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## Update - September 2002

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# Update

Volume 18, Number 2 (September 2002)

## **Just Put Me to Sleep...PLEASE! Ethical Issues in Palliative and “Terminal” Sedation**

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

I would like to start by drawing a clear, sharp line in the sand. On one side of that line is the withdrawal of life-sustaining treatment, such as stopping a ventilator or dialysis, and the withholding of potentially life-prolonging treatment, such as not using another round of chemotherapy or antibiotics. These are ethically permissible, legally permissible, and professionally sound. On the other side of that line is assisted suicide, such as the writing of a lethal prescription, and euthanasia, such as giving a lethal injection. Some people casually and loosely use the term ‘physician-assisted death’ to incorporate all of these entities, but I would like to assert that there is a sharp distinction.

Let me articulate the distinctions between euthanasia and physician-assisted suicide on the one hand and the decision to forego treatment on the other. The first difference is intent. The intention of euthanasia and physician-assisted suicide is death. When the decision is to forego treatment the intention is to stop prolonging the dying process. There is also a difference in attitude: an attitude of control in the former and an attitude of humility and resignation in the latter. There is likewise a difference of means. In euthanasia and physician-assisted suicide, the means is killing. In the decision to forego treatment, the means is allowing one to die. There is a difference in agency. In the former, the physician is the agent of death, but in the latter, the disease is the agent of death. Significantly, there is a difference in morality. From my perspective, euthanasia and physician-assisted suicide are morally wrong, whereas a decision to forego treatment is most often morally correct. Depending on the circumstances, even this can be questionable.

Palliative care and hospice care involve multidimensional care. Attention must be given to the social, psychological, spiritual, and physical aspects of care. In the physical realm, we clearly need to be experts in treating pain and dyspnea. But, we also need to be aggressive in giving intensive care for the control of other symptoms. Vomiting is a nuisance, but nausea is terrible in that it goes on and on, becoming debilitating. Constipation, cough, insomnia, confusion, itching, secretions, dry mouth, halitosis, and other symptoms all need our attention.

The two symptoms feared most by those confronting a terminal illness are pain and shortness of breath. Both of them are subject-

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tive and neither can be measured in frequency or severity. Sometimes we prescribe morphine or narcotics for pain at the end of life. But, we need to remember there are a multitude of pain types and our response should be multifaceted. We must be aggressive in treating pain.

I spend most of my time doing ethics consultations. Not infrequently the discussion revolves around whether or not it is ethically permissible to stop a ventilator on a particular patient, with the expectation they will not survive. This is a very important moral and ethical issue. But, once the decision is made, how it's done is also a moral issue. I have seen it done badly and I have seen it done well. When the plan is in place to stop the machinery, we need to discontinue the monitors and alarms and move the equipment away from the bed. Buzzers and whistles sounding off tend to be very disconcerting to the patient and their family. Free up the patient's hands by removing restraints. Hands are for holding. Remove any encumbering or disfiguring devices and take off any dressings that are not needed. Draw the IV sedation in the room, ready to give. It is not good enough to have the sedative down the hall at the nurse's station or even in the room in a vial. Sometimes we may want to give some premedication before withdrawing the ventilator. But, we must have these things ready beforehand, and then invite the family in should they choose to be there.

The person responsible, most often the physician, should be there. We should not merely write an order to have the respiratory therapist extubate the patient. There are some nurses

who do this better than physicians. But, we need to have somebody there who knows how to do it, knows how to give medication to treat any anxiety, shortness of breath and so on. We then remove the endotracheal tube, stop supplemental oxygen, and stay there. Some physicians get the tube out and are out the door. But it's the next several minutes, the next few hours that are so important. I do not mean we have to stay there until the patient draws the last breath, because it may take some time. And, the patient may occasionally survive. But someone needs to stay there with medication until it is clear the situation is stable.

What should the physician do when the patient has been given the maximal treatment and still has unrelieved pain or dyspnea? I only see three options. (1) Let them suffer, but, it is immoral to let them suffer. (2) Kill them, but, it is immoral to kill them. Some people talk about "the right to die." I put that in quotations because there is no such thing as a "right to die." There is a right to refuse therapy. There is a right to be left alone. But, there is no "right to die." Two hundred years ago, Francis Bacon said to treat the patient's symptoms not only that they might recover, "but also when, all hope of recovery gone, it serves only to make a fair and easy passage from life" (Francis Bacon, 1805). We should treat the symptoms aggressively with the goal of a fair and easy passage from life. (3) So, the third option is to knock them out.

