9-2005

Update - September 2005

Loma Linda University Center for Christian Bioethics

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Update

Volume 20, Number 3 (September 2005)

Just Care: Rationing in a Public Health Crisis

James F. Childress, PhD

This article is based on the Jack W. Provonsha Lecture delivered by James F. Childress at Loma Linda University, February 28, 2005

A visitor to the lovely campus of Loma Linda University can't miss the sculpted depiction of the parable of a good Samaritan on the main lawn. Historically, there have been many different depictions of this famous parable, including noted ones by Rembrandt and Van Gogh. Central to the story is the Samaritan who helps an injured traveler who was half dead after having been beaten by robbers. The Samaritan bandaged the man's wounds, brought him to an inn on the Samaritan's beast, took care of him, and arranged and agreed to pay for his subsequent care at the inn.

In western culture, this parable helps to orient our thinking about our responsibilities to those in need of care, including, in this case, health care. However, in some ways, it's not a very interesting parable, because it doesn't raise many of the ethical conflicts that we may face. First, providing assistance in the parable was presumably a low-risk venture. It could have been otherwise—the rescue could have posed major risks for the rescuer. Second, the robbers presumably had already fled. It could have been otherwise, and the rescuer might have had to decide whether to use force, even lethal force, to protect the victim from his assailants. Finally, in the parable, the Samaritan discovered only one injured man. In a different version, there could have been several injured people, and it would have been very difficult, probably impossible, for the Samaritan to transport all of them to an inn, take care of them, and arrange and pay for their later care.

And yet it's precisely such an altered scenario that is important when we begin to think ethically about possible responses to massive public health crises that could erupt in a bioterrorist attack or a flu pandemic: what would constitute "just care" in such cases? Before 9/11, Nobel Laureate Joshua Lederberg, in a letter dated August 30, 2001, and read before the U.S. Senate committee on foreign relations on September 5, 2001, noted the potential of a bioterrorist attack:

> Considerable harm could be done (on the scale of, say, a thousand casualties) by rank amateurs. Terrorist groups, privately or state sponsored, with funds up to $1 million, could mount massive attacks of 10 to 100 times that scale. Important to keep in mind: if the ultimate casualty roster is 1,000, there will have been 100,000 or one million at risk in the target zone, legitimately demanding prophylactic attention, and in turn a Draconian triage.

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Furthermore, Lederberg continued, several simulation exercises provide "dramatic testimony to how difficult would be the governmental management of such incidents, and the stresses on civil order that would follow from inevitable inequities in that management."

In a bioterrorist attack, we would face the very real prospect of massive triage, difficult government management, stresses on civil order, and inevitable inequalities (not necessarily "inevitable inequities") among our populace. Now, one of the questions I want to address regards the inevitable inequalities in provision of health care in such a crisis. The necessity to ration health care will obviously produce inequalities in treatment. The difficult question is whether those inevitable inequalities are at the same time inequities. Unequal distribution does not necessarily signal injustice or unjust care. While it may—and often does—it may not do so in particular circumstances. Hence, we need to explore various ways to address public health crises, if possible, without inequities and injustice.

"In a bioterrorist attack, we would face the very real prospect of massive triage, difficult government management, stresses on civil order and inevitable inequalities…"

Another issue of just care that will receive some but less attention in this lecture concerns the balance of individual freedom and communal responsibility, particularly if the victims in a bioterrorist attack or in a flu pandemic become infectious agents who can put others at risk. When would forcible isolation and/or quarantine be ethically justifiable as a form of just care?

A couple of years ago I taught, with a colleague in law and public health, a seminar titled "Confronting Plagues: Historical and Contemporary Responses to Epidemics." Starting with the Black Death in the 14th century and ending with the SARS outbreak, we moved back and forth in the seminar between historical perspectives and present realities. And, of course, in many earlier epidemics, apocalyptic imagery was prominent. When much of a population is wiped out, or at risk, especially when little is known about the causal agent, apocalyptic imagery is quite understandable. Furthermore, as we think about possibilities for our own time, such imagery may not be inappropriate, because the scale could be massive. Hence, the title of this conference of which this lecture is one part: "Apocalypse Now: Seeking Justice and Protecting Rights in Health Care Disasters." In each of the historic epidemics that might metaphorically be called "plagues," societies at risk had to confront both of the issues I have identified: determining the just distribution of scarce medical and other resources and determining the proper balance between individual freedom and responsibility to the community.

