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LOMA LINDA UNIVERSITY
CENTER FOR
CHRISTIAN BIOETHICS
Volume 7, No. 4 (December, 1991)

Update

The Physician As An Agent Of God: An Idea Whose Time Has Come

Jack W. Provonsha, M.D., Ph.D.
Emeritus Professor
Philosophy of Religion and Christian Ethics
Founding Chairman and Director
Center for Christian Bioethics
Loma Linda University

Victor Hugo once wrote that there is nothing as powerful in the world as an idea whose time has come. I wish to consider with you one such idea.

Some of us who have been around medicine for some time are developing mixed feelings about our profession. Around major medical centers, one cannot but share in the excitement that scintillates from the laboratories and clinics whose ever-novel gadgetry and techniques offer increasing prospects of the control of many of man's ancient physical foes. It is awesome to contemplate the pace with which this is taking place. It is ever more difficult even to be aware of everything that is tumbling out onto the stage of our medical lives, let alone develop the skills for utilizing that knowledge in the day-to-day care of patients. And so by necessity specialties divide like cells into subspecialties and they in turn into sub-subspecialties and into metaspecialties, and sometimes it is hard not to experience a touch of anxiety over whether the growing organism is exceeding its controls like some vast Andromeda strain.

And so there is mingled with the excitement a certain foreboding. There is also nostalgia and a sense of loss. It is hard sometimes to contemplate the gleaming stainless steel, polyethylene, and chrome of the present without wondering whether the golden age of medicine may have already slipped through our fingers into the past—a golden age when the doctor was the most beloved and respected professional in our society; when his was the role little boys and little girls could dream about playing "when they grew up"; when he was more a member of the family than a businessman or ivory tower scientist; a man trusted to do his best for you even if he wasn't God. In retrospect, he could have benefited from a bit more of science. He sometimes did some pretty "dumb" things to people medically, but he also did some wonderfully humane things and we are all the worse for his passing.

What happened? A lot of things. The world changed. People changed. The nostalgia is also one for a golden age of patients. Remember, you graybeards, when patients were loyal year after year—even generation after generation? But mobility has changed all of that. Who now can speak of "generation after generation" or even "year after year?" All kinds of people who used to live together in reasonaby stable configurations are now racing around rootless in every direction. We have become what Alvin Toffler called "citizens of the age of transience."

Ours is an age of fantastic mobility. According to Buckminster Fuller, the typical American of 1914 averaged about 1,640 miles per year of total travel counting 1,300 miles of just plain everyday walking to and fro; to the kitchen, to the bathroom (or outhouse), out to the lawn to pick up the paper, around the shop, to the store. This meant he traveled only about 350 miles per year with the aid of a horse or mechanical contrivance. In his lifetime he would travel about 88,560 miles. By contrast the present American covers some ten to twenty thousand miles per year. By the time he dies, he will have traveled between three and four million miles—more than thirty times the total of his 1914 counterpart.

In a typical year nearly thirty-seven million Americans (not counting children under one year) change their place of residence. In every year since 1948, one out of five Americans changed his address. In seventy major American cities the average residence is less than four years. For literally thou-

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Inside This Issue:

Ronald B. Miller, M.D. on MEDICAL FUTILITY

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sands of Americans, home has become "where you find it."

This sense of the transitory is further enhanced by the increasing brevity of our encounters with other people. We used to be able to depend upon certain social configurations as more or less enduring—the family, for example. The rising divorce rate and various family experiments have seriously threatened this continuity. One's neighborhood friends; even service people in the community, the grocer, the mailman, the barber, the physician, could once be counted on year after year—but now we briefly touch people, quickly, superficially, then hurry on.

In the process of all this change there has occurred a shift in the image many physicians have of their roles. Let me put it in the framework of a concept of "agency."

Time was when a physician thought of himself or herself as being the patient's "agent"—not in the sense of merely becoming a manipulated servant of patient wants and whims. Rather, the physician saw himself or herself as the agent of the patient's best interests—even if patients didn't always perceive what those interests were. In short, his care was patient-centered.

