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Update

FLETCHER AND CONOLLY DEBATE ACTIVE EUTHANASIA

Joseph F. Fletcher, Visiting Professor of Medical Ethics at the University of Virginia, explored the morality of active euthanasia with Matthew Conolly, Professor of Medicine and Pharmacology at UCLA, on April 8 at Loma Linda. Fletcher argued that active euthanasia is moral and should now be a legal option. Conolly took strong exception on both Christian and medical grounds. James Walters moderated the discussion as well as a Medicine and Society conference earlier the same day at which Fletcher presented a lecture on the "Management of Terminal Illness."

Professor Fletcher, one of the first Protestant thinkers to explore the bioethical dilemmas of the modern age, published his pathfinding *Medicine and Morals* in 1954. A longtime professor of ethics at the Episcopal School of Theology in Cambridge, Massachusetts, Fletcher and his wife now divide their time between Charlottesville, Virginia and Anna Marie Island, Florida. Fletcher celebrated his eighty-second birthday while at Loma Linda.

Doctor Conolly received his medical training at Westminster Hospital, London University. He now serves the UCLA Medical Center's Support Services Team which cares for the terminally ill. In addition to a distinguished medical career in England, Conolly served as Advisor to the House of Lords Committee Against Euthanasia in 1977.

YODER ADDRESSES ETHICISTS AT LLU

John Howard Yoder, Professor of Theology at the University of Notre Dame, delivered the presidential address at a conference of the Pacific Section of the Society of Christian Ethics hosted by LLU on February 20. James Walters, the Ethics Center's Associate Director, was elected chairman of the association. Jerry McCarthy, an ethicist at St. John's Seminary, Los Angeles Diocese, was elected program chair.

In addition to Yoder's presentation, seven ethicists presented papers that covered the waterfront of Christian ethical concerns: Mark Kowalewski, USC, "A Pilgrim People: Toward a Processive-Dialogical Ethics in the Community of Faith;" Anthony Battaglia, CSU, Long Beach, "Sects or Denominations: Possibilities for Theology in a 'Post-Churchly' Situation;" Vernard Eller, University of La Verne, "Another Big Try at Church and Sect;" Francis Colborn, Claremont Colleges, "Bernard Lonergan's Method and Theological Ethics;" David Larson, LLU, "Personhood's Priority in Biomedical Ethics;" Brent Waters, University of Redlands, "Star Wars and Just Wars;" and Paul Bube, USC, "Prayer and Social Ethics."

Yoder argued that the Bible is a decisive resource for contemporary social ethics. He cited five New Testament church practices, including baptism and the breaking of bread, which exemplify social norms for contemporary life. The practices are wholly human and empirically accessible as human actions, yet the Bible sees them as acts of God. "God is doing them in, with, and under the human practice. What is being done on earth is done in heaven," he stated.

From Yoder's close study of early Christian practices, he concluded that (1) there is no fundamental distinction between genuine sacraments and appropriate Christian social action, (2) the doctrine of redemption is just as important to social ethics as is the doctrine of creation, and (3) the "good news" has direct implications for the ordering of human life since these mandates are only generally realized through current notions of socialism, democracy and egalitarianism.

Yoder's paper produced lively discussion. Some wondered if the practices cited by Yoder were grounded in — or were merely corroborated by — the realm of redemption (or revelation). Yoder refused to draw a dichotomy between the realm of redemption or revelation and that of creation or reason; rather he argued that too often the Biblical affirmations of egalitarian and communal practices are ignored and undervalued.

The discussion of active voluntary euthanasia culminated a four-month series of Medicine and Society conferences on the treatment of the severely and terminally ill. Earlier sessions dealt with "Do Not Resuscitate" orders, the foregoing of nutrition and hydration, and the factor of cost in million dollar cases. Video cassettes of the Fletcher and Conolly discussion as well as the earlier sessions may be purchased from the Media Services department of the Loma Linda University Library for $25 each.