This brings me to the concept of "terminal sedation." I don't like the term. I wish we could call it something different. I wish we could call it "palliative sedation." The goal is giving sedation to render the patient unconscious when no other

means will bring the patient relief. The goal is the relief of suffering, and that is good. But, the patient may die sooner, and that is bad. I hope this rings a bell in people's minds, the bell being "The Rule of Double Effect." We owe a great debt of gratitude to Thomas Aquinas from the 13th century who said, "It is morally permissible to perform an act that results in both good and bad effects if all of the following five conditions are met." (Sulmasy, D. "The Rule of Double Effect," *Arch. Intern. Med.* 1999, 159:545-50.)

Let us see how this double effect applies in the situation where we are increasing the dosage of morphine knowing that we could potentially suppress respiration. Giving morphine for pain relief is good. The good effect, pain relief, must not be obtained by the means

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of the bad effect, an earlier death. So the relief is not obtained by killing the patient. The bad side effect, the possible earlier death, must not be intended, only permitted. Even if we can foresee it or we know it is going to happen, death is not our intention. There must be a proportionately grave reason for permitting the bad effect. We would not give increasing doses of morphine to the point of respiratory depression for somebody passing a kidney stone. They may be in horrific pain, but it would not be appropriate to allow them to die of respiratory depression from morphine. There must be no other way to achieve the good effect. If we can obtain pain relief through a nerve block or some other mechanism without causing respiratory depression, then we should do that.

I hasten to add that this discussion and analysis of the “Rule of Double Effect” in relation to respiratory depression from morphine is really theoretical. In actuality, pain is an excellent respiratory stimulant. Thus, if a patient is still in pain, it is exceedingly unlikely that increasing doses of morphine in reasonable steps will lead to an earlier death. I have given buckets of morphine to dying patients who were in severe pain, and can only recall one patient who I believe died more quickly from the large doses of morphine. It hardly ever happens.

A few years ago an interesting study was conducted by St. Christopher’s Hospice in London. This study was designed because of concerns that narcotic use at the end-of-life might shorten survival. The study noted the amount of opioid used in the last week of life and the implications for end-of-life decision-making (Thorns and Sykes. *Lancet* 2000; 356(9227):399). They looked at 238 consecutive deaths at St. Christopher’s and recorded the amount of morphine that was used in the last 24 hours. The average was only 26.4 mg, a little more than a milligram an hour. Those who received opioid increases in their last 24 hours did not show any shorter survival.

Now, “The Rule of Double Effect” is an agent-justifying rule, not an action-guiding rule. Its validity depends on the agent’s intentions. This is very important, as intentions are within the person. There is no way to look at a person to know their intentions. But, intentions are practically, morally, and legally important. The difference between physician-

assisted suicide and withdrawing life support is a matter of intention at times. And there is a difference between acting, intending, foreseeing, and desiring. When I am helping to extubate a patient with the expectation they will not survive, that is the action. My intention is to stop prolonging the dying process. I may foresee that they may die more quickly. They have been so uncomfortable and their family is so stretched, it seems like it would be a good thing for them to die. Each of those four things is separate and distinct. Intention requires intellectual honesty.

At the same time, we can look at the action and tell a little about what the intention is. For example, when we’re talking about sedation, we titrate to effect. We give a dose and if that is not adequate, we give some more, and then more until we have reached the appropriate dosage. The

agents we use may be narcotics, benzodiazepines, or barbiturates. When somebody is intending death, they do not give little bits. They give a bolus, using agents intended to cause death, such as potassium chloride, carbon monoxide, or other paralytic agents, generally after some sedation. I refer to carbon monoxide specifically because Jack Kevorkian used to say that he was using carbon monoxide to relieve suffering or pain. He said he was operating under the principle of double effect. He was not. Maybe he was deluding himself but he was clearly not following “The Rule of Double Effect.” Carbon

monoxide does not work in relieving suffering. Carbon monoxide causes death.