One other preliminary point needs to be made. When we engage in ethical analysis and moral reasoning, for example, about rationing or about quarantine in a public health crisis, we often appeal to general principles, values, and norms. Whether articulated in our foundational texts, religious or otherwise, or embedded in our culture, or affirmed in the professional codes of physicians and nurses, there are some core principles, values, and norms to which we must attend. They serve as fundamental points of reference as we try to think through particular cases, acts, policies, and practices.

In the process of deliberation we also engage in analogical reasoning. Our reasoning depends in part on precedent cases. When a crisis emerges, we begin to think about it in light of those precedent cases, which represent relatively settled moral judgments, and ask whether there's something distinctive or new that's really so different from what has been faced before. Such analogical reasoning may illuminate our decisions about the allocation of resources or about quarantine and isolation. Sometimes, however, we may need to rethink some of our moral precedents, our settled moral judgments about kinds of cases.

Just Care: Justice and the Distribution of Health Care

Now, as we begin to think about just care, the parable of the Good Samaritan could, in effect, be viewed as an admonition to "just care," that is, "just to care." The Samaritan in the story could provide only modest care in binding the victim's wounds and so forth. Furthermore, in the absence of competing loyalties to other parties at risk—for example, other victims—he didn't really have to face the question of "just care," in the sense of fair, equitable, just distribution of care among several potential beneficiaries.

If we inquire into "just care" in a distributive context, one of the first points of reference is formal justice, which,

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as Aristotle instructed us, requires that we treat similar cases in a similar way and dissimilar cases in a dissimilar way. But that does not take us very far—it simply lets us know from the outset that justice requires looking at similarities and differences, and treating people, or groups of people, accordingly, if those similarities and differences are relevant.

Any approach to justice, in a distributive sense, must also say something about material criteria. Moving beyond the formal criterion, material criteria help us identify the characteristics that constitute relevant similarities and differences. And here is the heart of the debate: Do we consider medical need, ability to pay, age, and a host of other characteristics to be ethically relevant from the standpoint of justice? And which ones are relevant in a public health crisis?

It is important to note that the language of distribution varies a lot. Policy analysts Richard Rettig and Kathleen Lohr once noted:

> Earlier policy makers spoke for the general problem of allocating scarce medical resources, a formulation that implied hard but generally manageable choices of a largely pragmatic nature. Now the discussion increasingly is of rationing scarce medical resources, a harsher term that connotes emergency, even wartime circumstances, requiring some societal triage mechanism.

Although this comment was directed at problems of distributing health care in the society at large, it applies with particular force to the distribution of various kinds of health care—for example, vaccines, prophylactic measures, therapy, and supportive care—after a bioterrorist attack or in a flu pandemic. "Allocation," "rationing," and "triage" do have somewhat different connotations. In ordinary discourse, "rationing" and "triage" seem harsher than "allocation," or, for that matter, "distribution," and "patient selection," among other terms. All of the latter terms seem more descriptive and neutral. Generally, "triage" implies systematic rationing using classifications of potential beneficiaries, based on need and probable outcomes, in an attempt to do "the greatest good for the greatest number" (utility).

These different terms clearly have a bearing on public communication and justification of distributional systems. But even a rigorous distributional system, which may seem harsh and perhaps Draconian, may not be unjust and unjustified. In assessing different systems, we need to determine which principles of justice are relevant for thinking about distribution in a public health crisis. In effect, which material principles identify the morally relevant similarities and differences?

I want to focus on two major kinds of principles, utilitarian ones and egalitarian ones. And I will argue that while these principles sometimes come into conflict, they need not always conflict. When they appear to conflict, we need to examine them very closely and imaginatively in the situation to determine whether the conflict is real or only apparent and whether one principle is weightier or stronger than the other in that situation.

Utility requires, in its simple formulation from Jeremy Bentham, John Stuart Mill, and others, that we do the greatest good for the greatest number. But that formulation does not help us very much in trying to determine whether a utilitarian approach is compatible with egalitarian principles that might be based, for example, on convictions about human beings as created in God's image or as destined for union with God.

It is only when we specify how utilitarian principles are or can be used that we can see whether there is a conflict or not and, if so, how it arises and can be resolved. So, let me distinguish the principle of social utility, where the aim is to maximize social welfare, from the principle of medical utility, where the aim is to maximize the welfare of persons suffering from or at risk for disease, trauma, and the like.

Utilitarian Principles: Social Utility and Medical Utility

Medical utility—doing the greatest medical good for the greatest number—involves two major considerations. One is medical need, which may be urgent, or moderate, or weak. The other is the probability of a successful outcome through a medical intervention.

