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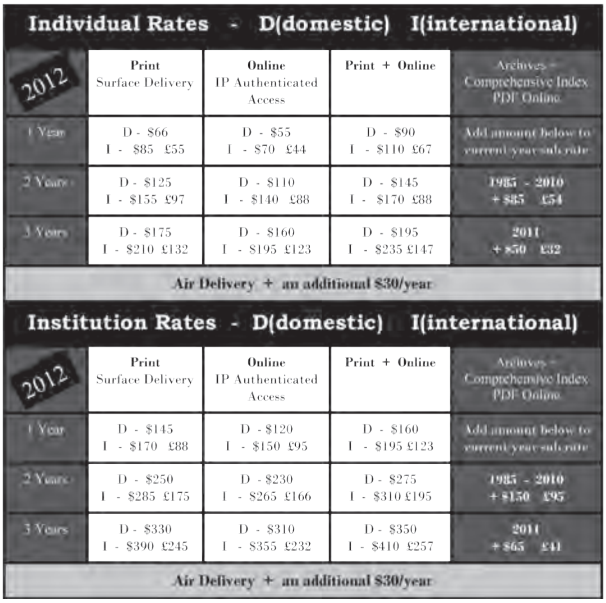

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EDITORIAL

# HIGH-FIDELITY HUMAN PATIENT SIMULATION

C. BEN MITCHELL, PHD

The institution where I now teach has a number of so-called high-fidelity human patient simulators. These are very sophisticated computerized mannequins which can be programed to reproduce many of the physiological responses of the human body. Behind one-way glass in a control room, nursing faculty run real-world clinical scenarios—complete with patients' voices and vital signs—while students examine, diagnose, and treat the mannequins. The scenarios are amazingly realistic and the students almost without exception become engrossed in the clinical context and forget it is a simulation. The obvious benefit of simulation is that no matter the level of skill, the students cannot harm real patients.

Recently, I and several of my colleagues, introduced ethical scenarios into the simulations. This has not been done before as far as I know. At least, there is very little literature on ethics simulation using high-fidelity human patient simulators. Again, the advantage of simulation is that no one is harmed in the process of sorting out the moral details of the case.

As I reflect on the usefulness of ethics simulation, I am struck by how important it is that medical training exhibits the vagaries of real life, including its moral dimensions. No two cases are ever exactly the same, either clinically or with respect to the personal details of patients, families, hospitals, or offices. That is why the art of medicine was to be taught in the context of a mentoring relationship. The Hippocratic Oath, for instance, enjoined the faithful physician, 'To consider dear to me, as my parents, him who taught me this art; to live in common with him and, if necessary, to share my goods with him; To look upon his children as my own brothers, to teach them this art.' The experienced medic taught his art to the inexperienced student. And it was at least as much art as it was science. The relationship between teacher and student entailed deep and lasting moral obligations. In this way the practice of medicine was an embodied practice in which the student learned not only good clinical skills, but had his character formed in the crucible of that relationship.

Human patient simulators are indeed valuable tools at the leading edge of medical education, but simulators will never be able to replace the relationship between the virtuous teacher and the malleable student. High-fidelity ethical simulation must be supplemented by high-fidelity ethical imitation, where the former refers to technology and the latter phronesis (practical wisdom). E&M


07 12-14 2012 HUMAN
RECLAIMING
DIGNITY
in a Culture of Commodification

CLINICAL ETHICS DILEMMAS

# How Does the Doctor Decide Between Cost and Care?

FERDINAND D. YATES, JR., MD, MA (BIOETHICS)

**Editor's Note:**

This column presents a problematic case that poses a medical-ethical dilemma for patients, families, and healthcare professionals. As it is based on a real situation, some details have been changed in the effort to maintain confidentiality. In this case, the community pediatric society struggles with appropriate pediatric care in the face of considerable financial constraints.

**Column Editor:** Ferdinand D. Yates, Jr., MD, MA (Bioethics), Professor of Clinical Pediatrics, State University of New York at Buffalo, and Co-chair of the Healthcare Ethics Council, Center for Bioethics and Human Dignity at Trinity International University.

## Question

Should a pediatrician use a less expensive and well-established vaccination product with adequate reimbursement rather than a newer, more expensive version with better bacterial protection that has a lower profit margin?

## Case Presentation

In 2001, Wyeth Vaccines (presently known as Pfizer) marketed a vaccine product known as Prevnar 7 (PCV7). The product enjoyed the full backing of the Center for Disease Control and Prevention (CDC), and several professional organizations recommended and endorsed its usage in the pediatric population. The product was used successfully for over a decade. As predicted, there was a definitive drop in the frequency of otitis media and, in addition, there was a diminished number of cases of blood stream infection and meningitis caused by the 7 (hence the name) subgroups of this particular bacterium.

In 2010, the vaccine producer was granted approval to market a new version – Prevnar 13 (PCV13) – that added substantial improvement in the vaccine protection rates, especially now that there would be protection for 13 subgroups instead of the initial 7 groups. As might be expected, the vaccination also came with a higher cost than PCV 7, and there was substantial hesitance, initially, on the part of local insurers to cover the vaccination – as PCV7 was still usable and well-established. Eventually, as it became apparent that the insurance carriers made PCV13 a "covered service" – meaning that the vaccine was allowed on the insurance company's immunization formulary – the reimbursement margin to physicians providing the new vaccination would be substantially less that the margin for PCV7.

Members of the local pediatric community engaged in a heated discussion regarding this issue. Some felt that the parents of the child should make the decision as to which vaccination they preferred and pay the difference (out of pocket) for the difference in the vaccine cost. Others advocated a boycott of the new product, noting that the PCV7 was adequate and that the protection was sufficient. One of the pediatricians, a local expert in infectious diseases, stated very clearly that national medical organizations such as the Advisory Committee for Immune Practices (ACIP) and the American Academy of Pediatrics (AAP) had issued statements supporting the use of the newer product. The local medical ethicist – also a pediatrician – argued that children should not be "held as a hostage" in the deliberation with insurance companies and that the pediatrician had a *prima facie* duty to offer the best available care to the child.

How should the individual pediatrician respond? Should the local pediatric committee act in concert?

## Discussion

The pediatrician has both an ethical and a fiduciary responsibility to the pediatric patient, the family, and the community. In discharging these responsibilities, the pediatrician must be cognizant of the available resources, the financial aspect of practice, and the administration of appropriate medical care.

The cost of immunizations is not insignificant and often comprises approximately 25-30 % of a pediatric practices' overhead. The up-to-date pediatric practice attempts to arrange cost-saving measures such as bulk ordering; sometimes by "piggy-back" ordering with other medical practices, and with the direct shipment from the manufacturer, it is possible to avoid the costs associated with the medical supplier. It is, therefore, not difficult to understand the pediatrician's concerns regarding vaccine cost margins.

The protection of vulnerable children from infectious disease is an important part of the modern-day pediatric practice. Presently, vaccinations are a routine part of pediatric care, and the vaccination process typically begins shortly after birth, before mother and infant are discharged from the hospital. Whereas some parents refuse vaccinations for their children, it is important for the pediatrician to engage in dialogue with these families, and they should not be discharged from the physician's practice because of refusal to vaccinate. Nonetheless, the physician should develop a policy regarding the outbreak of community-wide infectious disease, and this policy should be presented to the patient's parents at the time of the patient's initial visit. In this type of situation, parental prerogative should likely be suspended, and the pediatric patient should be vaccinated in the attempt to protect the child as well as the community.