This sense of patient-agency now appears to be changing. From being agent to the patient's highest interests, the physician has become to a large extent, I'm afraid, agent to himself. The patient-healing motive has largely been replaced by an income motive and physician's services have become geared to turning a profit—based on whatever the market will bear—and in the process the profession bids fair to become a business just like any other business. Something has been lost in transition.

And now with resulting skyrocketing medical costs far outstripping the national rate of inflation, a third concept of agency is about to be thrust upon us: the physician as an agent of the government. The kids are already starting to dream other dreams.

There is probably no way to counter the social forces that have brought us to this state of affairs. As population increases and the social structure becomes ever more complicated, it appears almost inevitable that government is going to become bigger, more centralized—and more meddlesome. Nor is there likelihood that in the very near future we are to become less mobile as a people. Probably just the opposite, unless we suddenly run out of gasoline, which seems to be down the road apiece.

The question is, "Is there anything we can do about these trends?" In searching for the answer to this question, we would do well to reexamine some underlying assumptions. It is time to develop not only a science of medicine or an ethic of medicine but a theology of medicine.

The phrase "theology of medicine" suggests a theological point of departure from which medicine as a clinical discipline may proceed to its task. As I surveyed the options, I first thought of eschatology as that point because it has to do with "finishing the work." Next I selected soteriology, the doctrine of salvation. There is a certain logic to that choice since medicine has to do with healing, making persons whole, "binding up the broken." The word "salvation" derives from the Latin, *salvus*, from which we also receive our word salve. To save is to salve, and *heal* and *whole* have a common etymology.

But the more I thought about it, the more I realized that the doctrine of salvation itself is a subset of a higher concept, the doctrine of creation. To be saved is to experience recreation. "Create in me a clean heart," cried the Psalmist, and Paul notes that in Christ I may become a "new creature."

And so I have chosen to base my theology of medicine on the doctrine of creation. I do not wish to elaborate what this means in extensive detail, but I will present a few of the implications of this choice. The doctrine of creation posits in main outline a Creator, temporally and logically prior to every creature. It thus stands in opposition to every attempt to grant creaturely ultimacy. In our present terms, to be an agent of the Creator is to place into subservience every other kind of agency, patient, self or institution.

Consider patient-agency, for example. *Creator-agency* equips one to deal lovingly with all patients in spite of their unloveworthy characteristics or the brevity of one's contacts with them. The love-as-principle derived from Creator-agency does not require that the objects of healing or love be loveworthy or that they even be our friends.

Zama Cunningham described an elderly woman she cared for as a patient as "a terrible old creature, vain and cruel." When asked why she took care of her all of those years, she replied, "She needed someone all the more just because she was vain and cruel. Her loneliness and poverty weren't any the less for that. If you love people you have to take care of

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Medical Futility: A Value-Dependent Concept

*By Ronald B. Miller, M.D.**

Futile therapy was recently defined by Lawrence Schneiderman, Nancy Jecker, and Albert Jonsen of the University of Washington as a therapy "that is predictably or empirically very unlikely to achieve the goal for which the therapy is given, though it is possible and plausible for the therapy to achieve the goal."(1) They go on to say, "In judging futility, physicians must distinguish between an *effect* which is limited to some part of the patient's body, and a *benefit* which appreciably improves the person as a whole. Treatment that fails to provide the latter is futile." They also include in their definition of futility "therapy that merely preserves permanent unconsciousness, that is the persistent vegetative state." Thus these authors emphasize values in their concept of "futility" by speaking of the goal of therapy, by distinguishing a benefit from an effect, and by implying their view of life without consciousness.

The term "futile," however, is too often misunderstood to be simply a value-free probability statement. For example, I have heard statements of these same authors taken out of context: "When physicians conclude that in the last 100 cases the medical treatment is useless, they should regard that treatment as futile"; and "physicians can judge a treatment to be futile, and are entitled to withhold a procedure on this basis. Physicians need not obtain consent from patients or family members."(1) Similarly, in an earlier paper John Lantos and his colleagues of the Center for Clinical Medical Ethics at the University of Chicago wrote, "Futile therapy is merely the end of the spectrum of therapies with very low efficacy. A physician is under no obligation to offer, or even discuss, futile therapies."(2)

However, Lantos and colleagues bring us back to values or goals: A decision to withhold therapy that is deemed futile, like all treatment choices, must follow (first) judgment about the chance of success of the therapy, and (second) consideration of the patient's goals for therapy." Thus they raise yet another extremely important component of the concept of "futility": the need to know the patient's as well as the physician's goals for therapy in order to properly judge futility.