THEOLOGICAL REFLECTIONS REGARDING AIDS

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Theology is thinking about the meaning of religious faith. Because religious faith is related to all of human existence or experience, so is theology. It is possible (and often useful) to "think theologically" about all sorts of things — that is, to think about the meaning of religious faith for an understanding of nature, science, medicine, education, sports, sex — whatever.

In a Christian context, to think theologically about AIDS includes at least these three ideas: (1) AIDS is not God's will for anyone; (2) AIDS is an opportunity for Christian service; (3) AIDS is not the final word about the patient. Let me try to unpack these ideas very briefly.

AIDS is not God's will for anyone. It is not punishment for sin ("divine retribution"). It is the result of a series of natural processes. Even if you regard intravenous drug abuse or homosexual activity as sinful, the fact remains that such activity is neither a necessary nor a sufficient condition for the occurrence of AIDS.

It is a basic Christian conviction that the best clue to the character and activity of God is Jesus of Nazareth. When some friends of Jesus asked about a particular victim of disease, "Who sinned, this man or his parents?" Jesus answered, "Neither" (John 9:2-3). The mistake made by Jesus' friends here was the assumption of a direct, cause-and-effect connection between one's moral choices and one's circumstances. Jesus pointed out that reality isn't that simple.

In the case of AIDS, this kind of mistake is probably a response to (and rationalization of) two universal human problems. On the one hand, there is our personal fear and anxiety. AIDS represents two aspects of human reality that often make people rather uncomfortable: sexuality and death. (This anxiety, by the way, seems to be as typical of physicians, nurses, and hospital chaplains as it is of the rest of humanity.)

On the other hand, there is human pride or self-righteousness, which has a convenient hierarchy of vices. Some sins, especially sexual ones, are often considered disreputable, while others, especially attitudinal ones, don't even count. According to Jesus, the truth of the matter is quite different: for the blatantly unrighteous there is the possibility of acceptance and forgiveness and an eternal future; but for the smugly self-righteous there is no future at all.

AIDS is an opportunity for service. Both its terror and its hopelessness give it a special claim on Christian attention and concern.

Jesus of Nazareth is not only our best clue to the character and activity of God; he is also our best clue to the meaning and fulfillment of humanness. In what he said and what he was we see what it means to be truly human. He said, for example, "Do for others what you would want them to do for you" (Matthew 7:12). And when he met the victims of leprosy (which was for his time and place what AIDS is for us), he listened to them, talked to them, touched them, healed them (e.g., Mark 1:40-45; Luke 17:11-19). When he was criticized for being too friendly with disreputable persons he said that the reason he cared about them was that God cared about them (Luke 15).

Jesus made it clear that humanness is fulfilled in giving, serving, helping. When he was talking about the ultimate meaning of human existence, he described a scene in which the King of all reality said to some people, "I was sick and you looked after me," and to others, "I was sick and you didn't look after me" (Matthew 25:36,43). To take the religion of Jesus seriously is to respond to human need.

The kind of service Jesus was talking about has two important characteristics. It is done without regard to the "worth" of those served: he washed the feet of Judas. And it was done without regard to self-interest: he was most interested in people who couldn't possibly return the favor. This, of course, is what God is and does: he gives himself for the benefit of the unworthy. This is the meaning of *agape;* this is the "good news."

And this is the kind of opportunity we have in relation to patients with AIDS. They can never pay us back. They will not become producti members of society. They will not do nate a small fortune to fund medical research; they often will not even pay their own medical bills. Those who are not already Christian will probably not be converted. But they are all sick, and they need to be cared for. And that is what matters.

There are many ways to care. One possibility is personal interaction: investing time and interest, being present and listening. Another possibility is the establishment of structures of care — such as volunteer organizations to make sure that patients are cared for, and hospices like the one established by Mother Theresa in New York.