The penultimate duty of the pediatrician is to provide proper health care for the pediatric patient and the community. The pediatrician, a health care professional, has a specialized body of knowledge and experience that appropriately informs him in the process of offering health care to the patient and family. Whereas there are practice-specific variations within the pediatric community, much of the routine health care recommendations and provisions should be virtually identical throughout the community. Much of the reason for this commonality is that a majority of the physicians in our community trained at the same location and that many of us have trained each other in a type of "mentor" model. In addition, a significant majority of the local pediatricians are Fellows of the American Academy of Pediatrics – an organization that suggests a certain standard of care in various healthcare scenarios and in particular the recommendation of routine vaccination of children.

Some of the recommendations (specifically for vaccinations) are routinely informed by national organizations with backing from the federal government. Often, for example, the ACIP is in routine agreement with the CDC, as the safety and efficacy of the vaccines is assessed (based on scrutinized study data presented by the drug company) and recommendations for vaccine use are proposed (based on this information). Rather routinely, medical professional organizations such as the AAP and the American Medical Association (AMA) adopt these recommendations in a timely fashion. So, if the practicing doctor volitionally delays adoption of these endorsements for a prolonged time or for inappropriate reasons, he may be at risk of tort action if a patient under his care acquires a vaccine-preventable disease.

## Conclusion

In providing proper health care for the child in the community, the pediatrician voluntarily aligns with various health care insurance organizations and, in so doing, agrees to abide by the endorsed recommendations from professional organizations. This is a fiduciary opportunity in which the pediatrician agrees to provide proper and standard care within the community. With the introduction of a new vaccine product, the pediatrician has the professional responsibility of considering the appropriateness of this new option. The implementation of the new product must be considered in light of its effectiveness, usefulness, and appropriateness within the routine medical care offered by the pediatric practice. Cost or professional preference may be germane decision parameters when medical products have comparable effectiveness, indications, and specific practice applications. Financial discriminations are inappropriate and ethically bankrupt where there is a clear medical benefit and indication for the use of the newly-available product. The professional pediatrician must not allow personal gain and profit to influence his decision-making regarding the fiduciary care and responsibility of his patients. In providing high-quality professional medical care for the pediatric patient, the pediatrician has an obligation and responsibility to provide the best appropriate care for the medical situation, keeping in mind the best interest of the patient, the family, and the community.

## Denouement

Many local practices (including the author's) depleted the stock of PCV7 and immediately replaced it with PCV13. It was not long before all of the pediatric offices within the community fully recognized the appropriateness of the new vaccination and were using the newer product.

## Resources

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GREY MATTERS

# Neural Signatures of Reason and Rhetoric

WILLIAM P. CHESHIRE, JR., MD

"Ethics," writes Albert Jonsen, "is disciplined reflection on ambiguity."[1] Ethics as it relates to healthcare is termed "bioethics," which is about disciplined reflection on the moral ambiguities that underlie decisions in biomedical science and medicine. Because it concerns people, bioethics is more than a procedure that just adds facts together and subtracts miscalculations. Bioethical discourse appeals to moral principles, justifies decisions, and offers rationales why others should agree. Bioethics considers how people live and die, moving beyond detached contemplation to engage in the struggle over ideas.

Bioethics, therefore, is intrinsically bilingual. Its deliberations apply the vocabulary of reason, while its arguments often employ the language of rhetoric.

## Reason

The *Oxford English Dictionary* defines reason as "that intellectual power or faculty [...] which is ordinarily employed in adapting thought or action to some end; the guiding principle of the human mind in the process of thinking."[2] Philosophy recognizes two categories of reason. Theoretical reason is concerned with matters of fact, their explanations, and whether propositions are worthy of acceptance. Practical reason, in contrast, is concerned with matters of value and what it would be desirable to do.[3] Accordingly, theoretical reasoning modifies beliefs, whereas practical reasoning modifies intentions.[3]

Alongside philosophy, neuroscience offers a complementary perspective on reason as a function of the brain. As in all disciplines, the tools of inquiry shape the questions. The neuroscientific view draws from a background of mathematically modeled neural networks, rippling cerebral electrical waveforms, arrays of gene sequences, encyclopedic catalogs of neurochemicals, colorful brain scans, and stunning microscopic images of dendrites, axons, and synapses. From the study of this inner world of the brain come intriguing questions. How do the properties of neurons give rise to cognition? By what means do frontal lobes generate logical thought? How does cerebral grey matter resolve philosophical grey matters?

Functional brain imaging studies offer increasingly detailed sketches of the neural connections involved in decision-making. These techniques allow for anatomic localization of the various brain pathways that interact to form judgments and reach decisions. Some clues have been found, for example, through investigating patterns of activation of brain circuits that mediate the intricate links between sensory input and motor output.[4] In the nexus between question and decision, no one quite knows the number of neurons involved in the brain processes that underlie reasoning.

Reasoning frequently involves assessment of probabilities when information is missing. Individuals differ in their level of comfort in making decisions involving risk (uncertainty with known probabilities) and ambiguity (uncertainty with unknown probabilities). Functional brain imaging has shown that impulsiveness or risk preference is associated with activation of the posterior parietal cortex, whereas preference for ambiguity is associated with activity in the lateral prefrontal cortex.[5] Other studies have found that the level of ambiguity when making choices correlates with activation in the amygdala and orbitofrontal cortex.[6]

Reasoning also involves anticipation of gain or loss, which correlates with activity in the striatum. Neurons in the orbitofrontal cortex encode the value of offered and chosen goods.[7] Another group of neurons in the parietal cortex adjusts their firing rate according to the magnitude and probability of anticipated reward.[8,9] Decisions correspond to activity in the dorsolateral prefrontal cortex, which integrates sensory impressions and receives a convergence of signals from neural networks involved in rational thought.[10]

The study of neurological patients with brain lesions has taught the crucial importance of the frontal lobes in rational decision-making. The tragic case of Phineas Gage is well-known. Following a devastating injury to his left frontal lobe, this formerly judicious and even-tempered railroad construction foreman became impatient, capricious, profane, unable to assess the consequences of his actions or make rational plans.[11] Patients with frontal lobe damage due to frontotemporal dementia and stroke may also lose executive functions. This dysexecutive syndrome is characterized by difficulty navigating through the complexities and ambiguities of daily life, interacting in a socially appropriate manner, and assembling rational sequences of thought.[12] Such patients have lost part of the ability to reason.

Within the framework of neuroscience, every kind of thought has a neuronal representation within the brain. Taking that principle to its logical conclusion, Michael Gazzaniga proposes that "there could be a universal set of biological responses to moral dilemmas, a sort of ethics, built into our brains."[13] Neuroscience is, in fact, tracing out the neural signatures of moral thought,[14] just as it has delineated the brain regions involved in other complex cognitive capacities such as visual perception, language, and memory.

If moral reasoning has corresponding neural signatures, then rhetoric, too, should be expected to have a basis in the brain.

## Rhetoric

The *Oxford English Dictionary* defines rhetoric as "the art of using language so as to persuade or influence others."[2] Rhetoric comes in many shades. Its words can be used to illuminate or darken meaning. Its power lies in motivating others to believe and act. Consider the following two quotations:

> What I may see or hear in the course of treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep myself holding such things shameful to be spoken about.[15]
>
> A covered entity must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use or disclosure of protected health information in violation of the Privacy Rule and to limit its incidental use and disclosure pursuant to otherwise permitted or required use or disclosure.[16]

The first comes from the Hippocratic Oath and the second from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The rhetoric of Hippocrates constrains physicians to virtue. The regulatory mandate of HIPAA compels providers to compliance. These examples aim for similar goals but differ considerably in their use of language and in what they presuppose about their audience.