Does terminal sedation meet the five conditions of “Double Effect?” The act of relieving suffering by making the person unconscious is inherently good. The good effect, relief of suffering, is not achieved by the bad effect of earlier death. The bad effect is permitted, but not intended, and is only done for proportionately grave reasons. There are no other means to achieve the good effect. It fits.

I can hear some people saying, “But, with terminal sedation the patient dies of starvation and that is awful!” Not true. When a patient is sedated into unconsciousness, they do not die of starvation. They die of dehydration, which actually may be good. It prevents fluid overload, which can

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## *The Rule of Double Effect*

- The act must be good in itself, or at least morally indifferent.
- The good effect must not be obtained by means of the bad effect.
- The bad effect must not be intended, only permitted.
- There must be a proportionately grave reason for permitting the bad effect.
- There must be no other way to achieve the good effect.

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cause respiratory distress. It remains possible to give good comfort care in the patient who is dying from dehydration. In a person who is wide-awake, dehydration is not perceived anywhere in the body except the mouth. And dry mouth is easily treated with good nursing care.

There is a different kind of suffering for many palliative care patients. It relates to those who are chronically ill and slowly dying of progressive neurologic disease, dementia, or other conditions that cause them concern and fear of what is in store. They may say they cannot stand the slow pace of dying and may request terminal sedation.

My problem with the term “terminal sedation” focuses on the fact that these are not terminally ill patients who are imminently dying and requesting sedation for unrelievable suffering. Their suffering doesn’t emerge from physical symptoms, but from a fear of death. My concern is that some people use the concept of terminal sedation with those who are fearful of death rather than suffering intractable physical pain. I would really like to keep these two types of suffering separate and distinct.

The moral and practical distinction is drawn very nicely in an article in the *Journal of Palliative Medicine* by James Hallenbeck (Hallenbeck, J.L. “Terminal Sedation: Ethical Implications in Different Situations,” *Journal of Palliative Medicine*, 2000, 3(3): 313-20). He called them both terminal sedation. I first saw the term “palliative sedation” in an arti-

cle written by Robert Kingsbury in the newsletter *Dignity*, from the Center for Bioethics and Human Dignity (Summer 2001; Vol. 7, no. 2). So we are talking about unrelievable suffering, physical symptoms of pain or dyspnea that support palliative sedation, which is permissible. When we are talking about nonphysical suffering of a social, psychological, and spiritual nature, I think terminal sedation is not permissible.

Whenever I mention the word “suffering” Eric Cassell comes to mind. He draws this very important distinction between pain and suffering. Suffering is often associated with pain, but they are separate and distinct. People will tolerate pain if they know what it is and that it will end.

Pain of lesser degree may be poorly tolerated if it appears to be endless, has dire consequences, or is unexplained. (Eric Cassell, *The Nature of Suffering*, Oxford University Press, 1991). H.R. Neibuhr says suffering “...is the exhibition of the presence in our existence of that which is not under our control”—that is when we start to suffer and lose control. Jeffrey L. Newswanger, in “Ethics and Medicine” (2000), expands that loss of control to loss of independence and loss of hope.

Vaclav Havel, president of the Czech Republic, has given a good definition of hope. “Hope is not the conviction that something will turn out well, but the certainty that something makes sense, regardless of how it turns out” (*Disturbing the Peace*, Vintage Books, 1991). It makes sense. This takes us back to meaning, to a spiritual issue. I had the privilege

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## Terminal Sedation: A Jewish Perspective

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*This article is drawn from the panel discussion following Dr. Orr’s presentation at the seminar held at Loma Linda University on March 13, 2002.*

Jewish bioethics deliberation tends to follow a pattern of legal formalism, which calls on classic texts to be applied to contemporary existential situations. The classic text is often a description of a concrete situation within Jewish lore, and from that situation a principle may emerge which is then used to help reckon what one ought to do in a present predicament. The “situation in the lore” is usually matched with a principle, which has also been extrapolated from classic biblical or rabbinic texts. This is how Jewish thought has stayed relevant in the face of vast technological and sociological shifts. Underlying the methodological formulas has been a principal that I believe has united the Christian, Muslim, and Jewish practice of bioethics: Our bodies belong to God and it is not our right to do with them whatever seems convenient at a given moment. Therefore, end-of-life issues are exceedingly weighty and strike at the very theological beliefs of our traditions.

