7-2002

Update - July 2002

Loma Linda University Center for Christian Bioethics

LOMA LINDA UNIVERSITY CENTER FOR CHRISTIAN BIOETHICS

Update

Volume 18, Number 1 (July 2002)

Having Enough Faith Not to be Healed

John D. Brunt, PhD
Senior Pastor
Azure Hills Seventh-day Adventist Church

This article is drawn from a presentation Dr. Brunt made at the "Dying Well: Integrating Vision and Hope into Practice" seminar held at Loma Linda University on March 13, 2002.

In her book "The Dying Process," British researcher Julia Lawton quotes Ann, one of the hospice patients she studied. "I don't like the idea of lingering. If it's going to happen, let it happen. Not all this hanging on, dying inch by inch, fighting every step of the way." In focusing on the dilemma of faith and fight, does faith demand fight? Is it a lack of faith to give up the fight for cure and accept palliative care? Is it a lack of faith on the part of the dying patient's loved ones to cease efforts of cure and healing and focus instead on comfort and support? Some families have been troubled by this question.

If God is an all-powerful God who can heal, then doesn't it show a lack of trust in him to give up the fight and quit trying for a cure? Before we answer this question, we need to lay some groundwork first in definitions. By "palliative care" I mean care that gives holistic nurture, comfort and support to a dying patient without continuing an attempted cure. As Andrew Billings says, "Palliative care is defined as comprehensive, interdisciplinary care of patients and families facing a terminal illness focusing primarily on comfort and support." Kathleen Eagan and Mary Ladbdad?? contrast palliative care with general medical care that seeks curative care and trying to reverse the disease process as medical care, while palliative care accepts the reality of impending death and involves the expert management of instage disease symptomology as a prerequisite to providing the opportunity for patients and family to find growth, meaning, and value in the dying and bereavement experience. Palliative care is then distinguished from curative care in that it's not trying to heal a person's disease. Instead, it attempts to be holistic, open to death and keeping the patient comfortable and supported in a loving way. Palliative care is also to be distinguished from euthanasia or assisted suicide. In palliative care the goal is not to hasten death as an end, although many palliative care givers are willing to give medications to ease pain even though they might hasten death, and are willing to avoid certain kinds of interventions that might prolong life. Some have criticized this aspect of palliative care. Julia Lawton, for instance, argues that focusing so intently on the easing of pain, palliative care givers forget the tragedy of other indignities of dying and believes that for some assisted suicide would be more of a humane way to deal with the total experience of suffering. Finally for the purposes of this paper,

Please turn to page 2

Having Enough Faith Not to be Healed continued...

when we speak of palliative care, we're not talking about the triage involved in financially based decisions not to provide services for certain illnesses within a given population. As we're defining it, palliative care does not withhold curative medical care because it is too expensive, but because it is futile or not desired by the patient. Lila Shawton defines futile care as "care that may be both incompetent and inappropriate and indeed harmful because there is no realistic chance of cure and there are side effects in the attempts at cure." In summary palliative care means giving comfort and holistic support where there is no reasonable hope that curative cure will be successful or desired.

How can you give up curative care and only comfort a loved one? Isn't God capable of healing? Shouldn't you keep doing all that you can? Shouldn't you keep going if you have faith? Some, as I said, have considered such treatments a lack of faith, and these are pastoral questions. And usually it's people of religious faith who face this issue. I will address it from my own Christian perspective in the hope that this perspective might also have relevance for those in other faith traditions. The route to an answer might seem circuitous. We are going to go in several directions before we get to the conclusion. We'll first look at the nature of death, then the nature of faith. Then finally we'll look at the conclusion.

First, a Biblical perspective on death. The last thirty years have seen a major paradigm shift in our understanding of death. Death has come into the open. We no longer try to hide it. Health care providers no longer try to pretend that everything is okay and avoid the subject of death. We have learned from people like Elisabeth Kubler-Ross how to deal with the various stages of response to death and be open and honest about it. However, some of this emphasis on openness to death has gone beyond the concept of facing death honestly and has tried to say that death should become a friend, to be welcomed as just another passage in life. For instance, I once heard Dr. Ross use the metaphor of a shooting star for death. She said that we enjoy the beauty of a shooting star even though we know it really is the death of a meteor. A similar fashion, we should come to see beauty in human death and consider it merely a transformation. In other death and dying literature, there exists a romanticizing of death.

However, the Bible refers to death as an enemy. Swiss theologian Oscar Kuhlman in his work titled "Immortality of the Soul: A Resurrection of the Dead" contrasted Socrates' death with Jesus' death. He pointed out that when Socrates drank the hemlock and faced death he did it with sublime calm. Death was a friend. But, when Jesus faced death, he sweated blood and prayed that this cup might pass from him. In 1 Corinthians 15:26, Paul calls death the last enemy. According to Genesis 3, death was introduced as the consequence of sin, in opposition to God's original plan. This Biblical picture of death comports with our experience. It is true that sometimes death is preferable to suffering or torture. It is true that many people come to the place in old age where so much of their body is already failing that they welcome death. But, it is only because evil has already taken away the qualities of vibrant lifethat death is so welcomed. Death is not beautiful. It is not natural. It is an enemy.

