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Update

Waitzkin, Kirkendahl and Likens Debate National Health Plan

Howard Waitzkin, a physician and economist who teaches at the University of California at Irvine, George Kirkendahl, an administrator at San Antonio Community Hospital, and James Likens, a professor of economics at Pomona College in Claremont, California debated a proposed national health plan at the May 5 session of the Ethics Center's monthly Medicine and Society Conferences.

Waitzkin, a member of the group of physicians who published the proposal in the January 12, 1989 issue of *The New England Journal of Medicine*, made the primary presentation. Kirkendahl and Likens responded. James Walters, director of the Medicine and Society Conferences, moderated the discussion.

Waitzkin pointed to mushrooming costs, millions of medically uninsured and expanding medical bureaucracies as indications that in the United States the present system of financing and delivering medical care should be replaced. Waitzkin advocated a comprehensive system that would be mandated by the federal government but funded and administered by states and communities. Among other things, this plan would eventually eliminate private medical insurance; however, medical care facilities would be privately owned and the salaries of physicians would not be lowered. Because of its greater efficiency, the proposed plan would be funded by taxes and mandatory employer contribu-

tions without, Waitzkin contended, increasing overall expenditures.

Kirkendahl and Likens agreed that in the United States patterns of delivering and financing health care are ill; they doubted, however, that the group of physicians represented by Doctor Waitzkin has discovered an economic cure. Kirkendahl feared that the proposed plan would stifle medical entrepreneurship with a resulting adverse impact upon research and development. Likens doubted the efficiency of the proposed plan. He particularly questioned the creation of another governmental bureaucracy that might be more sensitive to its own preservation and expansion, and to political pressures imposed by special interest groups, than to the medical needs of citizens.

Audio and video tapes of the exchange are available from Media Services, Loma Linda University, Loma Linda, CA 92350.

Edmund Pellegrino Delivers Jack Provonsha Lecture

Edmund D. Pellegrino, John Carroll Professor of Medicine and Medical Humanities at Georgetown University, and until recently the director of the Kennedy Institute of Ethics at that institution, delivered the second annual Jack W. Provonsha Lecture at LLU's School of Medicine Alumni Postgraduate Convention to a capacity audience at the Randall Visitors Center on February 15. Since then, Pellegrino has been appointed director of Georgetown University's new Center for the Advanced Study of Ethics of which the Kennedy Institute will be a part.

Pellegrino arrived with a formal lecture entitled "Character, Virtue and Self-Interest in the Ethics of the Professions," from which major excerpts will be published in a subsequent issue of *Update*. But on the occasion of his lecture he accepted an invitation to do something

Gerald and Betty Winslow Accept Positions at Pacific Union College

After having served at Loma Linda University for two years, Gerald and Betty Winslow have accepted positions at Pacific Union College in Northern California. Gerald Winslow will chair the department of religion at PUC, a school of liberal arts and sciences that Seventh-day Adventists have operated at Angwin, about an hour's drive north of San Francisco, since 1909. He will lead a group of theologians at PUC who provide general education classes in religion as well as courses for majors in religious studies and ministerial studies. He will also continue writing, consulting and lecturing in the field of biomedical ethics. Betty Winslow will teach in PUC's nursing and adult education programs as well as continue her doctoral studies at the University of Denver.

Gerald Winslow made several notable contributions during his two years at Loma Linda. In addition to teaching substantial numbers of students through the university's school of religion, he lectured extensively both on and off campus. Winslow was very active in the deliberations that established LLU's protocol regarding the use of transplantable organs from anencephalic newborns. An upcoming issue of *The Journal of Pediatrics* will contain his views on this controversial subject. He also authored several other scholarly articles and chapters that will appear in forthcoming publications. Winslow collaborated with James Walters in developing plans for a major project on "Ethics and Aging" that is currently scheduled for the 1989-1990 school year. He serves on the Human Life Committee of the General Conference of Seventh-day Adventists which, among other things, is reviewing the denomination's guidelines on abortion. But the Clinical Intensive in Biomedical Ethics, which attracted a number of scholars for eight weeks of full-time