While any of us can read these texts and ponder these issues, we use the word “decisor” to describe the individual within the community who is responsible for rendering a more or less official position.

I represent the methodological tendency, and as such I will speak with reference to such significant Jewish thinkers as Elliot Dorff

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and Laurie Zoloth, whose names are mentioned in several contexts. I will also suggest that there are other ways in which Jewish tradition can be utilized in our currently complex “end-of-life” environment. Some of these other ways have begun by both Dorff and Zoloth. I will argue that narratives of illness demonstrate that our current situations are more complex than most normative ethics situations allow, and that we are thus obligated to move beyond simple formulas to less grounded expressions of conscience.

I was moved towards a search for some new method by philosopher Sydney Hook’s argument in a *New York Times* Op/Ed piece some years ago. The article followed his survival of a cardiac arrest at 83 years of age. He was revived and argued that, with his children grown and great pleasure drawn from his grandchildren, perhaps he should have been allowed to die. He explained that his having been revived meant that he would have to experience death twice. On behalf of Jewish tradition, I question his conclusions in light of the issues surrounding dying patients and their care, but I have to admit that any thoughtful ethicist must reckon with Sydney Hook’s sense of life and death.

On the “conservative” side of the ledger, my colleague Laurie Zoloth does something with my rabbinic students which demonstrates the complexity of the environment we are in. She shows them a tape of a man with ALS who is asking for some kind of intervention to end his life. There is no hope for longevity; he is in considerable discomfort and is causing a great deal of turmoil within his home environment. Zoloth’s effective homiletical trick sets up my students to say: “Well, of course, let the man go.” She then tells the rest of the story, including the surprise that within the following week the patient was feeling better and watching his children play softball. And yet, it is Zoloth who has paid most attention to the relationship of end of life issues to public policy realities.

My hope is that we may begin to develop—within Judaism—a formal way to help people reach a range of choices around each situation, and perhaps include aspects of the larger context surrounding each issue within our description of the situation. Judaism is essentially conservative when it comes to end-of-life issues. As such, the distinction between terminal sedation and physician-assisted suicide is ambiguous. That is to say, physician-assisted suicide under any label cannot be permitted by

any responsible Jewish point of view. But Judaism does endorse the principle that when there are impediments to death taking its natural course, we may remove the impediments. Some cynics have asked the question, “Why is there so much discourse about this if the answers are so clear cut?” But, what makes the questions tougher—within mainstream Jewish bioethics—are the definitions of “impediment” and “natural course.”

The narrative of Rabbi Judah, the great compiler of the Mishna, is often used by decisors of such issues. It is partly a homily about the effectiveness of prayer. In the story, the people are praying for Rabbi Judah’s life to be extended. God hears the prayers and they are efficacious. Rabbi Judah does not die. His handmaid (unnamed) is on the side of the people until she experiences his suffering, which she notices by evidence that

he visits the privy too frequently. Finally convinced that his suffering is too much, she goes to the roof of the little house and drops a jar. The sound of the crashing jar startles the intercessors from their prayer, and in that split second when there is no prayer, God is distracted (so to speak) and Rabbi Judah’s soul is able to depart. This narrative provides the *locus classicus*, the basic textual warrant, for allowing death to take its course. While we may chuckle at the telling of this story, in Judaism we take special joy in

the problem of how to make modern analogies out of very old stories.

What are the analogies in the contemporary world? And how can we move beyond the analogies? In the world of analogy, the task is to decide whether or not a respirator constitutes the modern equivalent of prayer in the Rabbi Judah story. This is especially important given the fact that brain death is more commonly used as a criterion; but the most conservative Jewish decisors continue to consider respiration as the criterion. Perhaps there is an even more appropriate *locus classicus*. Morris Abram in his book, *The Day is Short*, wrote, “In accordance with the primary obligation of my 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, Morris B. *The Day is Short: An Autobiography*. New York: Harcourt, Brace, Jovanovich, 1982, 274). In the above quote from this great Jewish layperson, the argument to “choose life” can be interpreted to mean that we must keep

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*“We may have a fundamental responsibility to determine what God’s wish might be in a spiritual sense.”*

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life going at all costs. But, if we view “life” in the broadest terms possible, then we might include family considerations, economic status, the needs of the hospital, the social expense of medical care, and so forth. A patient, in other words, could choose “life” for his family.