Still another possibility is influencing public policy to address the public need. There needs to be massive public funding, not only for research but also for care, as the number of cases increases and the costs soar into billions of dollars. And there needs to be broad AIDS education in public and private schools and in the various information media. Such things are more likely to happen there is vigorous and persistent communication with legislators and other public officials, and if there is discus-

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“NO CODE” ORDERS: ARE THEY MORAL?

NURSES AND ‘NO CODE’ ORDERS

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Are “No Code” orders moral? Of course they are! The absence of “no code” orders on specific patients is immoral. Four major issues are especially important to nurses: (1) patient autonomy, (2) the role conflict of the nurse, (3) decision-making, and (4) family education.

Patient autonomy. Nurses place a high value on the ethical principle of patient autonomy. This principle was also supported by the President’s Commission on Bioethics, which recommended that treatment decisions should be discussed with a competent patient or the incompetent patient’s surrogate.

DNR decisions should be based on the moral values of the patient, preferences concerning the meaning, sanctity, nd quality of life from the patient’s own point of view. Are the patient’s present choices consonant with his or her nature as a person?

“Decisions should be based upon the moral values of the patient, preferences from the patient’s own point of view.”

Role Conflict. Role conflict is the greatest source of stress for the nurse who is caught in an ethical web. The nurse is responsible to three different entities. The nurses’ primary responsibility is to the patient; nurses act as patient advocates within their responsibilities as the most visible and constant care-givers during hospitalization. But the nurse is also responsible to protect the interests of the hospital and to carry out the orders of medical therapy. The nurse contends with these three sometimes competing interests, but she or he must also act according to her or his own ethical principles in each situation.

How can the nurse’s integrity be preserved when the wishes of a patient or family regarding a DNR response are in direct conflict with the physician’s orders or how can the nurse ethically justify disregarding the family’s or patient’s wishes in order to carry out hospital policy? What is the nurse’s obligation when a morally wrong decision is ade by someone else and the nurse is expected to implement the orders resulting from that decision? How can the institution provide “moral space” for nurses?

Decision-making. Health professionals, including nurses, do not usually have enough training in making ethical decisions. We feel that there are no right answers. We empathize and agonize with our physician colleagues over ethical decisions. Many discussions about whether it is time to write a DNR order for a specific patient are initiated by nurses. To postpone the decision or to make no decision is a decision to “code” the patient.

Yale-New Haven Hospital documented six communication problems related to DNR orders. Two of these are that: (1) Some members of the health-care team who have important information may not share it because they are unaware that a decision is to be made or because they are fearful that they may be viewed as overstepping their bounds. (2) Discussion with the patient is initiated much too late, so late that the patient may be incompetent.

A DNR order is a team decision. “None of us is as smart as all of us.” There should be interdisciplinary discussion of the patient’s status and goals. Each one on the team must understand the reason for writing or not writing the DNR order. It is important that the nurse be present when the DNR discussion takes place with the family. The nurse can then reinforce aspects of the discussion and can answer the questions of the patient or family based on the specifics of the discussion.

Members of the health team should talk with the patient or family before the patient is taking the last breath. Nothing is more stressful for the nurse than waiting “momentarily” for a decision to be made as the patient’s blood pressure and respiration decline.

Nurses care for patients on a sustained basis, attending to basic intimate, physical and emotional needs. Because of proximity, the nurse may be the one with whom the patient chooses to discuss the matter.

Physicians should document in the progress notes the discussion with the family or patient and then record the specific DNR order. Unfortunate errors of commission and omission have been made in implementing DNR orders because of paperwork blunders.

“How can the institution provide ‘moral space’ for nurses?”

Family Education. Do families really understand the terminology we use in discussing the patient’s condition?

Do they know what the "everything" means in "do everything you possible can?" Some families have been surprised by the presence of an endotracheal tube and a ventilator because they did not realize that this was part of the bargain in saying "everything."