In one of the most painful moments of my life, I stood with two of my closest friends, husband and wife, at the cargo receiving dock of the airport in Pasco, Washington. We watched in the distance as a plane approached and landed. Passengers got off, luggage was removed, and finally a large box was taken off of the plane. It was placed onto one of those luggage carts and driven from the passenger terminal over to the cargo docks where we stood. This plain, white box held the body of their 25-year-old daughter who had been senselessly, brutally, randomly murdered while serving as an intern in Washington, D.C. during her first year out of college. I found absolutely nothing in this moment that bore any resemblance to watching a shooting star. If death is an enemy, shouldn't we always fight to the end? *Please turn to page 3*

Update
Volume 17, Number 4 (May, 2002)

FAX: (909) 558-0336
Phone: (909) 558-4956
e-mail: hmorrison@ethicscenter.llu.edu
Website: bioethics.llu.edu

Letters to the editor and comments may be sent to:
CP 11121S, Loma Linda, California 92350

Having Enough Faith Not to be Healed continued...

Ah, but there is something else we should say about death. If we're faithful to the Biblical perspective, death is not only an enemy, but it is a defeated enemy. Jesus Christ is already the first fruits of the resurrection. According to Paul throughout 1 Corinthians 15, the world changed at the resurrection of Jesus Christ. We received the assurance that death would not have the last word. God will resurrect humans to a new life just as he resurrected Jesus. Yes, death is an enemy. But, it is a defeated enemy.

Viewing death as a defeated enemy does two things. First, it shows us the value of human bodily existence. Life in this world is valuable enough for God to raise the dead and resurrect bodily existence again. Second, life in this world, though valuable, is not ultimate. There is something beyond this life. Otherwise, Scripture could not tell us that there are things in life worth dying for. In Revelation 12:11, saints who remain faithful to Jesus Christ in spite of threats of persecution are commended because they did not love their lives so much as to shrink from death. This is why Jesus could say, "For whoever wants to save his life will lose it. But, whoever loses his life for me and for the gospel will save it" (Matt. 10:39 and Matt. 16:25). Life is valuable and transcends beyond this world. Therefore, death is an enemy, though a defeated one.

"Ah, but there is something else we should say about death. If we're faithful to the Biblical perspective, death is not only an enemy."

Before suggesting what this might mean for the question of whether it is a lack of faith to resort to palliative care, we must also attempt to gain a certain perspective on faith. Religious people sometimes think of faith in terms that God will act to answer all of their prayers and fulfill their agendas. After all, it was Jesus himself who said, "I tell you the truth. If you have faith as small as a mustard seed, you can say to this mountain, 'Move from here to there.' And it will. Nothing will be impossible for you" (Matt. 17:20). If one reads this passage isolated from other texts, one might easily conclude that it would be a lack of faith for the medical profession to cease curative care if nothing is impossible for God. How can we give up trying? If there is no cure, doesn't it just mean we haven't prayed with enough faith to move the mountain? But, a closer look at Scripture as a whole shows a different and deeper concept of faith.

Faith does not simply believe that God will fulfill our agenda. It trusts him even when our prayers seem to go unanswered. There are numerous Biblical examples of this. Daniel 3 recounts Shadrach, Meshach and Abednego, Daniel's companions, being placed in a blazing furnace because they would not bow down to "Oh Nebuchadnezzar. We don't need to defend ourselves before you in this matter. If we are thrown into the blazing furnace, the God we serve is able to save us from it. And he will rescue us from your hand, oh king. But, even if he does not, we want you to know, oh king, that we will not serve your gods or worship the image of gold you have set up." Notice the words "even if not." These men gave witness to a faith that continues its commitment to God even if he did not rescue them from this furnace.

Another Biblical example. After the Hebrew prophet Habakkuk had argued with God how it could possibly be just for the Babylonians, those evil people, to come and destroy Judah as God had predicted, his dialogue with God and his sense of the presence of God finally lead him to submission. And he said, "Even though the fig tree does not bud, and there are no grapes on the vines. Even though the olive crops fail and the fields produce no food. Even though there are no sheep in the pen and no cattle in the stalls. Yet, I will rejoice in the Lord. I will be joyful in God my Savior" (Hab. 3:17-18).

One more Biblical example. The apostle Paul, while imprisoned in Rome awaiting trial, facing the possibility of death, wrote to the Philippians. And he said, "But, even if I am being poured out like a drink offering on the sacrifice and service coming from your faith, I am glad and rejoice with all of you" (Phil. 2:17).