There is a small movement abroad within the Jewish community to expand the hermeneutic ground to include more narrative thinking, which means more contextualization of each individual case; a greater range of possibilities when decisions have to be made; and a greater willingness to overturn standard methods. These impulses come out of the narrative tradition, out of contemporary hermeneutics, and from the prophetic tradition, which operates more vigorously out of a concern with social welfare and rejection of current norms. These new approaches could represent a revolution which would make traditional Jewish decisors uncomfortable; they may force a change in intellectual discourse and make Jews feel as if they are following the Protestant non-legal model. Now, Jews never mind looking Protestant in social terms, but intellectually we pride ourselves in a distinct discourse which I believe may be coming under some scrutiny.

So the challenge for Judaism will be to learn to draw on Jewish sources without seeking out textual warrants in quite the prescriptive way that has held sway thus far. We live in communities and therefore an individual’s decision or condition is contingent on a community. We may have a fundamental responsibility to determine what God’s wish might be in a spiritual sense. We may want to consider more communal precedents. And we may want to re-examine the reading of some of our basic texts in any event.

This is risky business, but a business well worth the risk if religious thinkers are going to have an influence on practice in this delicate area as it is experienced in real daily situations. ■



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## **Terminal Sedation: A Catholic Perspective**

*James J. Walter, PhD*

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*This article is drawn from the panel discussion following Dr. Orr’s presentation at the seminar held at Loma Linda University on March 13, 2002.*

There is no official Roman Catholic teaching on terminal sedation. What you are going to read is a theologian’s idea of how the tradition might think on this topic. I will start with a couple of introductory comments and distinctions as well as the background to this discussion. Mainly it deals with the nature of suffering and the duty, within the Catholic tradition, to alleviate suffering. Then I will turn my attention to the two moral issues that are at stake in terminal or palliative sedation. Before you place the patient into a coma, you have made the decision not to artificially deliver nutrition and hydration, thus allowing the patient to die of dehydration. The other moral issue follows once the patient is in a coma. I will discuss the ethical dimensions of these two issues and their distinctions. Finally, I will finish with when I think it is morally permissible or not permissible to perform this procedure, according to the Catholic tradition.

First, I want to make two careful distinctions. The first involves intentions. Terminal sedation generally refers to the intent to end the life of the patient. In my mind it is very similar to physician-assisted suicide and euthanasia. Palliative sedation, on the other hand, refers to the intent from the perspective of the caregiver to relieve refractory pain. Only recently has this distinction entered into the literature.

The second distinction revolves around suffering. There are two types. One is neurophysiological suffering that originates from actual physical pain. Then there is one I call “agent narrative suffering.” It originates within the alienation of the patient, within the hopelessness that the patient experiences, and the burden the patient may feel he or she will impose on their family. How does the Catholic tradition view suffering? And does the tradition argue within itself a duty on the part of the health-care community to alleviate suffering when possible? These are important questions. The current Pope, John Paul II, in a speech titled “The Christian Meaning of

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Human Suffering,” (1984) makes a distinction between physical and moral suffering. He says that this distinction is based on the double dimension of the human being and indicates the bodily and the spiritual element as the immediate or direct subject of suffering.

Physical suffering relates to the body. Moral suffering relates to the soul. In one way what the Pope calls moral suffering is what I call “agent narrative suffering.” Physical suffering from the Pope’s perspective can have meaning. It is possible to find meaning and value within suffering when it is experienced in close connection with love received and love given. It can also have redemptive meaning in identifying one’s own suffering with the suffering of Jesus Christ on the cross.