Families need to understand that "no code" does not mean "no care." Although some treatments will be discontinued, the family needs to understand that we will vigorously pursue the goals of comfort and dignity for the patient and that we will make support of the family a high priority. Under these circumstances nursing care is intensified. The family responds best to nursing behavior directed toward patient comfort and the provision of information regarding the patient's condition.

In summary, patient autonomy should be a primary consideration in making the decision about the DNR order. The nurse has valuable information about the patient's view of what it means to be sick. Because of her or his proximity to the patient, the nurse plays a key role in aiding decision-making and family education.

WHAT IS A 'NO CODE' ORDER?

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"No code" orders are implemented in intensive-care settings by use of the term "do not resuscitate" or DNR. Many feel that this term is so inaccurate as to destroy the entire concept. "Do not resuscitate" sometimes wrongly implies withholding food and water, placing the patient "out behind the barn" or "leaving the litter along the trail" as the rest press on. In fact, all patients coming to the hospital are resuscitated — given air, either ambient or enriched, plus food and water. The real question is, should we give emergency cardiopulmonary resuscitation or emergency CPR? Some suggest that we should replace the term "do not resuscitate" with "no emergency CPR."

The great ethical dilemmas in medicine, such as those surrounding "no code" orders, center around establishing a balance among the demands of (1) justice, (2) beneficence, and (3) autonomy.

"Families need to understand that 'no code' does not mean 'no care.'"

To establish an ethical balance among these three areas is difficult and challenging. To complicate matters, the balance should be achieved in a setting where adequate discussion and reason are available. Unfortunately, intensive-care units are filled with patients, families, and staff who may be anxious, angry, disappointed, fearful, and guilt-laden. To find the right atmosphere in which to make "no code" decisions requires an active commitment on the part of everyone involved.

Balance must be achieved to serve the demands of justice, beneficence, and autonomy. However, other issues also demand consideration: the demands of science, law, cost containment, public relations, accurate record-keeping, and many more.

Nevertheless, if a hospital and its staff can deliver high-quality medical care in a setting of justice, beneficence, and autonomy for each patient, that hospital and staff will achieve a standing of inestimable value.

LET'S REPLACE "DO NOT RESUSCITATE" WITH "CARE FOR THE DYING"

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It is fitting and proper for medicine to establish guidelines to address hopelessly ill patients. Our humanitarian instincts dictate that irreversibly and irreparably ill persons facing imminent death or a vegetative existence should not be subjected to "advanced life support and maximal therapeutic efforts," which at best will forestall the inevitable, and at worst increase morbidity. (1,2,3) Experience has shown that these patients, even if they are successfully resuscitated, do not survive their hospital stay. (4,5) Economic constraints have emphasized the high cost of intensive life support, and a litigious climate makes a sanctioned hospital protocol desirable. The question is, what policy should guide us?

"Nothing is more stressful for the nurse than waiting for a decision to be made as the patient's blood pressure and respiration decline."

Closely examined, most current DNR policies fail the test of logic. They do not work well and do not serve the needs of dying patients. They are illogical because there are no characteristics inherent to CPR which qualify it to be the centerpiece of a medical policy towards the dying. Other interventions may be equally, if less immediately, required to reverse catastrophe and prevent death: chest tubes, transfusions, antibiotics, antiarrhythmics, cardiac pacemakers, and emergency surgery. Setting aside its urgency and drama, CPR is no different in principle from many other methods we use to preserve and prolong life. Even monitoring a patient's electrocardiogram or checking his blood gases, electrolytes and blood counts, serve the same purpose in their mundane way. While sometimes considered "heroic," CPR today is a rather ordinary procedure which in its basic form is taught to camp counselors, boy scouts, teachers and taxi drivers. Unfortunately, most DNR policies have elevated the status of CPR so that it dominates their philosophies and is considered the touchstone of our interaction with dying patients.