Even when one appreciates the value-dependency of the concept of "futility," problems remain. For example, Virginia Warren, a Professor of Philosophy at Chapman College in California, points out, "The use of the word 'futile' begs the question: that is, the word already has the conclusion within it."(3) Perhaps a better term is "inappropriate" therapy, but whichever term one uses, it is crucial that one judge both the goal of therapy and the probability of success of the therapy. Most would agree that the goal of therapy ought to be seen from the viewpoint of the informed patient, and some would say that the goal of therapy should be evaluated from the physician's perspective as well. With regard to the probability of success of the therapy, most would rely upon the physician for that judgment, perhaps confirmed by the judgment of a consultant physician.

What are the implications of a judgment of futility? The first level of implication of a judgment of futility is that the physician or institution is not obliged to offer a treatment that would be futile. In the recent *Annals* paper,(1) that would mean no success in the last 100 similar cases, or less than a two percent chance of success. The next level of implication of a judgment of futility is that the physician or institution may withhold or withdraw therapy, and we are all familiar with the fact that ethically it is felt there is no difference between withholding or withdrawing therapy. Although withdrawing is vastly more difficult psychologically for health-care workers than withholding, it is ethically problematic for one to be unwilling to withdraw therapy once instituted, since that precludes a therapeutic trial. It forces the patient to decide in advance, without trying the therapy, whether he would like it or not, and to accept or refuse it, based on hunch or inadequate information. The next level of implication of a judgment of futility I find particularly problematic: that such a judgment implies the physician is not obliged to discuss the possible therapy with the patient. My argument that patients should be informed is based on the belief that they have the right to seek treatment from another physician or from another institution if the treatment they would wish to try is judged to be futile. On the other hand, this argument could be extended to absurdity, requiring a physician to review a litany of ineffective treatments every time a treatment decision were to be made. The final level of implication of a judgment of futility is that the physician or institution is obliged to withhold or withdraw therapy irrespective of the patient's wishes. And this leads us to appreciation of the importance of shared

Ronald B. Miller, M.D., is Clinical Professor of Medicine and Director of The Program in Medical Ethics, University of California, Irvine

decision-making; that is, the importance of the views of both patients and physicians.

The table in Figure 1 compares what the patient wants with what the physician judges to be effective or futile. In the upper left-hand corner, when the patient wants a treatment which the physician judges effective, of course the treatment is provided. And in the bottom right-hand corner, when the patient does not wish a treatment, and the physician judges the treatment would be futile anyway, of course one does not treat. The other two circumstances are problematic. In the upper right-hand corner, when a patient does not wish therapy but the physician judges it to be effective, sometimes the physician may force treatment, even by going to court. This is particularly common in neonatology and in the care of children when the surrogate refusal of the therapy is based upon the parent's values which are not shared by all of society, for example a Jehovah Witness parent's refusal of blood transfusion for a child who would die without it, or a Christian Science refusal of treatment. In the bottom left-hand corner is the circumstance in which the patient wants treatment and the physician judges it to be futile. I believe the basis for such decision is commonly the strength of conviction of patient and physician, the certainty of prognosis, and non-medical considerations such as cost. Even when the chance of success is low, if the cost is also low (whether the cost is economic or risk), the physician will often allow the patient to have his way and not rarely the patient proves correct.

In Figure 2 the utility of therapy (that is the quantity of benefit if the therapy is successful) is compared with the probability of success of the therapy. In the upper left-hand corner, when both are high, of course, one treats. Conversely, in the bottom right-hand corner, when both are low, one does not treat. The other two circumstances are again problematic, and influenced by non-medical factors as well as by medical factors. With regard to the latter, the medical factors, in the upper right-hand corner when the benefit to be achieved is relatively small but the probability of achieving that benefit is high, one probably would treat. Similarly in the lower left-hand corner, when the benefit to be achieved is great even though the probability of achieving it is small, once again, probably one would treat.