Is there a duty to alleviate pain and suffering? When physical suffering originates out of pain, it ought to be relieved if possible. When patients seek relief, physicians have a duty to offer painkillers to alleviate the pain. This is not just an option; it is a duty for the physician within the Roman Catholic community. A document was written in 1980, titled “Declaration on Euthanasia,” states that “human and Christian prudence suggest for the majority of sick people the use of medicines capable of alleviating or suppressing pain, even though these may cause as a secondary effect semiconsciousness and reduced lucidity. As for those who are not in a state to express themselves, one can reasonably presume that they wish to take these painkillers, and have them administered according to the doctor’s advice” <[www.cin.org/vatcong/euthanas.html](http://www.cin.org/vatcong/euthanas.html)>. This now sets the stage for the two moral issues before us needing to be addressed as palliative sedation.

The first ethical issue is whether to put the patient into a coma. How would one approach this particular issue morally? Two Catholic principles may be used to address these issues. One could use the principle of double effect as it applies to a specific case. The case is that this is an instance in which one action produces two results: one good and one evil. From the Catholic tradition, one must consider the motive, intention, and means of the individual. The intention arises from the will. The will targets a specific end that it wants to achieve. The means are the ways to bring

about the desired end. However, in every action there are always further consequences: some I foresee and want; some I foresee, but don’t want; and some I don’t foresee and, of course, don’t want.

Henry Ford didn’t invent the internal combustion engine. What he did do is mass produce automobiles. And we can assume that what he intended to do, what he wanted and targeted, was in fact to bring about a machine in a mass produced way so people could move easily and quickly about their lives. He created factories in order to produce this. What moved him to do that? Probably profitability, among other things. There were a number of consequences or results of Mr. Ford’s actions, some of which he was aware of and foresaw and wanted. He certainly foresaw that people driving automobiles would be able to get where they wanted quickly. There are other things that he foresaw, but

didn’t want. He surely foresaw that people were going to kill one another with this machine. And presumably, Mr. Ford did not want that. There are other things he did not even foresee with the mass production of automobiles, and he obviously did not want them, such as the amount of pollution that would occur with this machine. Are we going to hold him responsible for everything that occurs as a consequence?

What types of consequences am I responsible for, even if I don’t foresee them? Even when I don’t want them, can I

attribute them morally to the person doing the action? One of the problems that can occur within this kind of schema is the reduction of all of the consequences and the end of the act into a single category. This category is called “results.”

This is what the circuit court of appeals did that preceded the *Vacco v. Quill* Supreme Court’s decision <[supct.law.cornell.edu/supct/html/95-1858.ZS.html](http://supct.law.cornell.edu/supct/html/95-1858.ZS.html)>. The second circuit court of appeals said, “Look, a patient has the right, under Cruzan, to refuse any treatment even if that results in death. So, what’s the difference if a physician gives the patient something that would take their life? The result is the same.” Here the court simply combines “results.” By doing that, one does not know what the agent intends and what the consequences are.

If you reduce intention and consequence into a single cat-

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*“The principle of double effect, along with the distinction between ordinary and extraordinary means, in fact, might justify limited cases of palliative sedation.”*

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recently of sharing the podium with Eric Cassell at a conference in Rochester, Minnesota. I learned much from him about suffering. He said, "Suffering is a failure of adaptation. Suffering starts when the patient is unable to adapt and remain intact in the face of disease, of treatment, or of the consequences." He pointed out two important aspects of suffering, two constant features: the importance of future, and the importance of meaning. One cannot suffer in the present, as it relates to the future. And, bodies do not suffer. People suffer. Bodies have no sense of future and do not assign meaning. Then he said something that I have thought about as well. When patients ask for help in dying, they don't want to die. Rather they don't want to live as they are or fear they will be. What they want is "not this."

When the patient asks for physician-assisted suicide, we need to focus on the patient. It is kind of common knee-jerk practice to tell them, "I'm not allowed to do that. It is against

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egory of results, then the second circuit court is absolutely correct. However, if the distinction between intention and consequences within terminal sedation is maintained, the intention of the physician, the target of the will, is to palliate the patient and free the patient from neurophysiological pain. The physician uses drugs to accomplish that, with the end of alleviating the patient's pain and with the further foreseen, but unwanted consequence of death of the patient. That seems to be morally legitimate as long as it can be shown that the physician has titrated the dosage of the drug, not walked in and simply given the patient 100 mg of morphine. As long as the dosage is given over a period of time to control the pain of the patient, it seems to be an entirely different scenario from physician-assisted suicide. Although the motive is the same compassion, the intention is different. In physician-assisted suicide, the consequence category is the alleviation of pain, and the death of the patient is the intention. These two categories get switched between terminal and palliative sedation.

