sayeed-Miller, JD (right)

to the Prophet Mohammad, “The greatest jihad is speaking truth in the face of an unjust ruler.” And that, she argued, is what has happened in what has been called the Arab Spring. Citizens gathered for non-violent demonstrations and protests throughout the Middle East.

Mumtaz A. Fargo, PhD, professor emeritus of history at Montana State University–Billings and an expert on United States policy in the Middle East, gave a brief overview of the Ottoman Empire. He mapped out the timeline of the Ottoman Empire and how that relates to today’s approach to just peacemaking

throughout the Middle East.

David Augsberger, PhD, professor of pastoral care and theology at Fuller Theological Seminary, opened his remarks by recalling a conversation he had with H.M.S. Richards. According to Dr. Augsberger, Pastor Richards identified Adventist attitudes toward war with those of the peace churches such as the Mennonites. Dr. Augsberger emphasized that one who is radically committed to following the teachings of just peacemaking could encounter persecution—persecution as suffered by Jesus.

Dr. Branson started the question-and-answer period of the panel by asking Dr. Augsberger, a theologian in a peace church, if he thought just peacemaking was really a third way to peace—a genuine alternative to both the pacifist and the just war traditions. Dr. Augsberger thought that it was. Just peacemaking is teaching the world to do peace better by avoiding the debate of whether a war is justified or not, and discussing peacemaking instead. There needs to be dialogue, he insisted, among all, and an acknowledgement, too, of what we have done to create the problem.

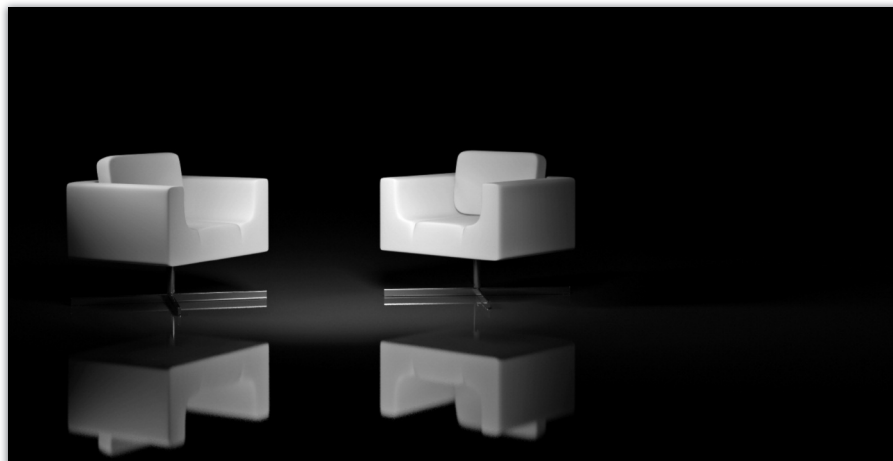
The audience members were then invited to pose questions to the panelists. You are invited to watch the entire presentation including the questions and answers online at <vimeo.com/23676376>.

CONVERSATION WITH AUTHORS

The center will continue “Conversations with Authors,” hosted by David Larson, PhD, this coming 2011–2012 school year. The first of the school year, October 1, will feature **Richard Rice, PhD**, author of *The Openness of God*, a book that launched a theological movement within evangelical Christianity in America. The sessions will take place six weeks apart at 3:00 p.m. Saturday afternoons, in a 98-seat amphitheater (3111) within the LLU Centennial Complex.

During the 2010–2011 school year, the Center for Christian Bioethics produced and recorded five hour-long “Conversations with Authors.” Dr. Larson, a founder and former director of the center, and a professor in the LLU School of Religion (LLUSR), created and hosted the conversations. Dr. Larson makes each conversation feel like a fire-side chat by asking authors about themselves as well as their writings. He invites the audience to also pose questions to the author.

In the inaugural conversation, December 4, 2010, Dr. Larson asked **Robert Orr, MD**, associate director of the Center for Christian Bioethics, what inspired him to write *Medical Ethics and the Faith Factor*, a clinical ethics handbook for clergy and health care professionals. Dr. Orr revealed that he had been the first physician invited by the C.S. Lewis Foundation to be a scholar-in-residence at The Kilns, the former home of one of the most widely read Christian apologists in the English language. Dr. Orr seized this unique opportunity by writing six hours a day. At the end of three months at The Kilns, he had written 12 of the book’s 15 chapters. Dr. Orr said that in his book he focused on those questions he categorized as “Should we?” questions. Just because we can use interventions (i.e., a ventilator) to postpone



death for a few days, should we?

The next conversation, February 12, 2011, featured **Bernard Taylor, PhD**, the scholar-in-residence at the Loma Linda University Seventh-day Adventist Church and a professor at LLUSR. Dr. Taylor is a world authority on the *Septuagint*, a commentary on the Hebrew Scriptures. In 1994, he authored the first *Analytical Lexicon to the Septuagint*. An expanded version of his lexicon was published in 2009. In it, Dr. Taylor analyzes the form of every Greek word in the Septuagint. Dr. Larson not only led Dr. Taylor into describing the staggering work of creating the computer program that made his lexicon possible, but he also made certain the audience learned what sort of person combines landmark scholarly achievement with pastoral care.