Inside this Issue:

**Clinical
Medical Ethics**

Clinical Medical Ethics

Gerald Winslow led an eight-week "Clinical Intensive in Biomedical Ethics" at Loma Linda University that began in January of this year. The purpose of the seminar was to expose students of bioethical literature to the moral challenges and dilemmas that occur in modern medical centers. The seminar attracted the full-time attention of the following individuals for two months: Beryl Bull (pre-medical student, Walla Walla College); Luz Diaz-Schreiber (chaplain trainee at UCLA Medical Center and doctoral student at LLU's School of Education); Mary Hardy (a physician in Glendale, California); W. Noel Keyes (emeritus professor of law at Pepperdine University); Sister Francesca Lump (a nursing administrator from St. Louis, Missouri); Marylee Meehan (a graduate student of biomedical ethics from Cape Cod, Massachusetts); Beverly Sloane (author and lecturer); Julie van Putten (an assistant professor of health education at LLU); and Sue Wholmes (a student of philosophy and classics at the University of British Columbia).

Paul R. Johnson, the author of the following essay, was an Ethics Fellow at Loma Linda University for the month of June. He received his doctorate in Christian ethics from Duke University and now serves as a professor of religious studies at D'Youville College in Buffalo, New York. He is the author of several articles on ethical issues in neonatology.

INSIGHTS AND INQUIRIES: Reflections on a Clinical Medical Ethics Internship

*By Paul R. Johnson
Ethics Fellow*

Like many teachers of bioethics, my knowledge of the field developed primarily at the theoretical level. A doctorate in Christian ethics, years of teaching at a college with several health-related major programs, and participation in a National Endowment for the Humanities Summer Seminar on bioethics led me to adapt general moral theory to ethical concerns of health professionals in the classroom and in several articles. But, as Robert Veatch has written, "Teachers should, when possible, have not only full qualification in ethics or the medical sciences, but also 'competent amateur' status in the other field. In other words, philosophers should know their way around the hospital."

Recognizing the value of such exposure to the clinical setting, I sought out a program which would give me an introductory acquaintance with clinical medicine as well as an understanding of the situational contingencies which form the context for actual medical decision making. Through the cooperation of Loma Linda University Medical Center and LLU's Ethics Center, a month-long clinical medical ethics internship was developed which offered the opportunity to follow physicians on rounds, attend ethics committee and IRB meetings, and interview a wide range of health-care and related personnel. This experience has provided new insights and raised new questions concerning the nature of decision making in the clinical setting. Although the comments

that follow are primarily personal reflections on my medical ethics internship, I hope to outline an agenda for my own future thinking in bioethics and to invite others into such analysis as well.

The Clinical Setting and Moral Decision Making

Within the clinical setting, three interrelated factors become quickly apparent: technology, complexity, and uncertainty. One is struck immediately with the technological sophistication and dependency of modern medicine. Technology has become central to all steps in the medical process. Highly refined instrumentation is used in patient assessment and diagnosis. Powerful computers generate and store data and transfer information quickly to terminals throughout the hospital. Technology is crucial to therapy as well, being the means to carry out treatment and monitor patient progress. Thus, technology has become a powerful ally in a more rapid, accurate, and effective fulfillment of medicine's goal of extending and enhancing life. But questions also arise. Does technology carry out *our* decisions, or does its presence begin to make decisions *for* us? Does it implement our values or obscure them? Does technology carry its own imperatives, and how do they relate to human choice? Ongoing bioethical consideration needs to involve philosophical and theological analysis of assumptions underlying technology and its relation to human nature and ethics.