Rhetoric often colors what would otherwise be shades of grey. Some examples of rhetoric are shockingly blunt. For example, Steven Pinker assails the principle of respecting human dignity as "stupidity" and attempts to stigmatize viewpoints different from his own as being tainted by mental "sickness."[17]

Some of the more interesting examples of rhetoric in bioethics are subtle. For example, restrained commentaries have objected to extremely controversial biomedical projects as being "troublesome,"[17] having "unintended outcomes,"[18] or raising "significant questions" in regard to justice, safety, and human nature.[19,20] Although judicious understatements have become virtually extinct in the news media from which the public forms opinions on crucial bioethical questions,[21] discretion has not completely departed from academia. Referring to the reserved tone of medical science, one writer referred to a particular academic physician as one who "operates in a world of similarly high-achieving, multiple-credentialed, respectable professionals, where insults tend to be delivered, stiletto-style, in scientific language that lay people aren't meant to understand."[22]

Regardless of the cultural decline of the art of rhetorical understatement, such restraint remains essential to civil discourse. Its intent can be to avoid embarrassing or maligning an adversary. Elsewhere, understatement is a form of irony that draws attention to a problem that can scarcely be exaggerated. Understatement is a corrective to spite and hysteria.

There is also a rhetoric of feigned objectivity. Commenting on a peer-reviewed research article published in a bioethics journal, the editor referred to his own perspective as a "position" in contrast to what he characterized as the "ideology" of the author, whose inconvenient recommendation was to insist on accuracy in word choice describing research involving vulnerable human subjects.[21,23]

Metaphorically, as well as literally, rhetoric strikes a nerve. Metaphorically, rhetoric stirs emotions that inspire, unsettle, or sometimes frighten or enrage. Literally, rhetoric triggers neural circuits corresponding to memories, social relationships, and emotional states. "The essential difference between emotion and reason," writes Donald Calne, "is that emotion leads to actions while reason leads to conclusions."[12] He adds, "Reason is a powerful tool, but one that is unable to determine goals."[12] Deciding which goals are worthwhile to pursue requires knowledge of how to recognize value in information and purpose in life. Rhetoric seeks to persuade others in matters of value and purpose, bringing to bear emotions, attitudes, desires, beliefs, and imaginative detail.

## Neuroscience of Rhetoric

Leon Mayhew, in his book *The New Public*, writes that, for the purpose of persuasion, rhetoric blends reason with four other elements of effective communication: norms, solidarity, coercion, and eloquence.[24] Inasmuch as brain functions underlie persuasion and argument,[24] each of these categories of rhetorical appeal has a neurobiological correlate.

Rhetoric calls upon existing normative commitments that motivate social conduct. "Persuaders and their audiences," writes Mayhew, "invariably bring preexisting norms to the rhetorical arena."[24] Cultural standards, commitments, attitudes, and beliefs form a tacit understanding stored in long-term memory, which is located diffusely throughout the cerebral cortex.[26] Memories are both explicit and implicit and consist of more than just facts and skills. Memories are laden with emotions that correspond to neuronal systems deep within the cerebral hemispheres.

Through reflecting on past memories and anticipating future possibilities, the brain recognizes universal moral principles. Aristotle referred to these as "first principles." The Apostle Paul wrote of a "law written on the heart" (Rom 2:15). Of this "natural law," which Thomas Aquinas systematically developed,[27] J. Budzizewski writes that there are aspects that one "cannot not know."[28] Research on the widespread cortical distribution of memory suggests that such thoughts cannot be traced to a specific spot in the brain.

Solidarity, too, is an independent basis for rhetorical appeal. According to Mayhew, "It cannot be presumed that reason, even if eloquently clothed, will impel others to accept arguments that run counter to their own interests just for the sake of sheer love of truth."[24] Recent research has traced the emotional and motivational factors underlying personal interest to pathways in the brain's limbic system. From this research is emerging a neurobiological model of human moral cognition.[29-33] The visual pathways leading to the fusiform gyrus, which recognizes and interprets faces, also contribute to solidarity through the capacity to recognize in others a shared humanity and common fate. Mirror neurons, which allow one to infer another's mental state, are yet another component of solidarity.

The coercive element of rhetoric may use superiority of knowledge as an advantage, it may deceive, or it may imply the unstated potential for the use of force. In the future, neuroimaging may develop the capability to measure coercive influences on brain function. Current research is applying new methods of recording electromagnetic signals from the brain in an effort to distinguish the patterns of brain activation associated with deception from those of truth-telling.[34] Additionally, studies utilizing magnetoencephalography have begun to tease out differences in brain wave patterns in the ventromedial prefrontal cortex during decision tasks with or without coercive influences.[35] These methods currently are far from an exact science, but if future developments were to achieve validity and reliability, their potential applications would raise considerable ethical questions.

Persuasion may not be the exclusive province of language. The neurobiological correlates of rhetoric might be subject to modification either by ideas or by neuropharmacology. The hypothalamic neuropeptide oxytocin, for example, when administered intranasally to healthy people, promotes trust and cooperation.[36,37] One of its mechanisms is attenuation of amygdala reactivity to threatening faces.[38] In an experimental paradigm, people given intranasal oxytocin were 44 times more trusting that their privacy would not be violated than participants given placebo.[39] However, this favoritism appears to be limited to within one's own social group.[40]

Such research raises interesting questions regarding the prospect of "rhetoricotropic" drugs that, intentionally or not, might adjust the brain's receptiveness to persuasion. Steven Hyman's comments equating behavioral discipline with psychotropic drugs could, in principle, extend to the means of persuasion. Hyman argued that both are "ways of accomplishing the same mechanistic aim: remodeling synapses within the brain. If that is really true, of course, it should make no difference to us which means we choose to reach the desired end when behavior needs to be altered."[41] In the use of rhetoric, as in the use of drugs, means actually do matter.

The quality of eloquence is more difficult to define in neurobiological terms. Eloquent speech is fluent but not excessive, graceful in style, and elegantly persuasive. Its opposite is the expletive, which passes through the cerebral cortex like a speck through a sieve and activates primal limbic structures that serve the social functions of venting anger and repulsing intruders.[42]

In debates over the meaning of human dignity, for example, crude epithets such as "stupid"[17] appeal to primitive brain centers, whereas more sophisticated language appeals to higher cerebral centers. Writing from an attitude of skepticism, Nick Bostrom perceives in the concept of human dignity a "profound vagueness."[43] Leon Kass affirms human dignity as manifest in "excellent human activity."[44] C. Ben Mitchell and colleagues write of its "special worth" that warrants respect and protection.[45] Elaboration of these perspectives engages the capacities in the cerebral cortex for reasoning, generalization, comparison, and distinction.