Notice the "even if" quality of faith in all three of these Biblical examples. The deepest Biblical faith is trusting God even if, even though. Even if he doesn't fulfill our agenda. Even if our prayers don't seem to be answered in our way. A more shallow view of faith can lead to cruelty. You see, if every person's failure to get what he or she prayed for is simply a lack of their faith, I can blame them for not having more faith. I remember a friend whose daughter was in a serious car accident. They thought she would die, but fortunately she lived. She did have some permanent damage, though amazingly small considering the severity of the accident. Some "friends," you know the kind, with whom you don't need enemies, came to them afterwards and told them that their daughter would have been healed completely if they had just been able to pray with more faith. The fact is, however, we do not have any way to answer the problem of why in some cases there is cure and in some cases there isn't. We have no way in this world of knowing the

Please turn to page 4

why to each of our questions. But, we do know ***who*** is with us.

Standing in front of my class several years ago, I specifically prayed for two things; that God would help them in their exam and that he would provide safety as they traveled home for Christmas vacation. God certainly answered the prayer for help on the test. I recall a bright and beautiful young woman sitting on the front row. She wrote a great essay and the "A" I gave her hardly did justice to the depth of her thought. A couple of hours later, I learned that halfway to her home in Seattle, the car she was traveling in hit ice on a freeway off-ramp, slid into another car, and she was killed instantly. She was the only one killed in the accident. I have no way of explaining why she died and the others lived.

Biblically, faith does not simply believe that God will do what we ask. It is the belief that God, according to Romans 8:28, continues to work for good in all situations, even those situations that are not good and are contrary to his ultimate will. True faith is persistent trust in God "even if" we cannot understand the tragedies of life. "Even when" we cannot answer why.

Biblical faith has a communal element to it. When Paul expresses his faith even if he is imprisoned and facing death., notice that he goes on to add, "I will be glad and rejoice with you and I want you to rejoice with me." For Paul, faith is not an autonomous, individual trust in God. It involves a shared experience with others. True faith means joining a body with others and, as he says both in Romans 12:15 and 1 Corinthians 12:26, rejoicing with those who rejoice and weeping with those who mourn. There is this "with each other" quality of faith as well. Faith is communal. Now we're finally ready to answer the initial question. Hence, I believe there are three reasons as to why curative care can move to palliative care while remaining consistent with faith.

First, consistent with the view that death is a defeated enemy, palliative care neither romanticizes death and accepts the easy road of practices such as assisted-suicide, nor avoids the subject. Rather, palliative care accepts death realistically and treats the dying patient holistically.

Second, palliative care is consistent with this even if quality of faith. Palliative care accepts the inevitability of death and seeks to confront that inevitability without giving up on life. It attempts to continue finding meaning and even joy in life for the dying and their families. Through its holistic approach, it seeks to face the inevitability of death without sinking into despair. It recognizes that fighting the disease is no longer sensible, but it continues to find strength and meaning in the atmosphere of nurture and support that palliative care provides. In this sense, palliative care can become a powerful example of that "even if" quality of faith, that finding meaning in God even though death is imminent. There's a skill in knowing when to fight and when not to fight. There comes a time when the decay of death has come so close that we must accept it's reality. Christians must fight death. Death is not God's will. But, there comes a time not to fight. It is a time to relieve suffering and try to make the most of each day. The reason that Christians carry on medical work around the world is the belief that death is the enemy. But, it is a defeated enemy.

Third, palliative care is consistent with the communal nature of faith and its holistic embrace of those elements that go beyond physical care and focus on the deeper issue of relationships, meaning, and the realm of the spirit. They are faithful to that "with each other" element of faith. I think of Grace, a member of my congregation. She was dying with cancer in an acute care hospital. Grace was a single, middle-aged woman, an only child who had no family. She had never married and both of her parents had died. She herself had been a nurse in this very hospital and knew most of the physicians and nurses who cared for her personally. I remember one day she spoke of the care she had received in that hospital and how every physical need had been met. I quote her directly at this point, not because I approve of her language, but because I fear that without quoting her directly I wouldn't be able to share the intensity of what she said. She said, "They've all been so competent and so kind. But, I wish that just once, they could be real with me and share the emotions of what is happening. I know it's hard on them." She went on to say, "I know they care. Sometimes I hear them go outside the door and cry in the hall as they leave. But I wish, just once, they could share that with me, but they never do. They're just too damn professional."

Palliative care seeks to take away this wall of impersonal professionalism and offer holistic support. It's willing to be with in the true sense of faith. Willing to rejoice with and weep with. Fighting not for cure, but for meaning. Offering no cure for the disease, but providing care for the discomfort. Always hoping for a miracle, but continuing to trust and hope even if no miracle occurs. Attempting to continue relating to the patient as a whole person with honesty, sensitivity and caring.