Additional serious concerns about the concept of futility are that the determination of futility may hide physician discretion or paternalism, may disguise social prejudice, or may mask a resource allocation decision in the guise of a medical judgment.

I will attempt to make these abstract comments about futility concrete by applying them to the circumstance of cardiopulmonary resuscitation. Leslie Blackhall of Boston University wrote a landmark paper(4) concerning futility in response to a poignant patient's plight and to increasing evidence in the medical literature of the strikingly lower success rate of cardiopulmonary resuscitation than originally reported by Kouwenhoven(5) who had observed 70 percent long-term survival following closed-chest cardiac massage. Blackhall stated, "Infrequently discussed is the situation in which a patient wants CPR but the physician believes that it is contraindicated. In these cases, patients almost invariably remain full code." She went on to say, "In cases in which CPR has been shown to be of no benefit, it should not be considered an alternative and should not be presented to the patient as such," that is, as a viable alternative. In such cases physicians could write, "This patient has a condition for which CPR has been shown not to be effective. In case of cardiopulmonary arrest, CPR should not be performed."

In a recent paper in the *Journal of the American Medical Association*(6), Tomlinson and Brody spoke of the same sort of case, one where CPR would be futile. They said, "No reasonable person would pursue the low probability or quality of survival that CPR offers in the kind of case at hand. This is a social judgment of reasonableness," not an individual one. Social judgments about the range and rational conception of the good set the boundaries within which individual, instrumental rationality can competently operate."

Indeed, in Tomlinson's and Brody's earlier paper in the *New England Journal of Medicine*(7), (but a later paper than that of Blackhall) they discussed three types of DNR, the first the Blackhall type. This is, when the rationale for a DNR order is that the patient cannot medically benefit, the patient's values are irrelevant, and there is no implication of the DNR order for any other medical treatment. In the second type of DNR, where the rationale is a poor quality of life after CPR, the patient's values are clearly relevant, but this type of DNR has again no implication for other treatment. In the third type of DNR order, that where the rationale is a poor quality of life before CPR, obviously again the patient's values are relevant and fundamental to the decision for the DNR, but furthermore this rationale has substantial implication for other treatment, which of course must be discussed with the patient or his surrogate and appropriately limited.

Let me return to the first issue, that of a DNR order when no medical benefit of CPR is perceived. Although Tomlinson and Brody point out that such a judgment can be made irrespective of the patient's values, I believe this is true only when one is absolutely confident that CPR would not restore life, for even brief restoration of life may be appropriate from

Figure 1

	Patient wants Rx	Patient does not wants Rx
Rx Effective	Treat	Sometimes treat (even go to court); Often don't treat
Rx Futile	Sometimes treat, Sometimes don't	Don't treat

Figure 2

		Utility of Therapy	
		High	Low
Probability of Success:	High	Treat	Probably treat
	Low	Probably treat	Don't treat

the patient's point of view, if for example even another few hours of life might allow him to visit with a relative coming from out of town to his deathbed. I have maintained, as has Stuart Youngner(8), that the physician does have an obligation to at least inform the patient that he does not intend CPR should a cardiopulmonary arrest occur. He does not necessarily have to ask the patient for this permission, but he needs at least to inform the patient so that if the patient believes the judgment is incorrect he can try to so persuade the physician. Once again, then, we are returning to the matter of the goals of therapy and the possibility that the patient's goals may be somewhat different from the physician's.

Tomlinson and Brody in their recent paper state, "The mixed messages inherent in requesting patient consent to withhold futile therapy serve to undermine rather than to enhance autonomous choice."(6) Indeed, I agree with this, but I do not believe it is equally true that informing the patient that one is going to withhold futile therapy necessarily undermines autonomous choice of the patient.

Indeed, I believe (though not all who have read their paper focused on it) Tomlinson and Brody wisely went on to say, "Our proposal would eliminate not discussion, but only the use of the consent process as the context for discussion. An ethically confused and misleading discussion focused on consent would be replaced by more honest and appropriate discussion focused on enhancing the patient's understanding of the limits of medical intervention."(6) They further state, "Although physicians should not offer futile resuscitation, in most cases they should inform the patient or family that resuscitation would be futile and should not be attempted, explaining the medical facts that support that decision."