Eloquence also avails itself of metaphor. C. S. Lewis writes of "men without chests" to illustrate the gaping moral deficit of a culture that has lost its human ethical sensibility.[46] Similarly, Yuval Levin argues that explicit reason alone is inadequate for ethical discourse, that there are moral truths that are reasonable but not fully rational. These, he writes, "are the realms where many ethical limits express themselves not in syllogisms but in shudders."[47]

The neural correlates of metaphorical language have been partially defined. In analyzing metaphorical expressions, the brain considers context, congruence, figurative language and novelty. Whereas the left hemisphere plays a dominant role in literal semantic processing, evidence points to the right hemisphere as playing a major role in nonliteral semantic processing. Functional imaging studies have shown that metaphor processing recruits the right insula, temporal pole, and inferior frontal gyrus in particular.[48-51]

## Rhetoric of Neuroscience

It is important to recognize that neuroscience itself carries rhetorical force. The rhetoric of neuroscience sometimes extends beyond scientific descriptions to moral prescriptions. Tassy and colleagues argue that greater knowledge in the neurobiology of moral cognition can elucidate why some moral rules are universally shared and others are dependent on context.[52] Gazzaniga takes the idea further and aspires beyond a descriptive brain-based ethics to a normative one, writing that his "hope is that we soon may be able to uncover those ethics, identify them, and begin to live more fully by them."[13]

Underlying these propositions is the assumption that one need look only to more complete scientific accounts of the brain for moral guidance in human affairs. Scientific language speaks authoritatively, but scientific theory is not infallible. Scintillating brain scans portray information convincingly, but they do not compose a complete picture. It is advantageous to look inward to the brain for knowledge. It is also worthwhile to use the brain to look beyond itself to additional sources of wisdom.

## Toward Ethical Rhetoric

Rhetoric may be used well, or it may be used injuriously. Although its abuses have given it a frequently negative connotation, there is still the possibility of restoring an ethical framework to rhetoric. John Milton wrote that "where there is much to learn, there of necessity will be much arguing, much writing, many opinions; for opinion in good men is but knowledge in the making."[53]

Reason is the foundation of clarity of thought. Rhetoric is intrinsic to language as a symbolic medium of expression and persuasion. Reason and rhetoric go hand in hand in bioethics. Reason devoid of rhetoric is inert. Rhetoric severed from reason falters.

The proper exercise of rhetoric seeks not to deceive but to clarify, not to coerce but to persuade, not to denigrate but to respect those who hold different views, not to highlight the speaker but to elucidate truth. Rhetoric at its best is sincere, charitable, and committed to virtue.

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# EFFECTIVE ENGAGEMENT IN GLOBAL BIOETHICS: THE BENEFITS OF QUESTIONS

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## Abstract

*American religious conservatives are frequently viewed as harsh, intolerant people who think they have all the answers. They often forget to speak the Truth in love. Because their presentations and writings focus primarily on persuasion via Scripture, logic, and rational argument, their speech is seen as unfeeling and cold. If we are to effectively engage in global bioethics, we need to incorporate methods that attract and engage, rather than alienate, people, not only in our own culture but cross-culturally. Non-western cultures put much more emphasis on stories and thoughtful questions than does the West. Indeed, so does Jesus' example in Scripture. This paper will examine the benefits and methods of using questions to engage listeners in examining bioethical issues. It will provide new tools for the speaker's toolbox and improve his/her effectiveness as a proponent of the Christian worldview.*

## Introduction

"The religious right," "Christian fundamentalists"—Who hasn't heard American religious conservatives described in terms like these? Christian conservatives are frequently portrayed as intolerant, ignorant people who think they have all the answers. Some even compare them to the Taliban. Certainly, the biblical Christian view is out of vogue in the marketplace and considered offensive in the classroom and in polite company. Unfortunately, too often conservative Christians argue their position clearly but forget to speak the Truth in love.

In addition to these issues, we need to consider the limitations of Western methods of teaching in a multicultural context. Western thinkers separate secular/scientific information from sacred/Scriptural knowledge. Western speakers tend to focus their presentations and writings primarily on persuasion via logic and rational argument. These methods are uncommon and often not comprehended by much of the world, where teaching and learning are more often focused on observation, memorization, stories, and thoughtful questions. Likewise, in the West there is great focus on the learner's autonomy and independence in thought and action. In other areas, learning is more holistic and focused on community and interdependence (Merriam, 2007, 178-86). If we are to engage effectively in global bioethics, we need to explore and incorporate methods that attract and engage, rather than alienate, people, not only in our own culture but cross-culturally.

Given these views of biblical Christians, how can biblical Christians effectively engage the large number of people in our multi-cultural society and the world today who ignore or reject biblical values? The goal of this paper is to improve our ability to effectively and less offensively engage others in bioethical discussions while stimulating them to examine their views. It will emphasize the usefulness of questions rather than lecture for this purpose. For often, "[i]t is not the answer that enlightens, but the question" (Ionescu, E. quoted in Clarke-Epstein, 2002, XIV). We will look first to Jesus' example and then to secular sources to learn the usefulness of questions and how to use them more effectively.

## Jesus' Example

"If anyone had a right to speak with authority … Jesus did. If anyone had a right to teach solely by … dogmatic instruction, he did. But that is not how he taught. Even the most casual reader of the Gospels cannot help noticing the great number of startling, unusual, unexpected questions which Jesus asked … More than one hundred … and practically all of them served some teaching purpose" (Piper, 1931, 64).

One of the few times Scripture speaks of Jesus' youth (Luke 2:43-50) it portrays him asking questions of the teachers in the Temple (Price, 1946). Indeed, Jesus' first recorded words are a question. In answer to his mother's inquiry Jesus answered, "Why were you searching for me? … Didn't you know I had to be in my Father's house?" (Luke 2:49) (Horne, 1975, 45). "Jesus was always asking questions and encouraging his disciples to ask questions of him. By so doing he stimulated the thought-life of his followers, and often changed the course of their living" (McKoy, 1930, 172). Isn't that what we want to do when speaking on or teaching bioethics?

Jesus was the Master teacher come from God (John 3:2). He followed several basic principles. His teaching was authoritative (Mark 1:21) but not authoritarian. He did not give simple, specific answers to every problem of life. Jesus lived what he taught (John 13:12). He loved those he taught (John 15:12). He was concerned for Truth but also for those who needed to hear the truth. His style incorporated five core values and implied five associated calls related to teaching: truth (a call to integrity); love (a call for care); faith/faithfulness (a call to action); hope (a call for courage to confront the human situation and bring hope); and joy (a call for celebration of hope and healing) (Pazmino, 2001, 76).

Jesus' primary focus was not on methods but on objectives, not on theoretical questions, but on practical ones. He concentrated on what he wanted to accomplish in the minds or hearts of his hearers and used the method that could best achieve it. He adapted his methods to the person and the occasion.

"Jesus taught in terms of life because his objective was not to impart information merely, but to change and transform life … Jesus had constantly in mind the struggles and sorrows, perplexities, worries, and ambitions of real people. That is why his precepts are not dry abstractions, but vivid pictures of life … Jesus was not teaching facts; he was teaching people to face facts…That is why he dealt with life situations and constantly had in mind the practical needs of his pupils" (Piper, 1931, 41).

Jesus used thoughtful, searching, even enigmatic questions. "He came not to answer questions but to ask them; not to settle men's souls, but to provoke them…not to make life easier, but to make it more educative" (Merrill, 1919, 42-3). Jesus sought to stimulate interest in his listeners, to expand their vision, and to convey experience to them. (Raven, 1919, 141) Jesus cared enough to discuss the truth, even with his enemies; he saw the root of their opposition as a heart, rather than knowledge problem (Pazmino, 2001, 79).