References

1. Julia Lawton, The Dying Process: Patients' Experiences of Palliative Care (New York: Routlage, 2000), p. i.

2. Andrew J. Billings, "Palliative Care," British Medical Journal, Vol. 321, Issue 7260 (September 2, 2000), p. 555.

Please turn to page 5

3. Kathleen A Egan and Mary J. Labyak, "Hospice Care: A Model for Quality End of Life Care," in Textbook of Palliative Nursing, p. 7-26, Betty Rolling Ferrell, Ed. (New York: Oxford University Press, 2001), p. 9.

4. Lawton, p. 176-181.

5. Leila Shotton, "Can Nurses contribute ot Better End-of-Life Care?" Nursing Ethics, Vol. 7, No. 2 (March, 2000), p. 134.

6. Elisabeth Kubler-Ross, [find source]

7. Oscar Cullmann, "Immortality of the Soul or Resurrection of the Dead?" in Immortality and Resurrection: Death in the Western World: Two Conflicting Currents of Thought, p. 9-53, Krister Stendahl, Ed. (New York: Macmillan, 1965), p. 12-20.

John Brunt recently became senior pastor of the Azure Hills Seventh-day Adventist Church in Grand Terrace, CA. His academic efforts often focus on ethics and spirituality in the life of faith.

Theological Warrants for Palliative Care

Karen Lebacqz, PhD
Robert Gordon Sproul
Professor of Theological Ethics
Pacific School of Religion

This article is drawn from a presentation Dr. Lebacqz made at the "Dying Well: Integrating Vision and Hope into Practice" seminar held at Loma Linda University on March 13, 2002.

Palliate comes from the Latin word "pallium," which means "cloak." To palliate is therefore to cloak something. To cloak can mean to lessen the severity or it can mean to make something appear less serious than it is. Hence, there is an ambiguity built into the root meaning of the word. One of the reasons palliative care may have some difficulty finding inroads in the medical world is precisely because of this ambiguity: while lessening the severity of something you cannot cure has positive connotations, hiding seriousness has a negative connotation. But palliative care is not intended to hide the severity of illness, but rather to recognize the severity and ameliorate the pains attendant on something that cannot be cured.

Palliative care thus implies at least two decisions. First, we do not try to resuscitate, or keep alive, or cure. Second, we do other interventions to ease suffering during a dying process. Questions arise around each of these decisions. With regard to the first, stopping efforts to resuscitate has sometimes been dubbed "passive euthanasia." While I think this definition is unfortunate and inappropriate, it makes clear that palliative care must be distinguished from euthanasia and runs the risk of being embroiled in the euthanasia debate. Is it ever acceptable to refrain from attempting to cure or to keep alive? With regard to the second, interventions to ease suffering, such as administering morphine, sometimes hasten death. Is it ethically acceptable to ease suffering if doing so has the effect of hastening death?

Theological warrants for palliative care therefore require support for three propositions: (1) first, that medical treatments need not always be offered or accepted; (2) second, that with-

Please turn to page 6

holding or withdrawing treatment is not equivalent to wrongful killing; and (3) third, that suffering is to be relieved, even if the relief of suffering hastens death. The bulk of the public debate has centered on the first two issues—whether treatments must always be offered and accepted and whether failing to offer treatment constitutes wrongful killing. However, we also need theological warrants for the third proposition-- that suffering is to be relieved even if the relief of suffering hastens death.

Let us begin with the first two propositions: that treatment need not always be offered or accepted and failure to do so does not constitute wrongful killing. The commandment "Thou shalt not kill" (Ex. 20:13) is the stumbling block for those out of Jewish and Christian traditions who would consider refusing to offer or to accept medical treatment. Is it theologically mandatory to offer or to accept all possible treatments to keep one alive? Is a refusal of treatment or refusal to offer treatment the same thing as actively killing ourselves or another, which we are commanded not to do?

Many people, myself included, believe the commandment "Thou shalt not kill," is probably better interpreted, "Thou shalt not murder." The commandment therefore deals with wrongful killing, not with any and all killing. However, Lewis B. Smedes, a fairly influential Christian theologian, has argued in fact that it is too narrow to think the commandment deals only with murder. (Smedes, 144) So I will not take the excuse of saying the commandment deals only with murder and does not apply here. Instead I will lift up three solutions to the problem that have been prevalent in the theological literature.

"…there are times when this struggle to preserve physical existence is not in fact what God would ask us to do."

I begin with the Roman Catholic tradition, because as Michael Panicola points out in a recent essay in the Hastings Center Report, the Roman Catholic tradition has often been misunderstood as requiring that all efforts be made to preserve life. But in the classical texts in Roman Catholicism, all efforts did not have to be made to preserve life. As early as the 16th century, Catholic moral theologians argued "That one is not held… to employ all means to conserve life." Further, these early theologians drew the line at some very common problems. Should I have to accept food if it was very difficult for me to swallow and was it almost a torture for me to eat? Their answer was no. Should I have to spend my entire fortune buying medicine to preserve my life? Their answer was no. Quite an important distinction was made then in this early Catholic literature: the person is bound to use only "ordinary" things that are not overly burdensome; the person is not bound to use "extraordinary" things that are burdensome. What is most important to notice is that the distinction between ordinary and extraordinary is whether the treatment presents a burden to the patient. If it presents a burden the patient, it is extraordinary and not mandatory.