Complexity in the clinical setting is a product of at least three components. Because of technology's ability to detect a greater range of possible medical problems in a person and to bring about a variety of cures and partial cures, and to slow down the process of decline, there is complexity in diagnosis and treatment of patients. Complexity is also present due to the specialization and organization of modern medicine. Medical care today is made up of the interaction of many professionals: attending physicians,

consultants, nurses, technicians, social workers, etc. While this may increase expertise in care, coordination of diagnosis, therapy, and other services is not easy to achieve. A third level of complexity involves the role of factors outside the immediate context of decision making. Hospital committees, institutional policies, state and federal regulations all may impinge on the process of making medical and moral choices. Medical ethics has often focused on narrowly defined moral choices apart from the highly complex context in which they occur. More attention needs to be paid to this complexity both for its importance in influencing the decision-making process and its possible implications for the actual decision that should be made.

Technology and complexity contribute to, but are not the whole of, uncertainty in the clinical setting. Two other sources are even more central to ambiguity in this context. The clinical process itself, both diagnostic and therapeutic, is characterized by more

uncertainty than usually recognized by the medical layperson. The tentative nature of this entire process became apparent during observation and interviews. Richard Zaner describes the method of clinical reasoning as more like arguing a court case than proving a scientific hypothesis. He outlines the tentativeness and uncertainty in each of three steps: diagnostic (which symptoms are significant, and which diseases might they represent?), therapeutic (which strategies of care may be effective?), and prudential (which action fits this particular patient best?). This last step points to the second inherent source of ambiguity, the possible difference in values and perspectives within the caregiver/patient/family nexus. Both the definition of illness (that which constitutes unacceptable disruption of normal functioning) and of therapy (appropriate outcome and acceptable means of achieving it) are colored by the world views, life experiences, and value perspectives of the various participants in the decision making.

A Baby Is Dying

*By Beryl Bull
Ethics Fellow*

A tiny baby with a fatal genetic abnormality is dying. His parents are holding him for the first time since birth, free from tubes and instruments. Medicine and science have been withdrawn and nature is taking its course. Staff and family members wait with the parents, hating the feeling of helplessness. Some busy themselves by plying each other with tissues and glasses of water. Others isolate themselves in their own silent misery.

I am observing in the neonatal intensive care unit for the afternoon. I have been here several times before on rounds. The babies lie in their beds while nurses hover over them. For a while, medical knowledge seemed to be winning against nature. Everything seemed orderly and under control. I had never seen one of the babies die or had any interaction with their parents.

Now here I am in a small conference room watching the death of a baby. I am surprised at my own reaction. I feel myself retreating from the situation, trying to deny what is happening. How do the nurses and doctors and students who work in the NICU deal with the suffering and death of so many of their patients? How can I learn to deal with the problems so that I can care for these children without distancing myself so greatly that I cannot empathize with those in pain? How can I avoid getting so involved that I burn myself out mentally and emotionally?

Several of the nurses mention having diversions to keep their minds off the children. Many have families and hobbies to divert them. Many young nurses who are just starting their careers get very involved in their patients and are devastated when they die. There must be a limit to the number of times a person can experience that wrenching ordeal before the scars get too painful and one starts protecting oneself by withdrawing from those in need.

One result of recognizing this uncertainty in the clinical setting is the possible construction of a model of medical ethics which parallels the clinical reasoning process described above. Bioethical reasoning has often sought to argue for definitive answers to specified moral problems. This results not only from the use of traditional forms of philosophical reasoning but from pressure for moral certainty from "ethical laypersons" (many health-care workers, patients, etc.). But a truer expectation is recognized by Erich Loewy who suggests, "Uncertainty in moral judgments is at least as inevitable as it is in the more technical considerations of medicine."