Jesus used rhetorical questions and counter-questions in response to stated or implied questions, in situations where a reply was expected, and especially in the face of hostile audiences like the Pharisees (cf. Mark 2:6-9, 19, 25; 3:1-4, 23; 10:3; 12:15-16). A verbal response was not always his goal; often, Jesus wanted to provoke thinking and a mental response from his listeners. In fact, rhetorical questions were the most frequent type of question used by Jesus. He used them to set the stage for his reply, to get agreement from his audience (e.g., Matt 7:16; Luke 15:8), to emphasize and add solemnity to a point (e.g., Mark 8:36-7; Matt 5:13), and even to reveal exasperation and frustration (cf. Mark 9:19; Luke 12:14) (Stein, 1994, 24).

Jesus used questions for at least nine reasons. To:

1. Make a point of contact.
2. Hold attention and start thinking.
3. Clarify facts and clear up errors.
4. Compel his hearers to think through correctly to their own conclusions.
5. Make his questioners answer their own questions.
6. Intensify right convictions.
7. Prepare his hearers for understanding and accepting a truth he was about to utter.
8. Appeal to conscience.
9. Bring faith to expression and obtain confession of faith in himself. (Piper, 1931, 73-4)

He relied on God's power (John 5:19, 30), "For teachers to foster both continuity and change in the culture … requires a wisdom and grace that God alone can provide" (Pazmino, 2001, 66).

Jesus, like us today, taught in a multicultural environment. Multicultural education seeks to create an educational environment which will help participants from all cultural groups learn. As a Galilean, Jesus was a cultural outsider (Pazmino, 1983, 67-71). He stood out from other teachers and from the crowd. Jesus' teaching incorporated a prophetic element in that he taught God's Truth. It was pastoral in that He knew the human heart and came to bring forgiveness and healing . Jesus' highest value in teaching was love and compassion, for obeying the greatest commandment required people to love God with all their being, including their mind . There was also a political dimension as the implications of his teaching confronted culture and power structures (Pazmino, 2001, 103). He, like believers today, was indwelt by the Holy Spirit, the Spirit of Wisdom, and sent from God to teach. Might his use of questions have been selected because of its particular usefulness in an environment in which listeners held many different views?

## Benefits of Questions in Education

But isn't the teacher's business to instruct rather than to ask questions (Piper, 1931, 64)? Every question is a potential learning opportunity. Many education theorists believe deep and significant learning occurs only after reflection by the learner. Reflection is induced by questions (Marquardt, 2005, 29). When asked his greatest accomplishment, Socrates replied, "I taught men to question" (Christensen, 1991, 156). John Dewey believed the educator's responsibility was to equally incorporate to two things. First, a problem associated with the learner's experience should be given to stimulate thinking. Secondly, the problem should arouse the learner to activity (an "active quest") for information and new ideas (Dewey, 1963, 40-45). For learning to occur, Freire believed in the need for what he termed *conscientization,* characterized by active learner engagement leading to critical awareness. “Education is communication and dialogue. It is not the transference of knowledge, but the encounter of Subjects in dialogue in search of the significance of the object of knowing and thinking” (Freire, 2008, 126). It is empowering and liberating. Mezirow believes, “The goal of adult education is to help adult learners become more critically reflective, participate more freely in rational discourse and action, and advance developmentally by moving towards meaning perspectives that are more inclusive, discriminating, permeable, and integrative of experience” (Mezirow, 1991, 224-5). This process generally begins with some type of “disorienting dilemma,” (Mezirow, 1991, 168) which can range from a challenge to their values and ideas to major life events such as death in the family or unemployment. This initiates critical reflection and self examination, eventually leading to renewed perspective (Mezirow, 1991, 168-9). The educator should not force or manipulate learners to his perspective but should encourage critical examination of their assumptions (Mezirow, 1991, 225). Questioning can itself be the disorienting dilemma. Questions are useful in all of these educational systems to foster learner engagement and participation.

Questioning can be used to bring together a wide range of ideas and groups—“known and unknown, past and present, teacher and student, youth and age” (Christensen, 1991, 156) —around a common problem. When we ask questions, we invite others to join the search for answers with us, to share not just information but responsibility (Marquardt, 2005, 28). Shared responsibility transforms listeners’ views of problems from “theirs” to “ours.” Ownership of results is shared. “People like to feel they have found the answer themselves” (Sydanmaanlakka, Pentti quoted in Marquardt, 2005, 28).

Questions can help people think about why they do what they do. Questions help them to see things from a different perspective and to surface and change unconscious biases. Questions help them get perspective and better understand others’ perspectives. Questions can help people better appreciate the complexity of a problem or issue and see more possible solutions. They can help them learn to search and ask questions themselves instead of looking for the “right” answer (Marquardt, 2005, 29). In addition, questions can help the teacher evaluate the understanding and response of students (Price, 1946, 106). This can be particularly important in a cross-cultural or multi-cultural setting. Questioning has even been reported to increase connections between neurons in the human brain (Marquardt, 2005, 30).

Effective and creative solutions to complex problems, like those in bioethics, are more likely to be found when a group is asked questions. Group collaboration can help “avoid responding to today’s problems with yesterday’s solutions while tomorrow’s challenges engulf us” (Dillworth, 1998, 38). Questions can help the speaker balance her need to guide discussion along desired paths and topics while allowing students the ability to explore the topic in ways they find meaningful (Christensen, 1991, 157).

“Questions have the potency and force to change individuals, groups, organizations, communities, and even nations and the world” (Marquardt, 2005, 174). They can help people see and articulate more clearly what they really believe, what they are facing, and how they might respond to change (Marquardt, 2005, 46). Speakers should encourage their audience to ask themselves questions to facilitate their own learning and application (Christensen, 1991, 162).

## Types of Questions

Having a mental picture of the types of questions that can be used can help the speaker develop questions targeted at his goal(s) and expand his question inventory. It can also serve as a "back of the mind" grid review to help rapidly select the most appropriate type of question to insert into an ongoing discussion. One author (Christensen 1991, 159-60) suggests the following typology:

- Open-ended questions
- Diagnostic questions
- Information-seeking questions
- Challenge (testing) questions
- Action questions
- Questions on priority and sequence
- Prediction questions
- Hypothetical questions
- Questions of extension
- Questions of generalization

Purposes of questions may include:

- Explorative questions (Marquardt, 2005, 71) to establish a point of contact or to open a line of thought (Piper, 1931, 65; Price, 1946, 111-13)

    * What do you think? (Matt 17:25)

    * Have you ever been in this situation?

- Rhetorical questions to surprise, challenge, hold attention, spur thought or drive home a point (Piper, 1931, 65-7)

    * What is the Kingdom of God like? To what can I compare it? (Mark 4:30)

    * What shall it profit a man to gain the whole world but lose his own soul? (Luke 9:25)

- Deliberative questions to invite participation and fresh thought (Piper, 1931,66)

    * Who do people say that I am? (Matt 16:13-15)

    * What can you do about it with current resources?