In the Roman Catholic tradition, these categories are kept distinct. There is the refusal to elide "end" and "consequence," what are called effects, one good and one evil. One of those effects will become the end. The other one will become the consequence.

What do you do once you have the patient in the coma? You have made the moral decision that you will not medically deliver nutrition and hydration. It makes no sense to place the patient into a permanent coma and then insert a feeding tube.

the law." It is far better to respond, "Things must be awful or you would not have asked me to do that." Then probe for the source of the suffering. How do you probe? By listening, listening, listening. When you learn of the problem, you do not have to fix it. You can simply respond, "I understand. We'll do the best we can. This is you and me together. We are walking this road together." That is what compassion is...to suffer with. ■



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The Roman Catholic tradition here would use the distinction between ordinary and extraordinary means. Ordinary and extraordinary are not defined by the references used in clinical practice, that is, by reference to what is customary versus unusual. Rather, these are very carefully defined moral terms in relating to benefit and burden. Ordinary means are all of those potential treatments, surgeries, medications, and anything else that could offer the patient a reasonable hope of benefit, *and* which can be offered without excessive expense, pain, or inconvenience. What is expensive, painful and inconvenient for me may not be for you. This is patient-centered. There are no absolute standards to determine what is excessively painful, excessively expensive, or excessively inconvenient. Notice two conditions have to be met. The treatment has to offer reasonable hope of benefit, *and* that it can be attained without burden. On the other hand, extraordinary means are all of those potential treatments, surgeries, medications and anything else that could not offer a reasonable hope of benefit, *or* could not be obtained without excessive pain, expense, or other inconvenience. This is always a patient or family determination after calculating benefit and burden. The claim might be made that the delivery of nutrition and hydration could be considered extraordinary for a patient in that it would offer no reasonable hope of benefit, *or* it would simply be too burdensome for that patient to accept treatment given their condition of unrelieved neurophysiological pain.

*Please turn to page 12*

# *Announcing the Center for Christian Bioethics National Conference in 2003*

## **“Promise and Peril of the New Genetics”**

*A conference to address developing  
social policy and enhancing clinical care*

**March 2–3, 2003**

**Goal:** Medical science is rapidly advancing knowledge about human genetics. Cloning and stem cell technologies are emerging that will change the nature of medicine and alter human society. This conference will focus attention on how social policy should respond to these new technological capabilities. Should the marketplace be allowed to utilize any and all technologies as they become available? Should government strictly regulate these technologies? What role should religion play in developing social policy? Furthermore, how can these new technologies be researched and put to use for therapeutic purposes in responsible ways?

### **Objectives:**

Upon completion of this conference attendees will be able to:

- \* Discuss how these new technologies are developed with concern for bioethics and social policy.
- \* Identify particular ways that religion can influence the development and use of the new genetics.
- \* Describe ways in which the therapeutic use of these new technologies can enhance care for patients in a clinical setting.

### **Target audience:**

- \* Physicians, nurses, social workers, and direct patient care professionals.
- \* Students and practitioners of bioethics.
- \* Chaplains involved in caring for patients with genetic emphases.
- \* Students, lawyers, and politicians interested in social policy.
- \* Genetic counselors.
- \* Laboratory professionals in genetics research and practice.

### **Featured speakers include:**

**Dede Alpert**

*California State Senator, D-San Diego  
Chair, California Senate Committee on Genetics, Genetic  
Technologies and Public Policy*

**Kathleen Blazer, CGC**

*City of Hope Cancer Genetics Education*

**Diana Fritz Cates, PhD**

*The University of Iowa*

**Paul Gelsinger**

*Father*

**Ronald Green, PhD**

*Dartmouth College*

**Christopher Morris, MD**

*Pediatrician, Loma Linda University Medical Center*

**Joan Morris, MD**

*Pediatrician, Loma Linda University Medical Center*

**Michael West, PhD, Keynote speaker**

*CEO, Advanced Cell Technology, Inc.*

**Tony Zuccarelli, PhD**

*Loma Linda University*

## Videos for sale...

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• <i>A Conversation with Jack Provonsha</i> —Four video set, interview by David R. Larson	(\$34.95)	_____
• <i>A Conversation with Graham Maxwell</i> —Four video set, interview by David R. Larson	(\$34.95)	_____
• <i>A Conversation with Harold Shryock</i> —Two video set, interview by David R. Larson	(\$24.95)	_____
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## Books for sale...