An approach to bioethical analysis which takes account of this ambiguity may take the pattern of clinical decision making as an exemplar. The ethicist in this model will analyze the situation for moral principles, categories or questions that may be applicable and propose the ones that seem most likely to be relevant (cf. diagnosis), will suggest ethically acceptable options to deal with the issue and/or point out ethically unacceptable choices (cf. therapy), and will assist the decision makers in selecting from among the options the one most appropriate to this particular situation (cf. prudential choice). A method such as this will have the advantage not only of fitting the decision context as actually experienced but also of taking a form recognized by health-care personnel, thereby gaining utility in this setting.

The Scope and Role of Medical Ethics

To many, the term "medical ethics" connotes dramatic situations of life or death decisions. This is not surprising since it is not the only form in which bioethical issues are addressed in the mass media; it is also the focus of much professional literature as well. Yet, as observation during the internship made quite evident, the greater portion of human interaction in the clinical setting was of a more mundane and routine variety. So, if ethics is concerned with the moral qualities of human interaction, medical ethics may more consciously and more frequently have to address itself to broader issues. These broader concerns here involve analysis of the situational contingencies of clinical ethics decision making. Three issues come quickly to mind.

To begin with, most human interaction in the clinical setting is of the mundane and routine nature referred to above. Daily repetitive behaviors, patterned procedures, generic forms of personal relationships are all part of the medical situation. Ethicists may need to consider what I would call an "ethics of ethos," i.e., the quality of the physical, behavioral, and interpersonal milieu in which the more specific bioethical decisions are made. The setting in which a choice takes place often affects that choice. For this reason, the ethos of this setting is itself an ethical issue. The milieu should be one which encourages, or at least does not discourage, informed, reflective decisions participated in by all concerned parties. Thus, the scope of ethics may need to be broad enough to include the architectural and physical configuration of the medical facility, availability of medical technologies, staff working conditions, patient and family interaction with clinical personnel, availability of other related staff (e.g., social workers, chaplains, patient representatives), etc.

A similar issue that should be part of the scope of medical ethics is the policy context within which decisions are made. One needs to be in a clinical setting only a short time before seeing the impact of hospital policies and governmental regulations. For example, federal Baby Doe legislation affects decisions about newborns; state and local funding of medical care influences access to treatment; institutional policies encourage some therapies and discourage others. In light of this, medical ethics can strengthen its contribution to clinical decision making by more extended analysis of policy matters. Past consideration of policy has often been focused on the outcome of the final decision. The analysis being

proposed here is twofold. First, we would benefit from an examination of the policy-formation process itself. How do policies come into being? Who is involved? That is, one can, at governmental or institutional levels, describe the methods of making policy and can assess the ethics of these methods. If ethics is to have impact on policy formation, it must understand the process and help foster a method which is itself morally sound. Second, ethics can be concerned with encouraging policies that go beyond predetermining a choice to those which facilitate the process of choice. Without mandating outcome, policies can be established which enhance, outline, and monitor sound and acceptable steps in the making of decisions.

The third issue that could expand the scope of traditional medical ethics arises out of the truly interpersonal nature of the clinical setting. Ethics tends to focus on the decision to be made. But there are numerous individuals involved in that decision whose concerns need to be addressed. It is not a simple matter of a physician/patient dyad. On one side of this relationship is a whole health-care team—physicians, nurses, therapists, social workers, etc. On the other side are patient, family, friends. If ethics relates to the involvement of and impact on human beings of actions that are taken, then some bioethical attention is properly devoted to this wider interpersonal network. This includes the ethics of the quality of relationships within staff or between staff and clients. More specifically, we may have to look further at the nature of involvement in decision making by a wider range of participants. Ethics should also be concerned with the effect of decisions on all participants in the setting. Medical ethics is typically interested in the impact of decisions on patients. But decisions also affect others who live with the consequences of these choices—staff who carry them out, and family who experience the long-term benefit and/or burden of the results of the choices. Thus, while legitimately focusing on the outcome to the patient, medical ethics needs also to integrate into the decision-making process consideration of consequences to others who are affected as well.