- Questions to compel thought and response to a story or case

    * Which of these three do you think was a neighbor to the man who fell into the hands of robbers? (Luke 10:36)

    * Which of them will love him more? (Luke 7:41)

- Questions which answer questions or provoke a dilemma

    * By what authority are you doing these things? ... And who gave you this authority? Jesus replied … John's baptism—where did it come from? Was it from heaven, or from men? (Matt 21:23-5)

  * Should we pay taxes to Caesar? ... Whose portrait is this? And whose inscription? (Matt 22:20)

- Questions to secure information or case history

  * What do you want me to do for you? (Mark 10:36)

  * How long has the boy been afflicted by the evil spirit? (Mark 9:21)

- Questions to make a point or clarify a situation

  * Can you drink the cup I drink? (Matt 20:22)

  * Why do you call me good? (Mark 10:18)

- Questions to help people reason from fact to truth, to convince or bring conviction. "A good question may be used as a sharp sword to pierce a calloused conscience. Though simply stated and quietly asked it may carry with it a far more powerful emotional appeal than a sustained exhortation" (Piper, 1931, 71), One author calls this using questions to "get people to persuade themselves" (Leeds, 2000, 157).

  * Who do you say that I am? (Mark 16:15)

  * Is it lawful to heal on the Sabbath? (Matt 12:9)

- Questions to evaluate the person's state of mind

  * Do you want to get well? (John 5:6)

  * Do you believe I can do this? (Matt 9:28)

- Leading Questions. These should be avoided as they are generally not real questions, but attempts to lay blame or force listeners to respond the way the questioner wants. (Marquardt, 2005, 75) A common example would be a question which ends in "don't you think?" (Christensen,1991, 162).

The level of abstraction or specificity of a question should be adjusted to fit the speaker's purposes. "Abstractions run to coolness, specifics to heat" (Christensen, 1991, 161). The goal should be to generate more light than heat! More abstract questions are less personal and help give a broad view of the topic. Specific questions are more useful when action is needed but can raise the emotional level of the discussion. For example, when discussing abortion, a question on what factors influence the country's current position on abortion would be more abstract than one on under what circumstances the hospital should allow abortions to be performed or in what case listeners would do or have an abortion.

Opening questions are the most important since classes rarely recover from a poor start. Opening questions should be linked to the speaker's opening comments, should be relatively general to draw in people with a range of interests and responses, and should give some suggestion of the response expected. For example, one might ask, "To see where we are as we begin to examine this topic, could several of you briefly give one or two sentences about how you view it?"

It is often wise to defer challenge questions and hypothetical questions until well into the session. Challenge questions asked early may make a student feel threatened. Asking hypothetical questions too early may keep the class from exploring the facts of the issue deeply. Difficult questions can be brought up early but not immediately discussed to give time for students to reflect on them. When they are asked, a "wriggle out" clause may be used to keep students from feeling too on the spot. For example, "This is a tough one—at least for me—what is one thing we need to consider?" Time can also be made for participants to ask the questions. For example, one can ask, "Given the points just made, what other questions should we consider?" (Christensen, 1991, 162).

## Characteristics of Good Questions

Wasserman writes:

> There is much more to the art of questioning than merely making interrogative demands…questioning must be sensitive to other aspects of the interactive process. These include an awareness of how questions are framed…and of how the way they are put may provoke anxiety, thereby influencing the nature of the students' responses. Good questions follow an interactive "rhythm" that produces reflection rather than interrogation. They allow for student responses that lead to continued examination of the issues. They are clear in what they are asking students to think about and not so broad or abstract that they defeat the process of thoughtful examination. Good questions invite, not command, students to respond. They build trust in the interactive relationship (Wasserman, 1992, 8).

Good questions should be simple, brief, clear, and to the point. They should stimulate thought (Price, 1946, 110). Open-ended questions are usually perceived as non-threatening and avoid making students feel they are "on the spot" (Marquardt, 2005, 32). Thoughtful, probing questions can improve communication, decrease misjudgment of others' motives, and make a wise decision more likely (Marquardt, 2005, 32). The wording of a question "can influence the style, content, and emotional character of the response" (Christensen, 1991, 158).

Especially in cross-cultural or multi-cultural situations, the speaker's role may not be to provide answers but to have the humility to realize that she does not "understand enough to have the answers and then to ask questions that will lead to the best possible insights" (Collins, 2001, 75 quoted in Marquardt, 2005, 21).

Good questions have some or all of the following characteristics. They:

- "Cause the person to focus and to stretch.
- Create deep reflection.
- Challenge taken-for-granted assumptions that prevent people from acting in new and forceful ways.
- Generate courage and strength.
- Lead to breakthrough thinking.
- Contain the keys that open the door to great solutions.
- Enable people to better view the situation.
- Open doors in the mind and get people to think more deeply.
- Test assumptions and cause individuals to explore why they act in the way that they do as well as why they choose to take action.

- Generate positive and powerful action" (Marquardt, 2005, 66).

The following questions may be useful for the speaker to keep in mind and use to evaluate the questions she develops:

- Is the question likely to increase the learner's will as well as capacity to learn?
- Will it help give her a sense of joy in learning?
- Will it help contribute to the learner, increasing their confidence in their ability to learn?
- In order to answer, will the learner need to do research, examine data, give a logical explanation for their answer, or just give their opinion?
- Does the question allow for alternative answers?
- Will answering the question tend to bring out the uniqueness of the learner?
- Would the question be likely to produce different answers if asked at different stages of the learner's development?
- Will the answer help the learner to send and understand the universals of the human condition and thereby enhance her ability to develop empathy and deeper relationships with others? (Postman and Weingartner, 1969, 66)

Research has shown that open-ended questions, giving time for reflection and response, and neutral praise stimulate people to think divergently, give more complete answers, and participate in classroom discussion (Rakow, 1986, 16).

## Questions and the Speaker

Becoming a master questioner is a life-long process. Effectiveness as a questioner progresses with practice, especially when we seek feedback from both students and other educators and review audio and/or videotapes of our teaching sessions. Preparing potential questions before class is helpful, but only practice will make one a master questioner (Christensen, 1991, 153-72).

Asking questions takes courage, since we can't predict or control listener responses. "Courage is always an act, not a thought" (Marquardt, 2005, 53). We should design questions to help respondents understand an issue from their perspective. Asking questions can be tough, especially asking follow-up questions or questions that require deep and intensive reflection and soul-searching (Marquardt, 2005, 53) . A key to good questions is contextual. We must ask what we want to accomplish and design the question for that purpose. "Questions can be very powerful in focusing attention … they send constituents on mental journeys—quests—in search of answers" (Marquardt, 2005, 61).

Our words can reveal our attitudes and behaviors, structures and concepts, rather than serve as neutral queries (Marquardt, 2005, 78-9). Tone and level of voice, speed of delivery, facial expression, body language and stance, and eye contact play at least as important of a role as the content of the question (Christensen, 1991, 158).

Speakers with a learning mindset tend to encourage response whereas those with judgmental mindsets tend to use questions which lay blame and alienate listenersThe learner mindset shows humility, genuine concern/interest, and love. It helps listeners see the speaker as a partner who sincerely wants to help, like a mentor or coach rather than a boss (Marquardt, 2005, 80-81). As Christians, we know there is only ultimately one Judge. Our role is to recognize our limitations and invite others to reason with us.

The speaker must be willing to ask questions that might challenge listeners' perceptions and habits. But she should seek to word them in a way which is designed to elicit a frank but friendly, rather than a defensive or angry, response. Practical suggestions to use which reveal a learning attitude are:

- Respond without judging the thoughts, feelings, or situations of other people.
- Take the role of an outside observer, researcher, or reporter.
- Look at the situation from multiple perspectives, especially your respondents'.
- Look for win-win solutions.
- Be tolerant of yourself and others.
- Ask clarifying questions.
- Accept and embrace change (Marquardt, 2005, 82).