Legally, of course, in the United States, one is permitted to refuse any and all treatments. Nonetheless, many caregivers feel very conflicted morally if patients refuse treatment that is routine in the medical world. But the theological distinction between ordinary and extraordinary is not based on what is "routine" but on the amount of burden to the patient. Patients can morally refuse any treatment that presents too much of a burden. For example, a woman facing the possibility of amputation of a breast for cancer can say this treatment is morally repugnant to me. It would present me with a burden I cannot bear and I do not wish that. That is morally acceptable in Catholic tradition. Pope Pius XII summed it up in 1958 when he said that human beings have the right and duty in case of serious illness to take the necessary treatment for preservation of life and health, but that one is required to use only ordinary means, that is to say "means that do not involve any grave burden for oneself or another." (Pius XII, 502)

But what about things most people would describe as "ordinary," such as giving food and water or normal antibiotics? Are these things mandatory, since they are so ordinary? The renowned and recently deceased theologian Richard A. McCormick argues that the logic behind the ordinary/extraordinary distinction in Catholic tradition extends even to those things we tend to think of as the most ordinary of all, including food and water. He argues that the love of God and neighbor means that the importance of relationship must not be lost in the struggle for survival. (McCormick, 547) Hence, even something that appears simple and not overly burdensome may not be offered or accepted under some circumstances. Preserving physical life is not the ultimate goal. The ultimate goal of the preservation of our physical life is our relationship with God. When that relationship is threatened by the burdensomeness of living, then we do not need to go on living, because it's not the most important thing.

That takes me to a second point. Life is not the ultimate good for anyone in the Christian tradition. Here I turn from Catholic tradition towards Protestant traditions in Christianity. With very few exceptions, most Protestants do not adopt the traditional Roman Catholic distinction between ordinary and extraordinary means. Paul Ramsey, one of the great early thinkers in the field of bioethics in the Protestant tradition, was

Please turn to page 7

one of the few exceptions. But many if not all Protestants hold the view that life is not the ultimate good. James Gustafson, a leading Protestant theologian, claims life is a gift that we receive from God. It is not the ultimate value, however, and while Gustafson believes human physical life should be preserved unless there are substantial grounds for regarding other values as more significant in the circumstances, he says human life is full of such other values. (Gustafson, 123) These values include love, justice, and peace. These are the things our lives are meant to serve. So there are circumstances in which the preservation of physical life must be subordinated to other ends.

Similarly, James H. Smylie, reflecting on the Reformed tradition, says life is a pilgrimage of suffering. Although dying may have its sting, from a Christian perspective, it is not the last word about the value of life. (Smylie, 233) Seeing physical existence as not the ultimate value permits opening up theological room to say there are times when this struggle to preserve physical existence is not in fact what God would ask us to do. Thus, both Catholics and Protestants are agreed that not all means must always be used to preserve life.

Further, Christians see death as a normal part of life. John E. Booty, reflecting on the Anglican tradition, suggests that there is a tension in Christian life between fearing death and welcoming it as a door to eternal life. Anglicans developed what is called the "ars moriendi," the art of dying well. (Booty, 249) The concept of dying well is one with a significant history in Christianity. We are not commanded to cure everything, but to care for those who are dying so that they may 'die well.' William F. May suggests that we are promised in Christianity a new life, a new body, and a new community/ communion with God. (May, 180) That is the power of the promise that we are given. Hence there are circumstances in which we cannot preserve this life but we still focus on, hope for, and prepare for the life to come.

It is not only mainline Protestants who take this view. Lewis B. Smedes, representing a more evangelical branch of Protestantism, says that the Bible pictures us nestled in the hands of a sovereign God, and God alone has the right to take life, but God shares authority with us. When life ceases to be a gift and becomes an unbearable burden, we do have the authority to say we are here to care and be in communion with, not to try to extend this life. (Smedes, 147) Any number of traditions concur, including the Seventh-day Adventist tradition. There is considerable agreement among all the communions of Christianity that it is permissible on occasion not to try to keep life going, but to recognize the dying process and to keep company with someone in that dying process.

It is true that Christian traditions have usually rejected active euthanasia. The idea that we should step in and kill someone who is suffering has been rejected across the board by Christian traditions, including Catholicism and every branch of Protestant ethics. Saying that we do not have to accept every treatment offered is not the same as saying we have permission to take our own life or to take the life of another. Arthur Dyck suggests that we should not use the word "euthanasia" as we usually do. He coins a new term-- "benemortasia," or "good dying"-- to try to get away from the language of euthanasia that has tangled us up in this debate. (Dyck, 531) (As noted above, stopping treastment has been dubbed "passive euthanasia." If passive euthanasia is acceptable, people query, then why not active euthanasia? This use of the term "passive euthanasia" is a deliberate ploy to gain acceptance for euthanasia by blurring the moral distinction between withholding treatment and actively killing someone.)