Four Contributions of Medical Ethics

A question was posed to me during one of my interviews. I was asked, "What do ethicists add to decision making?" The answer of the person who asked the question was, "Very little. They tend simply to ask questions. And there are enough questions already." While this comment significantly undervalues the importance of asking the *right* questions, it did pose a challenge to articulate more fully the contribution of ethics. Based on my observations during the internship, four roles for medical ethics in assisting decision making seemed most important.

First, ethics needs to be an important part of the formation of the character and outlook of health-care professionals. Constitutive of the clinical setting is the intrinsic promise to help and the relation of power and vulnerability between professionals and patient (Zaner). Such relationships demand high moral sensitivity and conscientiousness. Thus, ethical training should be a part of the formation of medical professionals. This should go beyond formal classroom teaching. The importance of role modeling and situational experience in medical education points to the importance of "ethics rounds" or "ethics consultations" as a source for formation of this sensitivity.

Second, as pointed out earlier, bioethical choices take place within a context, a context made up of governmental regulations, institutional policies, physical environment, and interpersonal relations. If ethics is to have an impact on decisions made in such a context, it will need to address itself to the moral quality and influence of the constituent elements of this context.

Third, in the words of one physician, the role of ethics should be to provide "perspective, a framework for consistency" in decision

making. The important function here is the clarification of concepts and principles and the relationships among them. More than values clarification for the individuals involved in making choices, it is also working toward some general framework within which individual thinking can be evaluated.

Finally, also in the words of the physician cited above, this general framework must be developed in a method which recognizes the practical exigencies of the actual clinical setting by making it possible to "sort out realistic options, not suggest exotic, unreal ones." A model such as the one outlined earlier, one paralleling the clinical reasoning process, may hold promise of meeting this requirement. In it, ethical problems and principles that are related to a particular decision are analyzed, the most relevant issues are defined, the range of ethically acceptable options is clarified, and the final decision making among appropriate participants is enabled.

Conclusion

The experience of a clinical medical ethics internship has both brought about new insights and raised challenging inquiries for me as a bioethicist. My goal in entering this experience was to see how the clinical setting might influence the actual decision-making process. My observations have pointed to the impact of technology, complexity, and uncertainty in that setting, the need to expand the scope of much traditional medical ethics, and the variety of roles for ethics in enhancing the decision-making process. These brief reflections are both a conclusion, drawing together my experiences into an overview, and an agenda for future work for myself and others in the discipline.

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Manners and Morals in Clinical Medicine

By David R. Larson
Medicine and Society Conference
December 14, 1988

The *Encyclopedia of Bioethics* contains no article on "manners." Few, if any, medical ethics anthologies include essays about "manners." There is no major reference to "manners" in either the table of contents or the "locater" of the 2nd edition of *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*, a widely used manual of useful moral instruction. Searchers for articles about "manners" in the professional journals of ethics and medicine uncover some material, but neither the quantity nor the quality of this literature is overwhelming. In 1986, Simon and Schuster did publish Edward Shorter's *Bedside Manners: The Troubled History of Doctors and Patients*. Its more than three hundred pages overflow with the raw material of human history that is required in moral reflection; however, as its title indicates, this volume is more historical than

ethical in orientation.

Why all this silence? Especially from professional biomedical ethicists?

One factor is that ethicists assume that we all applaud good manners and therefore moral debate is irrelevant. Who would attend a convocation organized to debate the topic: "Resolved, good manners are commendable"?

A second factor is that ethicists are usually normal human beings who expect that good manners will be taught and caught early in a student's academic career. One recent author contends to the delight of thousands that he learned everything he ever really needed to know in kindergarten. Sadly, everyone does not learn good manners in kindergarten, but everyone should (if not before!).

A third consideration is that ethicists often discuss good manners under different rubrics: truth-telling, keeping confidences, acquiring consent as well as the virtues of professional persons. Each of these three considerations contributes to the apparent conspiracy of silence among bioethicists regarding manners at the bedside.