Thus speakers should focus on questions which are open-ended and empower rather than those which threaten self esteem, offend, or imply blame (e.g, Why aren't you using the latest methods? Why is this taking so long to implement? What is the problem?). Empowering questions are not aimed solely to generate information or to show the speaker's cleverness. Rather they encourage people to think, evaluate their roles, come up with their own answers, and develop ownership for results. Good questions accomplish a purpose and build a positive relationship between speaker and audience. They can focus on content or process. The best results usually come from using process questions first, as they tend not to lead or limit responses.

"Answers often simply aren't! They are merely launching pads for further exploration, places to prepare for the creation of new and more insightful questions" (Christensen, 1991, 163). Often, a good question is an open, creative question built on the response one gets to a previous question. Open-ended questions have no clear right or wrong answer. They encourage people to expand the discussion, to explore the issue, and to limit what they reveal to what is comfortable for them. Most are useful in bioethics discussions. Open-ended questions often begin with "why" or "how" or a phrase such as "What do you think about …?"

"Why" questions can help reveal deeper purposes and assumptions but can also be more challenging. When asked in a tone of curiosity, rather than anger or judgment, they may be accepted and beneficial. Often the first response to a "why" question is superficial. For that reason, it may be useful to ask "why" consecutively up to five times to increase the likelihood of revealing most underlying factors and causes (Marquardt, 2005, 70-71).

A particularly useful and affective method is to use what is known as "appreciative inquiry" (Cooperrider, 2001; Whitney, Cooperrider, Trosten-Bloom, and Kaplin, 2002). This approach seeks to develop "a relational process of inquiry, grounded in affirmation and appreciation" (Marquardt, 2005, 84). It is based on the assumption that discussion of positives such as "strengths, successes, values, hopes and dreams are themselves translational" (Marquardt, 2005, 84). Appreciative inquiry does this through positive questions, such as asking what has gone well, how it could be improved, or what could be done (Marquardt, 2005, 84-5).

"In some … cultures … it would be taboo and dangerous to ask too many questions, especially questions that might rock the boat or cause someone to lose face" (Marquardt, 2005, 68). When speaking or teaching cross-culturally, especially in shame-based cultures, we need to carefully consider these issues. In these situations, it may be wise to limit oneself to rhetorical questions until one gets to know the people better and can assess how open they are to participative discussion. Open-ended, unbiased questions show respect for other's views, invite their participation, and are less likely to embarrass people in these cultures. Younger persons tend to be more open to questioning than older and higher status people in such cultures. Another useful method is to reframe your question as a request for advice or help. For example, the speaker could tell a group that he or she values their expertise or advice and could ask them to tell him what they know or think on the subject. Observing the body language of the audience gives helpful hints as to their reaction to questions (Marquardt 2005, 84). Questions such as "Who doesn't understand this?" and "Does everyone see how I reached that conclusion?" should be avoided as they inevitably cause those who respond to lose face (Christensen, 1991, 162).

Speakers need to listen well rather than rushing to judgment or giving their own answer. Selectively listen for value-laden words, critical judgments, stated and unstated assumptions, conclusions and patterns that develop in responses. Keep in mind two factors in evaluating responses—the respondent and the big picture. First, assess the respondent. Does their response show command of the basic material? What do their words, tone of voice and body language show about their sincerity and interest in the subject? How logical is their argument? Second, evaluate what contribution the response makes to the desired dialogue. Does it build on or strengthen earlier responses? Does it change the direction of the discussion? How does the rest of the group respond to the comments (Christensen, 1991, 164-65)? At this point, closed or direct questions may have a role in helping clarify responses. For instance, one can ask, "It sounds like you were saying … Is that right?" (Marquardt, 2005,74).

Only one question should be asked at a time. Allow time for reflection and response. Don't be uncomfortable with silence. Fewer, better questions are more useful and less offensive than a lot of brief, sequential questions. Asking multiple questions can make listeners feel interrogated or that the questioner is self-focused and not really interested in discussion (Marquardt, 2005, 75). If you have multiple sessions with the group, consider posing a question to consider at the end of one session and letting them know you will discuss it later but wanted to give them time to reflect (Leeds, 2000, 90).

Speakers should develop the habit of questioning their questions (Marquardt, 2005, 83). Think about how they sound and how your audience is likely to respond. If you are unsure about a question, either drop it or pose it tentatively. For instance, you might explain that you are unsure how the question might be taken but would like permission to ask it.

The timing of questions is also important. One might begin a presentation by asking a rhetorical or thought-provoking question. In other situations, especially those that are complex or sensitive, it may be wise to use a multi-step approach: ice breaking, setting the stage, asking the question, listening, and following up (Marquardt, 2005, 85-88). The first step is to break the ice with the group. This can be done by casual chatting before the session, a period of introducing each other, an introductory statement, humor, or a closed question. Once the ice is broken and a relaxed environment is created, the speaker should set the stage for the question. This is a good time to emphasize that the goal is to learn and not to judge and even to open yourself up by disclosing something about yourself or your own hopes and dreams or what you hope the outcome of the class or conversation will be. Then, before posing the question, explain what you want to discuss. Ask the question with a relaxed, calm, but confident and curious tone of voice, keeping eye contact with your listeners. Once the question is asked, listen attentively to the answers. As you listen, "Use verbal encouragers such as "I didn't know that, tell me more"; "what else happened?" (Marquardt, 2005, 88). Learn to "hear what isn't being said" (Marquardt, 2005, 91). Thank people for their responses. Avoid judging or criticizing responses as it will close off participation (Marquardt, 2005, 91). Instead, voice critical questions as if you were curious. You might ask, for example, "I would be interested in knowing more about why you chose that." Ask others what they think. To the extent it is possible, follow up on what is said by making changes in future presentations (Marquardt, 2005, 92-3).

A number of considerations should ideally underlie the instructor's response to a person's comments (Christensen,1991, 169-71):

- Were their significant factual errors which need to be discussed?
- Should I give the respondent an opportunity to restate an unclear point?
- Should I reinforce the point made when the class doesn't seem to recognize an exceptional insight or comment?
- Do I need to encourage this respondent who has been shy or reluctant to participate?
- How will my response affect the student's self-esteem or peer relationships?
- Which response will best balance the needs of the respondent and the group?
- Which response will best balance the tension between covering material and students' interests?
- Do I need to acknowledge the affective content of the response by pointing out the emotional sensitivity of the issue?
- Which response will stretch the group's knowledge and ability to discuss and yet not put anyone on the spot or cause them to lose face?
- Which response best fits the norms and values of this learning community?
- Which response will best balance coverage of the topic in appropriate depth with the time available?
- Was the response off topic and in need of being deferred until later?

It is also helpful for speakers to have a mental framework of possible ways to move the discussion after each response. The first decision to make is whether to continue the current teacher-to-student discourse or shift to a student-to-student mode. Christensen uses a decision tree of options for this purpose (Christensen,1991, 168).

Be willing to be asked questions yourself. Respond in a gentle, calm, thoughtful way, regardless of the emotions they provoke in you. Consider asking listeners to reflect back what they heard and felt in response to your comments (Marquardt, 2005, 91).