Sometimes these considerations come into conflict—a person who has an urgent medical need may also have a low chance of surviving even if the treatment is provided. For example, in organ transplantation, a patient's urgent medical need may reduce the probability that a transplant will be successful. However, in medical utility, we may have to balance medical need and probability of successful outcome.

Following this quick and rough sketch of medical utility, we can ask: what is social utility? Here, as noted earlier, the aim is to maximize social welfare. Again, we need to draw some distinctions, particularly between *broad* social utility and *narrow* social utility. In judgments of *broad* social utility, we consider a person's overall worth or value to the society. Judgments of broad social utility in rationing would lead to the provision of resources for the person(s) who would have the greatest comparative social worth or value.

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Narrow social utility is different. It focuses on particular social roles and functions. It asks whether some roles and functions are indispensable, perhaps in a crisis even if not in ordinary times. Should some people receive special priority in a public health crisis because of their particular roles or functions? Paul Ramsey, one of the pioneers in bioethics and the author of *The Patient As Person* (1970), generally argued against appeals to social utility. Working out of a theological perspective, he contended that we should be indiscriminate in the care we provide—just as God makes the rain fall on the just and the unjust alike, and the sun shine on the just and the unjust alike. For him "just care" is indiscriminate care.

Obviously, rationing involves discrimination—it gives some people, for some reason, priority over others. However, the question is whether such discrimination among potential beneficiaries is unjust. Ramsey's reasoning draws on analogical cases as well as on general principles, such as indiscriminate care and utility. His main analogy is to the lifeboat cases that have been prominent in religious and philosophical discourse over the centuries.

> *"In assessing different systems, we need to determine which principles of justice are relevant for thinking about distribution in a public health crisis."*

Suppose there is a shipwreck and several people, indeed too many, get on the lifeboat. It is clear that not everyone can be saved because the lifeboat is too crowded and at risk of sinking. Attempting to save everyone could cost everyone's life. Would it be appropriate to draw lots or make judgments of social utility in order to determine who should be saved? In light of his theological perspective, Ramsey emphasized drawing lots as a form of just care. Indeed, there are biblical grounds for casting lots as a way to discern the divine will (e.g., when the disciples replaced Judas).

But Ramsey also conceded that, under some circumstances, it is justifiable to make discriminating judgments based on narrow social utility. For instance, it would be unwise to include everyone on the lifeboat in a lottery if that meant throwing overboard the only people with enough maritime skills to help the lifeboat stay afloat and to increase the chances of rescue. In short, Ramsey conceded that in a "focused community," concentrated on communal survival (e.g., on the lifeboat), it may be appropriate to single out certain essential roles or functions for priority in rationing.

This is very different from judging whether a person has greater overall value or worth to society than someone else. Instead, attention is paid to specific, valuable, and essential roles and functions in a focused community. Nevertheless, hard questions will still arise about how to determine which social functions and roles are essential and, thus, should receive priority in the allocation of resources.

We can probe some of these hard questions by critically examining criteria proposed for allocation of health care after an attack with weapons of mass destruction. In a very helpful article a few years ago, Nikki Pesik and colleagues identified acceptable and unacceptable criteria for use in rationing health care in the context of such an attack. Most of the criteria they deemed acceptable focus on medical utility. Relevant questions based on these criteria include: What is the likelihood of benefit? What is the effect on improving quality of life? What is the duration of benefit? What is the urgency of the patient's condition? These questions probe medical utility, doing the greatest good for the greatest number of people, medically.

The authors also propose consideration of direct multiplier effect among emergency caregivers, a consideration that begins to blur the principles of medical utility and social utility. Emergency care is a social role but the concern here is primarily with its medical impact. In my judgment, it would also be justifiable to move beyond the social roles and functions that address the medical needs, because in a true public health crisis, social roles and functions that address transportation, security, etc., will also be vitally important. The final acceptable consideration proposed by Pesik *et al.* focuses on the amount of resources required for successful treatment. This is similar to what Gerald Winslow has called a principle of conservation, and it too reflects medical utility.

In general, Pesik and colleagues have identified acceptable specifications of medical utility. They also present a list of unacceptable criteria, and, by and large, I agree with this list of excluded criteria as well: age, ethnicity, or gender; talents, abilities, disabilities, or deformities; socioeconomic status, social worth, or political position; co-existent conditions that do not affect short-term prognosis; drug

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and alcohol abuse; and anti-social or aggressive behaviors. However much we may be tempted to use some of these criteria, they are ultimately ethically indefensible for rationing in a public health crisis. They are not required by medical utility or by narrow social utility, and they are excluded by egalitarian principles.