But perhaps a fourth factor is also responsible, one that is more subtle and significant than the other three combined: there is no universally accepted account of the good manners of a health care professional or anyone else. This lack of consensus is especially apparent in large hospitals that serve diverse populations each of which has its own expectations as to what manners are good and bad. Such differences are increasingly common and increasingly difficult to resolve in the pluralistic and dynamic societies of the so-called postmodern era.

Citizens in premodern cultures did not face this problem, apparently. Such societies were less diverse than our own. The daily lives of persons and communities were guided by stories and myths that located each society meaningfully within the universe and provided indications of what was approved and disapproved. Such societies apparently were also more stable than our own. Change did take place, but it occurred more slowly. The more relaxed pace of change enabled individuals and groups to share common expectations regarding common courtesies. This is no longer the case, at least in our society which may be more accurately described as a society of societies.

Our own time also differs from the modern era in the West, that period of time that stretched between the Enlightenment and World War I. Many of us now share the Enlightenment's preferences for evidence instead of authority, for the possibilities of the future rather than the traditions of the past. But from our perspective, especially for those of us who live and move and find our beings on the Pacific Rim, the modern era and its leading spokespersons now seem almost quaintly unaware of the intellectual appeal of ways of thinking and acting that have been thriving in other parts of the world for thousands of years. Western Europe and North America did experience profound changes in the eighteenth and nineteenth centuries; however, those transformations were like seeds that sprouted and then flowered and yielded a full harvest in the twentieth century. Our own era is marked by a cultural pluralism and dynamism virtually unmatched in human history. As a consequence, we have in many quarters virtually capitulated to ethical relativism, the feeling that because there are so many conflicting claims there must be no right and wrong. This feeling is more common among us and more important culturally than the theoretical defenses of ethical relativism because it gives us permission to become indifferent regarding the impact of our choices upon others.

What is the most appropriate way to respond to these circumstances? At least three options come to mind, the first two of which seem unacceptable in opposite ways. The first unacceptable option is that of *imperialism*. It expects all others to conform to one's own standards. The second unacceptable alternative is *conformism*. It requires one to submit to all the expectations of

others. Neither imperialism nor conformism is actually possible because no one can compel all others to do as he or she wishes and no one can conform to all the expectations of others. But imperialism and conformism are both unethical as well as impractical. This is so because the first treats others as one could not want to be treated and the second allows others to treat one as they could not want to be treated.

Putting the matter this way unfurls a logically attractive and widely acknowledged basic moral principle that is worthy of our attention irrespective of our other loyalties. One way to state this principle is to say that individuals who are similar in the morally relevant respects should receive similar treatment. Another way to put it is to claim that one should act in harmony with maxims one could will to apply to all persons, including one's own self, without exception. Still another way to put it is to say that persons should be treated as ends and not merely as means to our ends. The Golden Rule puts it more directly: do unto others as you would have them do unto you. This principle applies to us all.

This basic moral principle is useful as a corrective to the moral mushiness of postmodern life. It requires a firm rejection of both imperialism and conformism in behalf of what, for want of a better

term, can be called *transformism*. Transformism requires one to become increasingly aware of one's own expectations. It also requires one to become increasingly sensitive to the expectations of others. In addition, this alternative requires one to change one's ways that offend others if one can at all do so without violating one's own integrity and selfhood.

A guest who insists on wearing shoes in the home of a host who prefers shoes to be left at the door is ill-mannered and even unethical unless there are appropriate justifications that can be explained to the host. There is no one right place to leave shoes, but there are right and wrong ways of treating hosts. There is no one right way to conduct physical examinations, but there are right and wrong ways of treating patients. There is no one right way to administer a medical unit, but there are right and wrong ways of treating subordinates and superordinates. There is no one right way to arrange for consultations, but there are right and wrong ways of treating colleagues. The line that distinguishes right from wrong in each case is the line that distinguishes what we would experience as fair or unfair if we were the recipients of our own actions. Everything that does not pass this test runs the risk of being bad manners and poor morals.