Much confusion and inconsistency have been created in the process. A recent article stressed the widely-held view that "DNR orders do not and should not be interpreted to imply any other change in the level of medical or nursing care." (1) This dictum reverberates among most hospital policies. (6,7,8) Yet, what is the logic with a hopeless, dying patient, of withholding CPR on humanitarian grounds but intervening in other ways for "reversible conditions" which will prolong his dying? I am not referring to withdrawing ongoing treatment, pain control, water or nutrition. But, to the extent a physician is willing to judge his patient as irreparably and irreversibly ill facing imminent death or a vegetative existence, then all additional interventions, not only CPR, become useless and even intrusive. To the extent that a physician decides additional interventions are not useless, he has implicitly judged his patient as not irreparably and hopelessly ill, and it is arbitrary to withhold CPR alone.

> **"Some physicians fear that DNR status will expose their patients to less thorough care."**

We have all experienced this arbitrariness. Among 72 DNR patients, Evans and Brody found no consistent pattern in the range or kind of other interventions ordered — 6% received "all interventions except resuscitation," 50% received "some medical interventions for reversible conditions," and 36% received "no additional interventions." (9) Uhlmann and colleagues reported that 43% of DNR orders were ambiguous about further treatment limitation plans. (8) They noted that cross-covering physicians were uncertain how to interpret the intent of DNR orders toward transfusions, antibiotics, antiarrhythmics, and admission to the intensive-care unit. Highlighting confusion in this area, a recent editorial tried to "clarify" DNR policy by changing the name of the order to "No Emergency CPR," causing us to wonder who gets "non-emergency CPR?" (7) It is unlikely that simple name changes will add clarity.

> **"CFD would stress providing a new level of care and attention to the dying patient."**

Criteria for DNR orders are vague. A recent study found that 38% of patients declared DNR did not arrest and left the hospital alive. (11) Kyff, *et al.*, reported an 11% survival rate for patients who received CPR in the hospital and a 16% survival rate for ICU patients considered DNR. (12) Residents, attending physicians, and community practitioners were found to differ significantly in their DNR decisions. Residents more often favored withholding support than practitioners, with attendings holding an intermediate position. These physicians varied greatly in assessing the reversibility of a patient's illness and in their perceptions of a patient's quality of life. (13) Lo and Steinbrook stressed that some patients who accepted DNR status before a crisis changed their minds in the face of rapid deterioration. (16) These data raise disturbing questions about the accuracy and objectivity of DNR decisions.

Moreover, our DNR policies are not achieving what many see as their most important goal, to insure that physicians consult early with patients and families in order to allow them "autonomy of judgment." (14) Studies show that this occurs with disappointing rarity. Bedell and others found that of 389 patients subsequently placed on DNR status, only 11% had an abnormal mental status on admission. However, before the decision to write a DNR order was made, 76% had become confused or comatose, excluding them from involvement. (11) Uhlmann, *et al.*, reported that among patients declared DNR at the Portland VA Medical Center, only 43% were involved in the decision. (10) More striking was Evans and Brody's finding that only 26% of DNR patients were consulted by physicians. (9) Thus the practice of DNR policies is at variance with their ethical goal of prior consultation with patients.

> **"Each one on the team must understand the reasons for writing or not writing the DNR order."**

When physicians do discuss this sensitive issue, they vary greatly in their styles, vocabulary and demonstrations of empathy. Miller and Lo reported marked differences in the ways physicians described CPR and its possible outcomes. (15) Some physicians avoid describing CPR, feeling it would cause the patient "too much worry." Others hesitated to recommend a course of action, fearing to impose their wishes on patients even when guidance was requested. A simulation study found the physicians' personal assumptions and values, often unconsciously conveyed, influenced the patient's choice. (15)

In medicine we are at our best when guided by reason and compassion. Most DNR policies address the broad needs of dying and hospitalized patients with little explicit compassion. (3) This omission, perhaps stylistic, sends a regrettable message. Thus, while DNR policies mention the importance of providing continued comfort and support, in reality, patients on DNR status are frequently cast in a lesser role. An informal survey of house staff by Donnelly found that, to them, DNR was equated with "no hope," "no care," "do nothing," and "do not treat." Some physicians fear that DNR status will expose their patients to less thorough care by nurses and cross-covering physicians. (7) I believe these prejudices arise from the emphasis of DNR

> **"The great ethical dilemmas in medicine center around establishing a balance among the demands of justice, beneficience, and autonomy."**

policies on sparing the dying patient intervention, instead of intervening to ease his passage. DNR policies, as reflected in their name and by virtue of their focus, stress the withholding of care from individuals at a point in their lives when, even more than death, they fear abandonment and loneliness.