"The paradox is that we both see suffering as redemptive and at the same time have a duty to relieve suffering."

Is this stance that permits withholding treatment, does not see it as equivalent of killing, and requires efforts to care for the dying distinctive to Christian tradition? I believe not. Elliot N. Dorff, summarizes his understanding of Jewish tradition as follows: "Jewish sources have classified active means of euthanasia as murder, even when the motivation of the perpetrator was benign. They have, however, allowed passive euthanasia [sic.] when a cure is no longer possible... [T]he general principle is that Jews are commanded to cure, but not to perpetuate life beyond its natural bounds." (Dorff, 33) In fact, he points out that medicines that "delay the departure of the soul" were explicitly prohibited. The balance is between principles of respect for life and letting nature take its course. (One of my favorite stories is about a very beloved rabbi who was dying. His rabbi colleagues gathered around him and prayed for his life. As they prayed and prayed he continued to live, though he was still dying. The process was getting protracted. Finally, in exasperation, the good rabbi's wife went out into the kitchen, took a pot and smashed it to the floor. The noise startled the praying rabbis and they ceased praying for a fraction of a second. In that second, her husband died. His wife had liberated him and let nature takes its course.)

In both Jewish and Christian traditions, therefore, we find an affirmation that the body is the creation and property of God. Our physical existence is a gift to us and is to be received

Please turn to page 8

in gratitude, preserved and utilized for the sake of God's purposes or higher purposes of life, such as love, community, justice, and bringing about peace in the world. Therefore we are not commanded to try to keep people alive at all costs under all circumstances. There are clear theological warrants for palliative care in the sense of withholding, withdrawing, refusing certain kinds of treatment and bringing to bear other treatments that will relieve suffering.

However, this now takes us to the last question. What about relieving suffering if the medicines that we use hasten the dying process? My mother wanted to live to her 60th wedding anniversary. On the day after her 60th wedding anniversary, she said to me, "Now I want to die, and I do not want to live even until my birthday next month." In fact, she lived a few weeks beyond that. It was as though she had made a decision for herself-- a decision to let go of life on this earth. At the end of her life, she had some undiagnosed pain. We had taken her from one doctor to another without discovering the cause of her pain. Eventually we put her on morphine, which can be given in doses that hasten the dying process. One of my struggles was how to give my mother enough morphine to keep the pain under control. Was I hastening her dying process? Was that right or wrong to do?

When it comes to the management of pain, Christian tradition experiences an ambiguity or paradox. The paradox is that we see suffering as redemptive and at the same time have a duty to relieve suffering. Does relieving suffering work against redemption? Reflecting on the Jehovah's Witness tradition for example, Cumberland suggests that suffering, when patiently borne, strengthens character. (Cumberland, 482) In early Catholic tradition, women were not permitted to have painkillers during childbirth. Was this because their suffering was considered redemptive? The literature is ambiguous, but I believe the real reason pain killers were denied was that anesthesia diminished mental alertness and in case women died in childbirth and had to 'meet their maker,' theologians did not want the women doing so with diminished capacity. Nonetheless, Christianity has a strong tradition of understanding that suffering, when it is chosen and accepted under certain circumstances, can be redemptive.

This view was perhaps most strongly urged by Martin Luther King, Jr. I entered the field of Christian ethics because of the work of Martin Luther King, Jr., and I still consider him one of the great ethicists of the last century. King wrote a great deal about redemptive suffering and urged people to accept and sometimes even put themselves in situations where they knew they would suffer as a way of affirming some values that were important. (Washington, 41) At the same time, he was also clear that there are only limited circumstances in which suffering is redemptive or is to be sought. Human life, after all, is full of suffering. Suffering will find you, guaranteed. If you love deeply, you will suffer. Speaking as a Christian theologian, I believe that we are called to love deeply. I cannot imagine anyone living a life of deep, abiding love that does not also come to bear suffering. So we generally do not need to seek suffering. It will come and find us, whether it finds us in the form of societal oppression, or in the form of personal distress or familial suffering. Suffering surrounds us and we are generally called to relieve that suffering, to feed the hungry, to shelter the homeless, to liberate the oppressed. Suffering for those purposes can be accepted, can strengthen character, and can be redemptive. But it should be noted that when King spoke of redemptive suffering, he spoke of suffering that was both chosen and undertaken only under limited circumstances.