Egalitarian Principles

I've already appealed to egalitarian principles, but what exactly do they entail? What is crucial for me here, in language borrowed from Ronald Dworkin, is that we treat each person as an equal even if we cannot provide equal treatment. Egalitarian principles require recognition and treatment of others as equals. However, they do not require identical treatment or the provision of the same thing to everyone. Fair rationing can be justifiable even in a framework that involves equal regard or, as Dworkin states it, equal concern and respect. In addition, decisions about unequal treatments, for instance, in rationing, must reflect fair procedures, and the distribution should be fair—it should be just care.

Egalitarian principles do not necessarily preclude judgments of medical utility or even narrow social utility in certain circumstances, but appeal to broad social utility or broad social worth, which Pesik and colleagues reject, is difficult to justify in light of egalitarian principles.

Egalitarian principles may support impersonal mechanisms of allocation, such as queuing or a lottery, in different settings. For instance, if the preventive or therapeutic interventions cannot be provided for all of those in the priority groups set by medical utility, and more discriminating judgments of medical utility are not possible, then queuing or a lottery may be justified by egalitarian principles. In addition, if resources remain after treating the priority groups set by medical utility and by narrow social utility, then egalitarian principles could also justify the use of queuing or a lottery for the remainder.

In any event, it is important to remember that all methods of allocation must be justified to the public, in part because the public's cooperation is utterly indispensable to the society's successful response to a public health crisis.

A Test Case: Allocation of Flu Vaccine Fall, 2004

It may be useful to examine, as a test case, what occurred during the fall of 2004 in the allocation of scarce flu vaccine. Around the country and to different degrees, flu vaccine allocation basically involved medical utility and narrow social utility (embodying the principle of utility) and queuing and lotteries (embodying egalitarian principles).

The basic framework for allocation of the flu vaccine was set by the Centers for Disease Control and Prevention (CDC), which identified eight priority groups based largely on risk: all children 6 to 23 months; adults 65 years and older; persons aged 2 to 24 years with underlying chronic medical conditions; all women who will be pregnant during influenza season; residents of nursing homes and longterm care facilities; children 6 months to 18 years of age on chronic aspirin therapy; health care workers with direct patient care; and out-of-home caregivers and household contacts of children aged less than 6 months.

The CDC came up with those priority groups based on what I have called medical utility. Beyond these priority groups, which were considered to be of "equal importance," it recommended "first-come, first-served" both within and across those groups if scarcity prevented vaccination of all in the priority groups. Some jurisdictions used a lottery among individuals in priority groups. In addition, there was also some priority based on social function, beyond the health care workers with direct patient care.

I will quickly develop further features of this case study and consider the rationale used for—or implicit in—different allocation measures. Clearly the utilitarian and egalitarian principles I have emphasized were prominent, but practical considerations, including feasibility, were also important. After all, state and local public health officials and others had to determine whether a particular allocation method could be undertaken, what kinds of logistical problems it would encounter, whether those problems could be overcome, etc. The cooperation of the public was crucial as was the cooperation of health care professionals, especially because the allocation of the flu vaccine involved both private institutions, physicians, and other health care professionals, on the one hand, and public health officials, on the other.

As noted, the justification for the CDC's priority groups focused on individuals most at risk for morbidity and mortality. The problem was that the pool was still too large. Thus, hard decisions were left to state and local health departments about how to address rationing in and among eight priority groups of equal importance. One possibility to consider was further prioritization. But there was too much scientific uncertainty.

As a result, queuing (i.e., "first-come, first-served") became important as a way to provide fair equality of opportunity to individuals in priority groups. Some persons in priority groups had limited mobility; others had work

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commitments. And some persons suffered health crises—including at least one death—while waiting in line for a flu vaccine. As a result, even though "first-come, first-served" (which Ramsey viewed as an ongoing lottery) is in principle an acceptable method, its implementation evoked concerns about both risk and fairness.

A partial solution to these problems, in some jurisdictions, was "first-call, first-served." Individuals in priority groups could call and obtain a number in order to receive the vaccine at a scheduled time. In other jurisdictions, a lottery was adopted among individuals in priority groups, because of the problems with "first-come, first-served." Another ethical concern about either queuing or a lottery focuses on background conditions, such as access to health care, transportation, etc., that often determine who will enter the pool and when.