Finally, I wish to briefly relate the concept of futility to the just allocation of resources. "Although care that is futile is also not "cost-worthy," care that is not cost-worthy relative to other uses of medical resources may still offer benefits to the patient and so not be futile."(6) The Seattle group also states, "Our notion of futility does not arise from considerations of scarce resources. Arguments for limiting treatments on grounds of resource allocation should proceed by an entirely different route, and with great caution, in our open system of medical care."(1)

Endnotes

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3. Warren V., Personal communication 1990.

4. Blackhall, L. J., "Must We Always Use CPR?" *New England Journal of Medicine* 1987; 317:1281-1285.

5. Kouwenhoven, W. B., Jude, J. R., Knickerbocker, G. G. "Closed-chest Cardiac Massage." *Journal of the American Medical Association* 1960; 173:1064-1067.

6. Tomlinson, T., Brody, H. "Futility and the Ethics of Resuscitation." *Journal of the American Medical Association* 1990; 264:1276-1280.

7. Tomlinson, T., Brody, H. "Sounding Board: Ethics and Communication In Do Not Resuscitate Orders." *New England Journal of Medicine 1*988; 318:43-46.

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PROVONSHA, continued from page 2

the unattractive ones too."

Being an agent of God makes it possible also to be an agent for even unattractive patients. It may in fact be the only possibility. Certainly that may be the case with those patients whose contacts with us are so brief that we and they remain strangers. To love in principle as an agent of God may be the only basis for my being the stranger's agent. And of course being thus able to remain patient-oriented protects me from those other agency dominations which follow when patient-agency is lost—that is, self-agency or government-agency. Only on this basis will the physician of the future avoid burying his patients in the burgeoning morass of inevitable government red tape.

The doctrine of creation in which the creature is dependent upon the Creator for his total existence provides a barrier to that self-sufficiency which is the essence of self-agency. If

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one lives out one's life with a pervasive sense of stewardship over all one has received from the Creator and employs his gifts as one accountable to God, there is less possibility that they will be turned in upon the self. Self-sufficiency is the primal sin. It is the attempt to be God. Only the Creator is self-sufficient—by definition. It was Lucifer's sin in heaven and it was the temptation in the garden—and it is the growing sin of physicians as they multiply their wizardry and gadgets.

We all know of course that in the ordinary practice of medicine, members of our profession are frequently confronted with decisions that might more properly be placed in the hands of someone all-knowing. But alas, the Omniscient One has placed them in ours. We are also at times given power over life that might seem more appropriate to the Omnipotent One. But there is no escape. Use it we must. There is no one else to whom to turn. So we sometimes seem to be playing God—and it is only a short step from playing God to developing illusions about being God. To recall that we are creatures can help us to carry such awesome responsibility with a measure of humility.

It can also prevent us from surrendering our souls to other creature-gods beyond ourselves. There may be no escaping the increasing interference of governmental power in our lives—and institutional power at all levels—but never must such power be allowed to steal our souls, seal our lips, or sear our consciences. Tangled up in red tape and institutional directives we may be, but we stand responsibly before a Creator Who is higher than any human structure. "Thou shalt have no other Gods before me" is not a dead command. No human institution must be allowed to come between me and my carrying out my God-given task of acting for the good of my patients.

Another implication of the doctrine of creation is the manner in which such a doctrine affirms the material world. When God finished His work in the Genesis account, it is written that He said of it, "It is very good." This included all that He had made. That first Sabbath was a celebration of the goodness of all of the creation—including man. Material substance was good; the woods, the sky, animal life, man—even man's social order and functions—were pronounced good. How often has the creature forgotten that truth as he has devalued himself and polluted his environment!