The conversation on April 23 was with a New Testament scholar and social activist who is also a physician: **Sigve Tonstad, MD, PhD**, an associate professor at the LLUSR. Dr. Larson spotlighted Dr. Tonstad’s books exploring the two convictions captured in the name Seventh-day Adventist—his recent volume *The Lost Meaning of the Seventh Day* and his earlier book, *Saving God’s Reputation*, that draws on Dr. Tonstad’s scholarship on the book of Revelation. Dr. Larson also drew Dr. Tonstad into reflections on mentors, including Carsten

Johnson, a fellow Norwegian philosopher, and theologian; Graham Maxwell, whose lectures he heard during medical school at LLU; and Richard Hayes, a New Testament scholar at Duke University.

The most prolific author at LLUSR is its dean, **Jon Paulien, PhD**. Dr. Larson invited Dr. Paulien on June 4 to briefly describe the volumes he has contributed to commentaries of the Bible—particularly the book of Revelation—and his books explaining the Bible to informed laypersons. Many of the books have been translated from English into a variety of languages. Dr. Larson elicited from Dr. Paulien that he actually enjoys the withdrawal from administrative and family responsibilities that writing requires.

In the final conversation of the school year, June 18, Dr. Larson carried on spirited exchanges with his long-time friend and fellow-ethicist **Charles Scriven, PhD**, president of Kettering College of Medical Arts. A prolific essayist and lecturer, Dr. Scriven was happy to focus on his latest book, *The Promise of Peace*. He was clearly delighted that Dr. Larson appreciated the style of this work—non-technical, yet profound. Dr. Larson quoted from memory a phrase recurring throughout the book: “We live, all of us, in the space between our dreams and disappointments.”



LOMA LINDA UNIVERSITY

Center for Christian Bioethics

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JUNE 2011

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CENTER FELLOWS SERVE LLUMC

Clinical ethics consultants represent the institution well

Gina Mohr, MD, director of palliative care, as of July 1, also assumes the directorship of the clinical ethics consultation service at Loma Linda University Medical Center (LLUMC). Dr. Mohr completed two years as a fellow of the Center for Christian Bioethics, working under the supervision of Robert Orr, MD, associate director of the center, and the founder and director of the clinical ethics service at LLUMC.

At a graduation dinner held June 9, 2011, in the home of Carolyn and Ralph Thomson, MD, longtime supporters of the center, Dr. Orr handed each of the fellows certificates for completing their two-year fellowships. During that time, fellows had attended bi-monthly seminars, participated in weekly case conferences, delivered bioethics lectures, and written a scholarly article.

President Richard Hart, MD, DrPH; Provost Ron Carter, PhD, Vice President Gerald Winslow, PhD; other leaders of LLU, and members of the board of the center congratulated the fellows and thanked Dr. Orr for his many years of nurturing clinical ethics at LLU. He is stepping down from both the center and the clinical ethics consultation service to assist Dr. Winslow in a new clinical bioethics consulting project.

In addition to Dr. Mohr as director, Dr. Tai Kim will be associate director of the clinical ethics consultation service and lead the LLU School of Medicine clinical ethics elective course offered to fourth-year medical students. Dr. Marquelle Klooster and Dr. Katja Ruh will also continue as members of the consultation service. Dr. Grace Oei will concentrate on completing her pediatric intensive care fellowship.

Health care providers at LLUMC may ask the clinical ethics consultation service for a consultation involving the



Pictured left to right: Marquelle Klooster, Tae Kim, Katja Ruh, Robert Orr, and Grace Oei

care of a particular patient. Consultations result in a written report describing the medical condition of the patient, the ethical issues raised by the case, and the judgment of the consulting physician-ethicist. The director of the service works closely with each consultant and chairs the weekly case conference, which reviews each report. At each case conference, a confidentiality pledge is signed by each attendee, which sometimes include LLUMC physicians and administrators trained in bioethics, ethics professors from the School of Religion, university attorneys, and medical and graduate students studying bioethics.

- ✦ Issues that can lead to requests for ethics consultations include:
- ✦ Decision-making for a possibly incompetent patient who lacks a family or designated surrogate.
- ✦ Decisions about limitation of treatment.
- ✦ Interpretation of written advance directives (i.e., durable powers of attorney for health care, and living wills).
- ✦ Management of infants born with life-threatening anomalies.
- ✦ Clarification of ethical issues in conflicts among health care providers, patients, or family members regarding possible courses of treatment.



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The success of the center is YOUR success. It is your support, your energy, your foresight, and your long-range vision that we celebrate each and every day. For this we thank you and for your continued contributions to the center.

Here are some activities you have helped support:

- Conversations with Authors
- Publication of Jack W. Provonsha essays (being compiled and edited by David Larson, PhD)
- Publication of 2008 Jack W. Provonsha Lecture Series, *Moral Status of the Human Embryo*
- Roundtables
- Thompson Ethics Library
- UPDATE

Please feel free to contact the Center for Christian Bioethics at bioethics@llu.edu, or (909) 558-4956.

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