In the flu vaccine shortage of 2004, social functions were also used as a prioritizing tool. As noted previously, the CDC prioritized health care workers with direct patient contact. The justification here is a mixture of medical and social utility. But a big problem is determining which functions and which roles are more important and even essential as well as who decides these matters. It was easy for the public to endorse the priority assigned to the operational forces in the global war on terror, as the Department of Defense proposed. When people objected to the priority given to members of Congress, several members declined the vaccine. Even more problematic was the allocation of flu vaccine to the players on the Chicago Bears football team! Decisions about essential roles and functions for purposes of setting priorities in rationing in a public health crisis need public input especially because the public's trust is necessary for the success of any rationing program in a public health crisis.

"…the public's trust is necessary for the success of any rationing program in a public health crisis…"

Liberty and Community: Justifying Quarantine and Isolation

Beyond rationing, I want to note a few other problems of public trust, particularly related to liberty and freedom of movement. When the initial victims become the unintentional secondary agents of bioterrorism or infectious disease, it may be justifiable to resort to isolation and quarantine. (Isolation restricts individuals who have the disease in question, while quarantine restricts individuals who have been exposed to the disease but may not have it.) Both isolation and quarantine can be voluntary or involuntary or non-voluntary. One important commitment of a liberal society is to use voluntary measures whenever possible. However, coercive quarantine or isolation can be justified under several conditions, reflected in the following questions: Would it be effective? Is there a balance between the probable good and the probable negative effects? Is it necessary? Is it the least restrictive or intrusive? Is it impartially applied? These are all important ethical considerations, as well as (frequently) legal ones, in thinking about quarantine and isolation.

Mark Rothstein and colleagues at the University of Louisville conducted a study for the CDC on how countries around the world responded to SARS. Different societies implemented quarantine and isolation by requests for voluntary cooperation, provision of incentives, or coercion, or some combination of these approaches. Canada, by and large, relied on voluntary quarantine and isolation, which worked well for the most part. Many wonder whether voluntary isolation and quarantine would work as well in the United States, particularly because we may be more individualistic in our orientation than Canada and a number of the other countries that were afflicted with SARS.

Let me draw a distinction between *imposing community* and *expressing community*. Clearly, in coercive quarantine and isolation, a society attempts to impose communal responsibility through coercion. It attempts to make people responsible at least to the extent of not engaging in actions that would put others at risk. For the most part, in our society as well as in Canada, imposition of community should be a last resort.

One alternative is to seek to engender voluntary cooperation and compliance by expressing community and communal solidarity. A big difference between the United States and Canada is that the latter has universal access to health care. In such a context, it may be easier to convince people that the society is on their side than in a setting where more than 45 million people are uninsured and millions

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more are underinsured. I would argue that, wherever possible, we should express community rather than imposing it. Nevertheless, in some circumstances, imposition of community may be necessary.

When societies confront tragic choices—where fundamental social-cultural values are at stake—they must, as Guido Calabresi and Philip Bobbit stress in their book *Tragic Choices*, "attempt to make allocations in ways that preserve the moral foundations of social collaboration," or, in my language, to create and maintain public trust. The same point holds for measures to ensure quarantine and isolation. With luck, following a bioterrorist attack or pandemic flu or some other public health crisis, a society will return to normal life. But normal life presupposes that "the moral foundations of social collaboration" are still intact. "Just care" can help to preserve those foundations while responding effectively to the public health crisis. ■

***James F. Childress, PhD,** is the John Allen Hollingsworth professor of ethics, director of the Institute for Practical Ethics, and public life professor of medical education at the University of Virginia.*

Editorial

For the entirety of our existence as a Center for Christian Bioethics here at Loma Linda University (21 years now), James F. Childress, PhD, has been a key thought leader in the field. We are so pleased to include his article in this edition of *Update*. Along with his colleague and co-author, Tom L. Beauchamp, PhD, Dr. Childress has shaped the field of bioethics in this country and abroad since the initial publication of *Principles of Biomedical Ethics* in 1979. This text is now in its fifth edition and remains an essential reading on the bibliography of millions of students around the world. In addition to this and others of his publications, his work on multiple federal government panels, commissions, and counsels has been influential in the development of social policy for the United States.

What we publish here for our readers is the core material from a lecture that Dr. Childress presented for our annual Jack W. Provonsha Lecture, in the spring of 2005. His lecture was placed in the evening between the two days of our 2005 national conference titled, "Apocalypse Now: Seeking Justice and Protecting Rights in Health Care Disasters." Among other items noted in our conference and in Dr. Childress' lecture we find reflection upon the issue of quarantine in situations of health care crisis. As I write this editorial our country's president is talking about the possibilities of limitations of travel and quarantine in the face of a possible bird flu pandemic! This article by Dr. Childress will help shape our thoughts on such matters now, and for years to come.