Under other circumstances, suffering can destroy our humanity rather than increase it. Cicely M. S. Saunders, so important in the hospice movement, put it bluntly: "Terminal pain can be so total that it obliterates everything else." (Saunders, 512) Such pain can and should be relieved. More importantly, the earlier we step in to relieve the pain, the fewer and lower the doses that are needed. To Saunders' insights, additional insight about the significance of community has been established. People who are in pain experience less pain if someone is in the room with them. You do not have to talk with them. You do not even have to touch them. If you are just there, they will feel less pain than when you are not there. So there are many, many ways in which we can step in to relieve pain and suffering. Saunders once wrote, "It is far better to have a cup of tea given slowly on your last afternoon than to have drips and tubes in all directions." (Saunders, 513) When I picture what dying well would look like for me, it would involve a cup of tea with one or more of my best friends, preferably at home. My entire church community would sing to me. Finally, I would meander into my backyard, fall over the fence into the graveyard behind my house, and be buried there!

Having said all of this, I think it is very clear that we have theological warrants for palliative care, and very strong ones at that. But I need to add two caveats. First, today there is an emerging debate about medical futility. (Rubin; Zucker and Zucker) Physicians do not need to offer to a patient a treatment that is futile or offers no hope. This fits with the classical understanding of extraordinary care. But, "futility" is not simply a medical judgment. It is also a value judgment. We need to be reminded that those value judgments must be made in the context of individual patients, as 'extraordinary care' was determined for each patient.

A second caveat comes from Morris Abram's story. In 1973, Abram was diagnosed with acute myelocytic leukemia, which was considered invariably fatal at that time. He could have cho-

Please turn to page 9

sen palliative care, as recommended by his physicians. He recalls two physicians being in his room, thinking him asleep. They stood in front of him and talked about the futility of offering horrific chemotherapies to a patient with this disease. Clearly, these were morally sensitive people who were struggling with the idea that to treat him was to torture him. But Abram decided that he would accept every treatment they had available. He made himself a human research subject. He not only received every standard treatment, but also received every experimental treatment imaginable. Instead of dying within the six months that had been predicted, nine years later he wrote his book, The Day is Short. In addressing the question whether it was worth all the agony he went through, he writes, "It was!…[I]n accordance with the primary obligation of my [religious] tradition [Judaism], I choose [life], embrace it…I am daily reminded of an ancient Hebrew text that says, 'The day is short, the work is great…It is not thy duty to complete the work, but neither art thou free to desist from it.'" (Abram, 274)

Abram's story is a reminder that all human life is a mystery. That which seems eminently reasonable and well supported by arguments both philosophical and theological may not ultimately be the right thing to do in a given case. Every action runs the risk of being wrong. Theologian Reinhold Niebuhr used to say that every justice brings about an injustice. Everything we do that we think is right runs the risk of bringing an accompanying wrong. We are promised not that we will live a long life, but that God wishes abundant life for us. The theological quandary is, what is abundant life? Is it a life rich in meaning, but short in days? Is it a life filled with service to others, even at cost to ourselves? Abundance of life is surely not about quantity of physical life. We are not commanded to live at all costs. Palliative care is often theologically warranted, for all the reasons listed above. Nonetheless, there is this small dilemma that remains, because sometimes we should continue the living process in order to add to the abundance of a life the opportunity to forgive and be forgiven, or to say, "I love you" or "thank you" or simply "goodbye."

References:

Abram, Morris B. The Day is Short: An Autobiography. NY: Harcourt, Brace, Jovanovich, 1982.

Booty, John E. "The Anglican Tradition," in Ronald L. Numbers, and Darrel W. Amundsen, eds. Caring and Curing: Health and Medicine in the Western Religious Traditions. NY: Macmillan, 1986.

Cumberland, William H., "The Jehovah's Witness Tradition," in Ronald L. Numbers, and Darrel W. Amundsen, eds. Caring and Curing: Health and Medicine in the Western Religious Traditions. NY: Macmillan, 1986.

Dorff, Elliot N., "The Jewish Tradition," in Ronald L. Numbers, and Darrel W. Amundsen, eds. Caring and Curing: Health and Medicine in the Western Religious Traditions. NY: Macmillan, 1986.

Dyck, Arthur J. "An Alternative to the Ethic of Euthanasia," in Stanley Joel Reiser, Arthur J. Dyck, and William J Curran, eds. Ethics in Medicine: Historical Perspectives and Contemporary Concerns. Cambridge, MA: MIT, 1977.

Gustafson, James M. "The Transcendence of God and the Value of Human Life" in Stephen E. Lammers and Allen Verhey, eds. On Moral Medicine: Theological Perspectives in Medical Ethics. Grand Rapids: William B. Eerdmans, 1987.

May, William F., "The Sacral Power of Death in Contemporary Experience" in Stephen E. Lammers and Allen Verhey, eds. On Moral Medicine: Theological Perspectives in Medical Ethics. Grand Rapids: William B. Eerdmans, 1987.