It is my view that instead of a "Do Not Resuscitate" policy, we need to "Care for the Dying" (CFD). A CFD policy would acknowledge the logical and consistent view that once a patient has entered the process of dying or a vegetative existence, all additional interventions to prolong life, be they heroic or mundane, should properly be withheld. This would include CPR, antibiotics, antiarrhythmics, transfusions, intensive care and surgery. These patients should also be spared the pain of venipuncture and arterial blood gas determinations, as well as the unnecessary discomfort of radiological procedures and frequent awakenings for vital signs. At the same time, CFD would stress providing a new level of care and attention to the dying patient. Sufficiently potent and frequent doses of pain relievers could be given without ambivalence. Visiting hour limitations could be suspended. Family members in emotional distress could be provided with trained support. Children could be encouraged, with guidance, to say good-bye to their loved ones. Remote family members could be contacted and assisted in paying one last visit. Religious needs and involvement of the patient's clergyman would be emphasized. Rounds could be used to the staff's benefit by discussing the specific emotional and ethical issues the patient's treatment raises. The medical and nursing team would see their roles as positive ones, of providing care, comfort and company to the patient and his family. This shift in attitude would do much to prevent the demoralizing negation which at times repels us from the dying patient's bedside.

"Intensive-care units are filled with patients, families, and staff who may be anxious, angry, disappointed, fearful, and guilt-laden."

"Most current DNR policies fail the test of logic. They do not work well and do not serve the needs of dying patients."

CFD could address other needs of hospitalized, dying patients and their physicians. Not all patients need to or should die in the hospital. There is much to be said for allowing a person to die among the comforting familiarity and memories of his own home. Physicians may feel uncertain or uncomfortable about judging certain patients hopelessly ill. They may desire and should receive assistance from medical, religious or bioethical consultants. A CFD Committee could be helpful to monitor the application of hospital policy towards the hopelessly ill.

In my opinion, a policy to Care for the Dying would be intuitively more satisfying for members of the medical team and for patients. It would allow us to face our patients and their families early and speak to them without apology about withholding unnecessary interventions, because we would offer them at the same time a supportive and positive approach to ease their passage. It would remove the burden of trying to reconcile the artificial distinction between CPR and other interventions. By being more logical, a CFD policy would be more consistently implemented. By being explicitly compassionate, it would be more emotionally acceptable to physicians and nurses who would be able to see themselves as providing for, not just withholding from, their patients. Hopefully, while achieving these goals, it would also encourage us to remember — perhaps with regret, but certainly without shame — that even in this advanced technological wonderland of modern medicine, we can cure all too rarely and treat only sometimes. Yet, we can comfort always.

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The Pandora's Box of Human Life

Society's Issue: Is Biology or Personality the Essential Ingredient?

By JAMES W. WALTERS

The Vatican has opened a Pandora's box that won't be closed until society answers a fundamental question: Is biology or personality the essential ingredient of valuable human life? Rome says biology. Society increasingly says personality. The question is not new, but the debate is ratcheted up several notches by the promulgation of the Roman Catholic Church's statement of doctrine, "Respect for Human Life in Its Origins and on the Dignity of Procreation."

The biological model holds that every manifestation of *Homo sapiens* is of intrinsic worth. Therefore the Vatican speaks of the embryo as "the unborn child" who "must be cared for, to the extent possible, in the same way as any other human being as far as medical assistance is concerned."