Mark Carr, PhD, MDiv
Co-Director,
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Volume 20, Number 3 (September, 2005)

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Graduate profiles

With this issue of *Update* we are starting a new section dedicated to our nearly 40 graduates of Loma Linda University's biomedical and clinical ethics program. Each issue will highlight one or two of the graduates, what their experience at Loma Linda meant to them, and what they are doing now.

Brian Foxworth
Class of 2002
MA biomedical and clinical ethics
Loma Linda University

My working definition of ethics is not composed of a clear-cut standard for what morally speaking is right and wrong, but rather how morals, personal ethics, and life situations influence the actions we choose and how these actions affect others. When I was a young student in the Christian bioethics program at Loma Linda University, a professor once said that "the law tells us what we cannot do, while ethics tells us what we ought to do." As I delved into learning basic principles of ethics and gained experience within the clinical setting, I realized that ethics training provides a foundational framework that allows us to make the most caring and respectful decisions in the face of seemingly hopeless situations that manifest themselves in the clinical setting.

Two common questions that I am asked when I tell people what my graduate degree is in are "what is that?" and "what do you do?" The worth of graduate education for some inherently involves jobs, businesses, and publications you produce after you graduate. I never went into the bioethics program to produce anything, but rather did so to seek understanding not only of the foundational components of ethics but also of how they relate to the medical field. What I gained was a better understanding of how my own morality and/or personal ethic affect the decisions I make on a daily basis. And the natural progression after discovering how one thinks is to learn to recognize the motivations behind decisions made by family members, patients, and caregivers in the clinical setting.

This form of understanding is what helps clinical ethicists discover underlying factors that often contribute to ethical dilemmas in health care, thereby enabling them to develop options for resolving those dilemmas. In the biomedical and clinical ethics program you study religion, philosophy, ethics, spirituality, law, and many other disciplines. The most important subject of study however is the complexities of the human spirit and how it is affected by health and disease. There are no high paying corporate jobs for such knowledge, but the richness of this form of study is invaluable.

Since graduating from Loma Linda University I am continuing my graduate education both at Loma Linda University and Claremont School of Theology where I hope to earn my terminal degree. My ethics degree has opened up doors that even I never thought possible. I currently teach online ethics courses for the bachelor of science in nursing and master's level nursing students attending Regis University in Denver, Colorado. Utilizing technology to discuss ethics with future and practicing nurses has been a wonderful form of continuing education in and of itself. This past summer I co-wrote new ethics curriculum for first-year medical students at Western University of Health Sciences and just finished several hours of lecture to more than 200 future physicians.

The reaction of the students to the topics covered and spirited discussion reaffirmed my belief in the importance of ethics education and my desire to be involved in it. Future endeavors are the writing of second-year curriculum for the medical students at Western and continuing my own studies. I am thankful for the academic experience at Loma Linda University as well as the personal relationships built with students, faculty, and staff. In closing I will state that I have not gained personal wealth, prestige, or social status by studying ethics, but the knowledge and appreciation I have with regard to how ethics affects our everyday lives in and outside of the clinical setting is of much greater worth and has brought me true personal wholeness!

Rachel Mason
Class of 2002
Certificate biomedical and clinical ethics
Loma Linda University

My experience in the biomedical and clinical ethics program at Loma Linda University was truly rewarding and enriching. Since all of my education has been focused on psychology and end-of-life issues, I found the ethics program to be a complementary addition to the breadth of my educational growth. I found myself in an industry I am passionate about.

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Loma Linda University
Center for Christian Bioethics

presents

Jack W. Provonsha
Lecture Series

Physician-Assisted Suicide: A Religious Perspective

In February 2005, California legislators introduced assembly bill 654, the California Compassionate Choice Act, shaped in the image of Oregon's Death with Dignity Act. Although the bill was recently sent back to committee, this legislation was written with the intent to move Californian society in the direction of allowing physicians to help patients end their lives. Do we want our society to move in this direction? Could there be reasonable Christian arguments to support this legislation? What of other religious perspectives on this issue? With these questions in mind, the Center for Christian Bioethics has gathered an outstanding group of scholars who will speak to the religious perspective of physician assisted suicide at the 2006 Jack W. Provonsha Lecture Series. The 10-week Jack W. Provonsha Lecture Series will meet each Thursday evening beginning January 5, 2006, and ending March 9, 2006. Loma Linda University students may attend the lectures for credit; health care professionals may attend the lectures for continuing education purposes; and community members may attend the lectures purely out of interest in the topic, at no cost to themselves. An opportunity like this does not happen often; please be sure to mark your calendar to attend the 2006 Jack W. Provonsha Lecture Series.