McCormick, Richard A., "To Save or Let Die: The Dilemma of Modern Medicine," in Stanley Joel Reiser, Arthur J. Dyck, and William J Curran, eds. Ethics in Medicine: Historical Perspectives and Contemporary Concerns. Cambridge, MA: MIT, 1977.

Panicola, Michael. "Catholic Teaching on Prolonging Life: Setting the Record Straight," Hastings Center Report 31, no.6 (2001): 14-25.

Pope Pius XII, "The Prolongation of Life," in Stanley Joel Reiser, Arthur J. Dyck, and William J Curran, eds. Ethics in Medicine: Historical Perspectives and Contemporary Concerns. Cambridge, MA: MIT, 1977.

Ramsey, Paul. The Patient as Person: Explorations in Medical Ethics. New Haven: Yale University Press, 1970.

Rubin, Susan B. When Doctors Say No: The Battleground of Medical Futility. Bloomington: Indiana University Press, 1998.

Saunders, Cicely M.S. "The Care of the Dying Patient and His Family," in Stanley Joel Reiser, Arthur J. Dyck, and William J Curran, eds. Ethics in Medicine: Historical Perspectives and Contemporary Concerns. Cambridge, MA: MIT, 1977.

Smedes, Lewis B., "Respect for Human Life: 'Thou Shalt Not Kill'" in Stephen E. Lammers and Allen Verhey, eds. On Moral Medicine: Theological Perspectives in Medical Ethics. Grand Rapids: William B. Eerdmans, 1987.

CONGRATULATIONS!

The masters program in biomedical and clinical ethics is pleased to applaud the members of our largest-ever graduating class.

From left to right: Ruthanne Williams, Bethany Washam Gardner, Dr. James Walters, Kristi Wilkins, Brian Foxworth, and Dr. Mark Carr

Brian Foxworth entered our program after completing a BS at California Lutheran University. One of his areas of special interest is environmental ethics. During his time here his research focused on theological perspectives on this global issue. Look for Brian's name on future publications in this important area. Brian begins medical school this fall.

Bethany Washam Gardner continues her education here at Loma Linda University in the nursing program. Her undergraduate education at California Baptist University was influenced by one of our previous graduates, Amy Timmons Stumpf, who works as the associate academic vice president there. Bethany's research focused on fairness in allocation of scarce resources.

Kristi Wilkins is an assistant professor of dental hygiene here at Loma Linda University. Her research focused on developing standards of ethical competencies for oral health care faculty. She now teaches a course in ethics in dental hygiene for the dental school here at Loma Linda University.

Ruthanne Williams came into the program with many years of practice as a licensed clinical social worker. Working at the LLU medical center provided continual practical applications for Ruthanne's classroom ponderings. Her involvement at the medical center now formally includes work as an ethics consultant.

Congratulations to our first ever Certificate graduate. ***Elisha Injeti*** traveled here from India to engage in our program. Practicing there as a pharmacist, Elisha's interest in bioethics grew to the point of desire in joining our program. He will continue his education here in a PhD program in pharmacy. It has been our pleasure to be involved in the education of one of the finest gentlemen we have ever known.

And one final note of congratulations goes out to a former student, ***Katrina Bramstedt*** ('97). She recently accepted a position as associate professor with the Cleveland Clinic's Department of Bioethics in Cleveland, Ohio. Additionally, she recently received her PhD from Monash University in Australia. Katrina's publication work has focused on the ethical issues in mechanical heart therapies and she has rapidly become a highly recognized, worldwide expert in this field. We wish her well and applaud her accomplishments.

SAVE THE DATES

2002-2003 Grand Rounds

Wednesday, October 9, 2002
Wednesday, November 13, 2002
Wednesday, December 11, 2002
Wednesday, January 8, 2003
Wednesday, Februay 12, 2003
Wednesday, April 9, 2003
Wednesday, May 14, 2003
Speakers and topics to be announced
All Bioethics Grand Rounds are held in the A-Level Amphitheater in the Loma Linda University Medical Center. They are held from noon to 1:00 p.m. All are offered for no cost and open to the public.

2002 Contributor's Convocation

Saturday, November 2, 2002
9:00 a.m. to 4:00 p.m.
Mirmonte Resort
Look for invitations in the mail in September

2003 Bioethics Conference

Tuesday, March 2, 2003
Wednesday, March 3, 2003
Time to be announced
Wong Kerlee Conference Center
Loma Linda Univeristy
Look for more details in future UPDATES and Save the Date mailings

2003 Provonsha Lecture

Tuesday, March 2, 2002
7:00 p.m.
Place to be announced
Look for more detaiils in future UPDATES and Save the Date malings.

LOMA LINDA UNIVERSITY
Center for Christian Bioethics

LOMA LINDA UNIVERSITY
Center for Christian Bioethics
Coleman Pavilion, Suite 11121S
Loma Linda, California 92350

Change Service Requested