		<u>Qty</u>
• <i>Abortion: Ethical Issues &amp; Options</i> —edited by David R. Larson	(\$9.95)	_____
• <i>Remnant &amp; Republic: Adventist Themes for Personal and Social Ethics</i> — edited by Charles W. Teel Jr.	(\$9.95)	_____
• <i>The New Relatedness for Man &amp; Woman in Christ: A Mirror of the Divine</i> —by V. Norskov Olsen	(\$9.95)	_____
• <i>War No More: Options in Nuclear Ethics</i> —edited by James W. Walters	(\$9.95)	_____
• <i>More Life &amp; Death Decisions</i> —by Robert Orr, et. al.	(\$9.95)	_____
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Center for Christian Bioethics  
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## Center news...

### Center for Christian Bioethics begins new Speakers Bureau

The Center for Christian Bioethics has recently formed a Speakers Bureau to help promote the center and assist other health-care or educational institutions. The bureau consists of a number of scholars associated with the center whose expertise covers a wide range of topics. When health-care institutions contact the center for help with arranging ethics committees or with on-going ethics education, the Center for Christian Bioethics is prepared to offer its services. If you or your institution have a need for ethics education or consulting, please feel free to contact Heather Morrison at (909) 558-4956.



### Center for Christian Bioethics holds 11th annual Contributor's Convocation

The Center for Christian Bioethics hosted its 11th annual Contributor's Convocation on November 2, 2002.

Approximately 60 donors gathered together at Miramonte Resort in Indian Wells for the day discussing Adventism, bioethics, and social policy.

The morning began with Pamela Rathbun, MA, assistant chaplain, Loma Linda University, performing a sacred concert. Charles Scriven, PhD, president of Kettering College of Medical Arts, Kettering, Ohio, discussed the importance of character in relation to other qualities of ethical behavior of students attending medical school.

Following a luncheon on the lawn, Mark Carr, PhD, MDiv, theological co-director of the Center for Christian Bioethics, and associate professor of Christian ethics,



*Pamela Rathbun, MA, assistant chaplain, Loma Linda University, and Steve Robertson provide special music for the convocation.*



*Charles Scriven, PhD, president of Kettering College of Medical Arts, Kettering, Ohio, discusses the important of character in medical students.*

Faculty of Religion, shared news, upcoming events, and goals for the current academic year.

Charles W. Teel Jr., PhD, professor of religion, La Sierra University, Riverside, spoke on social ethics in relation to his book "Remnant and Republic." Concluding the day, Robert W. Gardner, PhD, director, office of institutional research, and professor of social work, Graduate School, spoke of Adventism's view and reaction to politics of the day.

The Center for Christian Bioethics is completely funded by donations and endowment income throughout the year. For more information on the center, or other ways to contribute, please contact Heather Morrison at (909) 558-4526.

*A Roman Catholic Perspective, continued...*

Given those two, I think it is possible to justify limited cases of palliative sedation, but not terminal sedation. Cases that are not morally permissible within the Roman Catholic tradition are as follows: placing patients into a coma that involves “agent narrative suffering” resulting in hopelessness, alienation, and so on; and/or when the intention is to end the life of the patient. Neither of these instances is permissible and are instances of “terminal sedation.” Cases that might be morally permissible within the Roman Catholic tradition involve neurophysiological suffering that give rise to refractory pain. I have heard that under the most optimal conditions, approximately 5% of dying patients experience

refractory pain. The principle of double effect, along with the distinction between ordinary and extraordinary means, in fact, might justify limited cases of palliative sedation. ■



*James J. Walter, PhD, is currently director of The Bioethics Institute at Loyola Marymount University in Los Angeles.*



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