Some thinkers even demeaned those professions whose primary concern was that creation, including man's body. Those celebrated Roman baths which were a hallmark of Roman civilization were destroyed and repressed by Christian Rome as undue pampering of the body. The body was always suspect by such Christians. The baths survived for a time in the Islamic world, where the body was conceived of differently—along, interestingly enough, with about all the scientific medicine the world had to offer during that period. The Christian emperor Justinian I closed down the medical schools at Athens and Alexandria in the fifth century. To many of his contemporaries, medicine was rejected as a materialistic use of drugs and potions and therapies instead of mystical things like prayers and religious incantations. Tatian lodged a protest against the invasion of science. He regarded it as not becoming to ascribe to matter the relief of the sick. Monasticism carried this notion to its logical conclusion in its denying of the body as a means to spiritual excellence. St.

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Dear Friends:

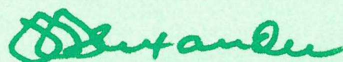
I recently celebrated the 10th anniversary of my 7th birthday. Usually 3 score and 10 seems to wind life up for many septugenarians. Not so for this one. I feel wound up for life. One of the things that really excites me is the work of the faculty that make up our Center for Christian Bioethics. I am constantly amazed at how much our ethicists do, and at the many dreams they have and share.

I would like to thank you for your interest, prayers and for the generous gifts that many of you have made. It is your involvement that makes our work at the Center possible. One of our dreams is to build our endowment up to a full $1,000,000 by the year 2000. Our endowment is now at over $632,000. We would like to be close to the $700,000 mark by June 30, 1992.

I think you know what's coming next. Yes, I would like to ask for your financial gift. Please make the largest possible gift that you can to assist us in building our endowment. If the options we provide in the enclosed return envelope are not ambitious enough, please set our sights higher. As you well know, endowments and their proceeds enable the Center to maintain and extend its activities without having to depend strictly on operating support.

Our God is good to us. We thank Him for this. You are with us too. Thank you for your interest and for your generous gift.

Shaluha,



Wil Alexander,
Dean, Faculty of Religion
Chairperson, Center for Christian Bioethics

Contributors

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PROVONSHA, continued from page 6

Hildegard wrote, "God rarely dwells in a healthy body," a view, of course, tinged by a Gnostic-Manichean concept of matter (and the body) as degenerate and evil. Such attitudes forced scientific medicine to develop largely outside of the church.

But if the body is God's creation and good, although it may sometimes need assistance because some things have gone awry in God's creation, quite another philosophy of therapeutics emerges. There is an inherent "wisdom" in the body placed there by the Creator. If the body for one reason or another fails to live up to the Creator's design, it may require assistance; but the assistance is only to the end that the body may fulfill the Creator's intention. It is the role of the physician who believes in the creation to cooperate with the body's own "wisdom"—not merely to manipulate it according to his own.

Remember Ambrose Pare's statement of some 300 years ago, "I dress the wound, God heals it"? This is, I think, the sense of Ellen White's often-repeated expression, "natural remedy." A "natural remedy" should be understood as any remedy that cooperates with and assists nature in its God-given physiologic process—anything whatever, whether it comes off a bush, out of a water tap, or an electric light socket, or in a pill, an infusion bottle, from a machine, or involving the skilled application of a scalpel. Does it respect the "wisdom" of the body? That is the question. The doctrine of creation prescribes that it must. (Obviously not all remedies are unmixedly "natural" in this sense. There are often unwanted side effects, but the principle still holds. A physician conditioned by respect for the body will choose agents according to their greatest positive and least negative affects—while searching for better ones.)

Last but not least, a belief in the doctrine of creation will also include that secondary subset—re-creation—the subject of soteriology. Anyone who takes creation seriously will also be dedicated to the total restoration of man as nearly as possible to the Creator's ideal. Since humanity's fall included all of its dimensions—so must humanity's healing.

I submit that if our profession is going to retain those qualities that have made it so powerful a force for good in the world, and made it so exciting and appealing to us in those idealistic days of our youth, as it undergoes agency transition it must discover its true role as an agency of the divine Creator.

The concept of the physician as the Creator's agent provides for a truly patient-centered medicine in a world in transition. It may also provide the physician with an escape from functioning as profit-oriented agents of self-centeredness, or of finally becoming merely the agents of impersonal governmental bureaucracy.

The physician as an agent of the Divine Creator is an idea whose time not only has come but is long overdue. ■

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