Schedule of Speakers

January 5, 2006
Dennis Prager, PhD
University Church
7:00 p.m.

A 23-year veteran in talk radio, Dennis Prager is "one of America's best five speakers," according to Toastmasters. Dr. Prager has a pulse on ethical issues and has been referred to as a "moral compass" and someone whose mission has been "to get people obsessed with what is right and wrong." Dr. Prager is known for his interfaith dialogues with representatives from virtually every religion in the world in addition to being a well-published author.

January 12, 2006
David Novak, PhD
Randall Visitors Center
7:00 p.m.

David Novak, PhD, holds the J. Richard and Dorothy Shiff Chair of Jewish Studies as professor of the study of religion, professor of philosophy, director of the Jewish Studies Programme, and member of University College and the Joint Centre for Bioethics at the University of Toronto since 1997. He is founder, vice president, and coordinator of the panel of inquiry on Jewish law of the Union for Traditional Judaism and founder of the Institute of Traditional Judaism in Teaneck, New Jersey, where he regularly lectures. Dr. Novak is primarily engaged in the study of the philosophical aspects of the Jewish legal tradition. He is the author of nine books and numerous articles that have appeared in numerous scholarly and intellectual journals.

January 19, 2006
H. Tristram Engelhardt Jr., MD, PhD
Randall Visitors Center
7:00 p.m.

H. Tristram Engelhardt Jr., MD, PhD, holds full professorship, department of philosophy, Rice University, is professor emeritus, department of medicine and department of community medicine, Baylor College of Medicine, and is a member of the Center for Medical Ethics and Health Policy. Dr. Engelhardt is senior editor of the journal *Christian Bioethics* and editor of *The Journal of Medicine and Philosophy*. He is also senior editor of the book series *Philosophical Studies in Contemporary Culture* and editor of the *Philosophy and Medicine* series with about 90 volumes in print.

January 26, 2006
Ana S. Iltis, PhD
Randall Visitors Center
7:00 p.m.

Completing her PhD from Rice University with a dissertation titled "A Philosophical Exploration of the Possibility and Implications of Institutional Moral Agency," Dr. Iltis specializes in the area of human subjects research and organizational ethics. She joined the faculty of the Center for Health Care Ethics at Saint Louis University in January 2003 as a tenured-track assistant professor. In addition to her faculty position, Dr. Iltis is assistant editor of the *Journal of Medicine and Philosophy* and co-editor of the *Annals of Bioethics*, a book series published by Routledge.

February 2, 2006
James W. Walters, PhD
Randall Visitors Center
7:00 p.m.

James Walters, PhD, is a professor of religion at Loma Linda University. He is now the principal investigator of the Adventist Health and Religion Study (AHRS), a project looking at the possible effect of religious beliefs, values, and practices on mental and physical health outcomes. A grant application from AHRS is now pending at the National Institute of Aging. Dr. Walters' most recent work, *Martin Buber and Feminist Ethics*, appeared in the fall 2003.

February 9, 2006
Margaret Mohrmann, MD, PhD
Randall Visitors Center
7:00 p.m.

Margaret Mohrmann, MD, PhD, completed her residency in pediatrics from John Hopkins and served as director of the pediatric residency program and medical director of the pediatric intensive care unit at Medical University of South Carolina, before pursuing a PhD in religious studies from the University of Virginia. Remaining at the University of Virginia, she is currently Harrison Medical Teaching associate professor of pediatrics and associate professor of both medical education and religious studies. She has authored *Medicine As Ministry: Reflections on Suffering, Ethics, and Hope*, and co-edited *Pain Seeking Understanding: Suffering, Medicine, and Faith*. Her most recent book is *Attending Children: A Doctor's Education*.

February 16, 2006
S. Cromwell Crawford, PhD
Randall Visitors Center
7:00 p.m.

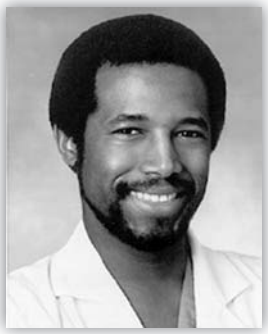
S. Cromwell Crawford, PhD, joined the University of Hawaii, where he has had a long and distinguished career as professor and now chair of the department of religion. Dr. Crawford has been involved in several research projects abroad in places such as London, Bombay, and Brazil. His publications are numerous and varied but focus primarily on Hindu bioethics, world religions, and global ethics.