The Vatican is unflinchingly consistent in reasoning that the embryo "must be treated as a person." Even in-vitro fertilization, which utilizes the husband's sperm, is banned because, among other objections, unused embryos might be used for experimentation or destroyed outright. The incapacity of one out of five couples to procreate is lamented but is no excuse for sinning against the natural, hence moral, method of human reproduction.

The personality model argues that the essence of being human is not genetic composition but uniquely personal capacities—for example, the capacity for rational creativity. Thus the more artificially procreation is done, the more "human" it is because it involves personal creativity.

The personality model draws a fundamental distinction between mere human being and valuable personal being. All humans are not personal, and all persons are not human. Individuals in a permanent coma are undeniably human, but questionably personal; "ET" is an engaging little person, but surely is not human.

Persons are defined as individuals who are capable of self-awareness, rational choice, loving and being loved. An embryo does not possess these capacities; neither does a fetus, nor for that matter a newborn. Those who advocate personhood criteria for determining valuable life are liberal regarding abortion and nontreatment of severely handicapped newborns; however, they are the first to contend for animal liberation—particularly the right to life of dolphins, whales and primates.

Neither position takes its case to a logical, if extreme, conclusion. The Vatican gives weight to humanhood, but it does not conclude that medical science should attempt to arrest the high rate (over 50%) of spontaneous abortions of embryos, and thus potentially save millions of lives. Philosopher Michael Tooley, a leading advocate of personhood, argues that infanticide is intrinsically moral but, because of untoward social consequences, unwise.

The question is not one of absolute rightness, but of weighting. And such weighting in a democracy is determined by neither Pope nor philosopher, but by a people's collective experiencing of and thinking about human life. The church is to be praised for putting a long-simmering discussion on the front burner. Indeed, legislation is needed to keep technology in place, but the contours of the legislation must emerge from public discussion.

An appropriate social policy in a pluralistic, non-sectarian state is neither a thoroughgoing biological nor a personal model of a human being, but a reasonable compromise. A basic reasonableness suggests two important standards determining the value of early human life: potentiality and proximity—derived from the biological and personal models, respectively.

Potentiality suggests that the human conceptus is not just any tissue, but is uniquely endowed with the potential of attaining full human status if nature takes its normal course. In one sense all humans are merely potential persons, for no one has achieved his or her ideal potential; the embryo is merely the weakest of the weak. As such, it could be argued that the conceptus deserves the protection of law, just as the law now protects other classes that have faced discrimination at the hands of the strong—slaves, foreigners, blacks, women. The civility of a society may be determined by the manner in which it treats its most vulnerable members. (The norm in Western countries that are involved in embryo research is to limit invasive procedures to subjects fewer than 14 days old.)

Proximity means that the embryo-fetus is a person in the process of becoming, and the greater the approximation of personhood, the greater its value. Proximity grants the potential of the newly fertilized single-cell zygote but distinguishes between its value and the value of a mature human person. The difference is so significant that most reasonable persons do not believe that the right of a conceptus to life is as weighty as the right of a woman to take a morning-after pill.

The Supreme Court's Roe vs. Wade decision used approximation-of-personhood reasoning in dividing human gestation into trimesters. During the first trimester a woman has free choice without the possibility of state regulation; in the subsequent trimesters the state may sequentially regulate and then ban abortion.

Approximation-of-personhood now also applies at the other edge of life. A year ago this month the judicial council of the American Medical Assn. ruled that physicians could ethically withdraw all artificial life support, including nutrition and hydration, from patients who were in comas reasonably determined to be permanent. These individuals are fully alive human beings in that their brain stems are intact and sustaining circulation and respiration. But because their personal capacities for self-awareness and rationality are irretrievably lost, they no longer possess a unique claim to continued existence.

Coma cases are the opposite of embryos. With coma patients, proximity is great but potentiality is nil. With embryos, proximity is small but potentiality is great. In both cases many persons will ethically justify termination of support because the human subjects are so distant, in either potentiality or proximity, from personhood.