Abortion Conference Papers*

Author	Title	Pages	Author	Title	Pages
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KEVIN PAULSON Freelance writer Loma Linda, CA	Authentic Adventism and Abortion	na			

* Photocopies of these papers from the conference on Adventism and Abortion the Ethics Center convened in November of 1988 are available for fifteen cents per page. A book that will include several of the papers is being prepared. Those who wish to acquire one or more of the manuscripts before the book is available may contact Mrs. Gwen Utt at the Center.

Winslows *continued from page 1*

study in January and February of this year, was perhaps Winslow's most innovative contribution while at LLU.

When he arrived at Loma Linda in September of 1987, this seminar was merely a dream that was "resting" in the Ethics Center's files. Winslow made the idea take concrete form by rewriting the proposal, organizing an advisory committee, making arrangements for students at many clinical services, publicizing the program nationwide, finalizing the financial arrangements, screening the applicants and convening the entire seminar when the participants arrived on campus. The entire program was an outstanding success. It is not likely to be offered again, however, until Gerald Winslow's permanent successor arrives at LLU.

Roy Branson, a Harvard-educated scholar at Georgetown University's Kennedy Institute of Ethics, and Michael Pierson, an ethicist at England's Newbold College who recently received his doctorate at Oxford University, will cover as many of Winslow's LLU assignments as possible as visiting professors during the 1989-1990 school year. A permanent successor is being sought.

Those who wish to contact Gerald or Betty Winslow after September 1 may do so in care of Pacific Union College, Angwin, California 94508 (707) 965-6311.

Update

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Public Lecture

Free Admission

Helga Kuhse

ACTING DIRECTOR

Center for Human Bioethics

MONASH UNIVERSITY
MELBOURNE, AUSTRALIA

author of

The Sanctity of Life Doctrine in Medicine: A Critique

OXFORD: CLARENDON PRESS, 1987

7:30-9:30 p.m.

Thursday

October 26, 1989

Disciples Lounge

School of Theology at Claremont

FOOTHILL BOULEVARD AT COLLEGE AVENUE
CLAREMONT, CALIFORNIA

This lecture is presented as part of a two-day conference on "The Right to Die" co-sponsored by the Center for Process Studies and the Miller Social Ethics Fund of the School of Theology at Claremont and the Loma Linda University Ethics Center. The entire conference is open to the public. For further information, please contact the Dean's Office, School of Theology at Claremont, Claremont, California 91711 (714) 626-3521.

Pellegrino *continued from page 1*

for which he is justly famous: he composed a lecture extemporaneously in response to questions posed by the audience. This provided a lively and thought-provoking exchange that was entertaining as well as informative.

The audience presented five questions: (1) Is there a distinctively Christian approach to medical care? (2) What procedures and priorities should one follow in rationing scarce medical resources? (3) How can physicians more effectively respect a patient's autonomy? (4) What are the important components of a physician's professional identity? and (5) How can doctors reduce their moral perplexity when confronted by genuine ethical dilemmas?

Pellegrino's responses focused upon the nature of the relationship between

the physician and the patient, a bond of relatedness he described in terms of mutual trust. He emphasized the moral priority of the patient's well-being in the eyes of a virtuous physician, a consideration that should take precedence over the physician's financial status, his or her research interests or institutional commitments, or on occasion even over a patient's expressed wishes. He doubted the necessity in the vast number of cases of not serving a patient because of "fiscal constraints," particularly if the society at large can be persuaded to invest more of its resources in ventures that promote health and healing instead of illness and death.

Audio tapes of Doctor Pellegrino's presentation are available from Media Services, Loma Linda University, Loma Linda, California 92350.

ETHICS CENTER

School of Religion

Loma Linda University

Loma Linda, California 92350

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