February 23, 2006
Abdulaziz Sachedina, PhD
Randall Visitors Center
7:00 p.m.

With an MA/PhD from the University of Toronto, and having lectured widely across the globe, Dr. Sachedina is internationally

"Jack W. Provonsha Lecture Series" continued…

known and respected in his field. He is currently professor of religious studies at the University of Virginia and a core member of the "Islamic Roots of Demographic Pluralism" project in the CSIS preventive diplomacy program and a key contributor to the program's efforts to link religion to universal needs and values in the service of peace-building. Dr. Sachedina's numerous articles can be found in various journals and publications in addition to encyclopedias and dictionaries.



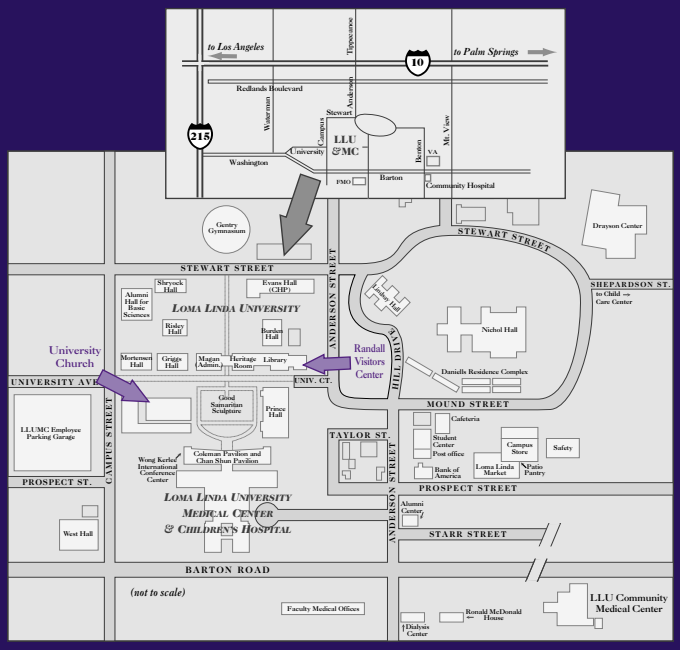
March 2, 2006
BEN CARSON, MD
University Church
5:30 p.m.

Benjamin Carson, MD, completed his residency at Johns Hopkins Hospital before acting as the senior registrar in neurosurgery at Sir Charles Gairdner Hospital in Western Australia. As the director of the division of pediatric neurosurgery and co-director of the Johns Hopkins Craniofacial Center, Dr. Carson is a leading physician in his highly specialized field. Active in research programs as well as clinical practice, Dr. Carson is also known for his three best-selling books, *Gifted Hands*, *Think Big*, and *The Big Picture*.

March 9, 2006
GERALD WINSLOW, PHD
University Church
7:00 p.m.

Gerald Winslow, PhD, is professor of ethics at Loma Linda University. For the past 30 years, he has specialized in teaching and writing about ethics, especially health care ethics and resource allocation. His books include *Triage and Justice* and *Facing Limits*. His articles have appeared in such journals as *Western Journal of Medicine*, *Journal of Pediatrics*, *Journal of Medicine and Philosophy*, *Hastings Center Report*, and *General Dentistry*. He has presented lectures and seminars throughout North America and in Australia, Europe, and China. In addition to his academic work, Dr. Winslow serves as an ethics consultant to a number of health care organizations.

The 2006
Jack W. Provonsha Lecture Series



Thursday evenings
7:00 p.m. to 8:30 p.m.

January 5, 2006
through
March 9, 2006

For more information on the Provonsha Lecture Series, please contact Dawn Gordon at Loma Linda University, Center for Christian Bioethics, at (909) 558-4956, or dpgordon@llu.edu

Graduate profiles continued...

I am currently working as the business and community development officer at Hospice of the Valleys in Sun City, California. My unique background in psychology and ethics has served me well in this position. I find that I am able to better communicate with other health care professionals about the challenges of end-of-life care because I understand the moral and ethical concerns that they have about end-of-life issues. For example, the recent right to die case of Teri Schiavo was brought to my doorstep when a local newspaper called Hospice of the Valleys looking for education about the issues being brought up by the case. I feel that my education and experiences in the ethics program allowed me to clearly communicate the underlying issues and express the true nature of the case; such that, the emotion and biases could be set aside and the crux of the matter was exposed. I feel fortunate that I had many excellent mentors in the ethics program and know that I try to continually honor their investment in me.

The next gradate profile will be in UPDATE *21.1.*

LOMA LINDA UNIVERSITY
Center for Christian Bioethics

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