This balance, or conflict, will be crucial in sorting out the numerous conundrums that await us in the Pandora's box of policy decisions affecting human life.

James W. Walters is an associate professor of Christian ethics at Loma Linda University and the chairman of the Pacific section of the Society of Christian Ethics.

AIDS *(continued from page 2)*

sion in public forums like letters to editors and talk shows. We can let people know that AIDS patients must be cared for, even if it means — as it surely will — less money for ourselves because of higher taxes and insurance premiums.

AIDS is not the final word about a patient. It is a terrible, tragic word, but it is not the last word. Jesus of Nazareth is the best clue to the meaning of human existence and everything it contains. For him, suffering and death were not the last word. The last word was *victory over* suffering and death.

As of now, AIDS is absolutely fatal. But the patient as a person can be healed in the way that matters most (I do not say this glibly, but very deliberately). Typically the patient feels abandoned by family and friends. If the patient is homosexual, he already feels rejected by society in general. And this feeling may be internalized as guilt — not only because of what he does, but because of what he *is.* In this abandonment and guilt, there is no good medical news — no prospect of a cure, not even any hope of a miracle. Despair is eminently understandable.

But there is the possibility of love and acceptance, mediated by persons who are willing to care. This is even more important than extending the patient's life. And for this we will need people. We will need personnel for whom caring is not only a professional function but also a personal ministry. We will also need an army of volunteers who will invest themselves in terms of their presence.

For a Christian health-care community AIDS is a challenge to *live* its theology.

COWART, CAMPBELL, PROVONSHA ASSESS "ETHICS AT LIFE'S END"

Dax Cowart, Ross Campbell, and Jack Provonsha were the principal speakers at "Ethics at Life's End," a seminar the Ethics Center presented on March 9 at LLU's 55th Annual Postgraduate Convention. About 125 physicians, nurses, and other professionals participated in the day's activities.

The seminar began with the presentation of "Please Let Me Die," a filmed interview of Dax Cowart several months following a 1973 automobile accident that left him blind and severely burned. During the interview, Mr. Cowart repeatedly and thoughtfully requested that his treatments be terminated so that his life could end. When questioned at the LLU conference, Cowart reasserted his belief that his therapy should have been discontinued even though he has been able to complete college and law school, pass the Texas bar, and establish a law practice since his accident.

Ross Campbell, a health-care attorney with Musick, Peeler, and Garrett in the San Francisco Bay area, detailed the expectations of current California law as available in recent statutes as well as in the Barber, Bouvia, and Bartling cases. He emphasized the usefulness of durable powers of attorney for specifying legally authorized decision-makers in difficult cases.

Jack Provonsha, a physician and ethicist who serves as chairman of the Ethics Center's Board of Directors, discussed the issues of the day from the perspective of Christian moral thought. He distinguished several forms of death (mind, brain, organ, cellular) and argued that modern technological resources require one to focus upon the death of the mind even as the body is respected for its symbolic value. Provonsha also emphasized the priority of a competent patient's free and informed decision.

PAPERS SOLICITED FOR THE 1988 ABORTION CONFERENCE

Scholarly papers from a variety of perspectives and professions are solicited for the Ethics Center's 1988 conference on "Abortion and Adventism Today." These papers will be presented at the conference, revised at their authors' discretion in light of questions and criticisms, and published in an anthology that reveals current Adventist thought. This collection of essays will enable Adventist individuals and institutions to formulate their own conclusions regarding abortion with awareness of what their colleagues are thinking.

Papers may be either descriptive or prescriptive. Descriptive studies will analyze the denomination's past and present attitudes. Prescriptive essays will defend recommendations regarding abortion in Adventist families, institutions and political efforts.

Any person with a point of view regarding abortion in Seventh-day Adventist thought and life who is interested in presenting a paper at the conference is invited to contact David Larson at the Ethics Center as soon as possible.

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