## Why Use Questions in Bioethics?

"The operations of many minds on a subject can be far more illuminating than a single taught point of view" (Christensen,1991, 155). Phillip Johnson begins his book, *The Right Questions*, by stating, "In a lifetime of studying and participating in controversies, I have learned that the best way to approach a problem of any kind is usually not to talk or even think much about the ultimate answer until I have made sure that I am asking all the right questions" (Johnson, 2002, 27). This is a critical step because if the right (foundational or underlying) questions are asked in sequence, they lead the listener down a logical path to the right conclusion. Johnson is convinced "the truth will not be heard unless the lecturer is sufficiently interesting not only to draw an audience, but to disarm some of their prejudices so they will pay attention to what they are hearing and then think about it … afterward" (Johnson, 2002, 50). Questions can serve this purpose.

Speaking in the context of the intelligent design vs. evolution controversy, a foundational issue underlying many bioethics debates, Johnson further explains that asking the right questions is vital because "[m]ost people have accepted a biased definition of the conflict, a definition which assures that scientific naturalists will win all the important arguments" (Johnson, 2002, 60). This principle of asking the right questions can be applied to any controversy between faith and science, because the issue is really a battle between two religions (scientific materialism and Christianity or another faith) and two definitions of science. Science is supposed to be about following observable evidence to its logical conclusions, not about prejudging what is and is not an acceptable conclusion. Modern science is presented and viewed by society as a neutral method; the assumptions on which it is based are usually not articulated and therefore not recognized. Johnson says that his concern "is not with presuppositions as such, but with *concealed* presuppositions, which come disguised as facts" (Johnson, 2002, 89). Only occasionally is contemporary science's philosophical bias clearly admitted. For example, a letter published in one of the world's most prominent scientific journals, *Nature*, concluded, "Even if all the data point to an intelligent designer, such an hypothesis is excluded from science because it is not naturalistic" (Todd, 1999, 423).

Both camps look at the same basic facts but interpret them through different lenses, based on their assumptions or philosophical presuppositions. Scientific materialism has not proven but assumes that the natural world is all that exists; by definition, then, it excludes any cause or interpretation not observable. Religious views assume there is a real supernatural world in addition to the natural one.

Scientific materialists have their own creation story just as do those with religious views. For example, the Christian view is that "in the beginning was the Word … and all things were made through Him." The scientific materialist story, based on evolutionary naturalism, believes that "in the beginning were the particles and the impersonal laws of physics" (Johnson, 2002, 64). It promotes agnosticism and scientism (Johnson, 2002, 66). These two views underlie many of the conclusions reached in bioethical debates. Astute questions can be used to highlight and help listeners recognize the basic philosophical assumptions underlying each view.

Bioethics involves issues which are often very sensitive. An effective method to involve and engage all listeners is to begin a presentation with a question and give them time to think. Or better, if the setting will allow it, ask listeners to huddle in groups to discuss it. One such method is what Dr. Donald Guthrie calls think-pair-share (Guthrie, 2009); this has the advantage of not making listeners' views public. Even if no time is given to share their views more widely, listeners will not only be more interested in the presentation but will realize that you value their thinking (Bateman, 1990, 36). Discussion or questions about such issues may provoke emotional and even hostile responses. Many of these situations can be diffused by initiating one's response with a question, especially a rhetorical question, rather than a statement.

## Questions to Consider in Bioethical Writings/Presentations

Effective use of questions in bioethical discussion can involve the general types of questions already discussed. However, great benefit may come from more bioethically-oriented questions. A great deal more work needs to be done to develop "the right questions" to use in discussion of these issues.

## Applications

There are many practice applications in bioethical presentations and discussions we may glean from our considerations of the use of questions in these settings. In brief,

- Prayerfully ask God to help and guide you to increased effectiveness in winningly engaging the culture from the Christian worldview.
- Remember the surreptitious role questions can play in opening hearts. As Bengis put it, "The real questions are the ones that intrude upon your consciousness whether you like it or not" (Bengis, I. quoted in Clarke-Epstein, 2002, 41).
- Consider when and how you can better use questions in your bioethics activities.
- Work with other Christians interested in bioethics to develop and share effective questions on specific bioethical issues.

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# Ethics of Palliative Sedation and Medical Disasters: Four Traditions Advance Public Consensus on Three Issues

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## Abstract

*Background and Purpose: After Hurricane Katrina, despite investigations of "painkiller" usage among 140 Katrina-related deaths at hospitals and nursing homes, formal charges were never made, and allegations were dropped; the state paid legal fees of accused. Contested practices occur in plural cultures amidst counterclaims of bias. This aims to identify common metrics among diverse traditions as an ethics of palliative sedation and medical disasters.*

*Methods: Palliative sedation practices raise three kinds of issues; clinical, ethical-legal-political, as well as public health and cultural arguments about accompanied rest (including religious claims). Quantitative data and detailed qualitative commentaries yield consensus among four traditions.*

*Results: Aaron Mackler weighs Jewish practical reasoning. Daniel Sulmasy probes clinical applications of historically Christian double effect categories. Aziz Sachedina explores Muslim end of life decision-making, and William J. Buckley surveys palliative sedation and common law.*

*Conclusions: Three issues demonstrate consensus: (1) who decides (patient-caregivers), (2) how (futility, last resort, no PAS, right to pain management, safeguarded therapy) and (3) why (accompanied rest). Seven practical maxims include: (I) Informed consent in shared decision making processes connects treatment refusals and the provision of palliative sedation (e.g., DNR choices). (II) Futility is collaboratively negotiated with severe, unremitting, refractory symptoms. (III) Palliative sedation is a therapy of last resort. (IV) Palliative sedation does not deliberately terminate terminal patients (not PAS/Euthanasia). (V) Palliative sedation enacts rights to aggressive pain management (VI) by converting mandated relief into cost-effective, safeguarded therapy with consultations, monitoring, and practical stakeholder re-assessments (VII) thereby ritualizing dying as an "anticipatory memory" of accompanied transformation.*

## Introduction

Public arguments from Hurricane Katrina examine pain-free dying. In dramatic narratives, agents made particular decisions amidst cataclysmic circumstances, interpreted by diverse discourses glancing at larger social practices.[2] Bans on killing aren't focal; greater insights emerge from how decisions about pain relief and sedation shape cultural performances of dying. Persons in a story beckon discernment from four traditions: Jewish, Christian, Muslim and American Common Law. A concluding consensus names three issues: who decides, how, and why. Seven maxims contribute to debates about health care reform and suggest areas for further inquiry. Aaron Mackler examines Jewish practical reasoning that furthers his previous work *Life and Death Responsibilities in Jewish Biomedical Ethics*. Daniel Sulmasy explains and clinically applies double effect reasoning—so influential even beyond Christian traditions—which advances in new directions his many publications, including his co-edited work *Methods in Medical Ethics* and his own work, *The Rebirth of the Clinic: An Introduction to Spirituality in Health Care*. Aziz Sachedina interprets Muslim end of life decision-making in an enlarged frame that newly sharpens the practical focus of his *Islamic Biomedical Ethics: Principles and Applications*. William J. Buckley surveys palliative sedation and common law that extends his co-edited work with Karen Feldt, *Taking Sides: Clashing Views on Death and Dying.* Questions of racism and "circumstance" are explored.

## Background and Purpose

After flooding 80% of New Orleans and 90% of coastal Mississippi, Hurricane Katrina of 2005 remains the USA's costliest disaster ($100 billion in damages) and is among its five deadliest (1836 deaths).[3] In a record year of twenty-seven tropical storms, debates about responses to Katrina are complicated by claims that some related deaths were intentional. These assertions were culturally constructed in several ways. Some analyses targeted class, gender, and ethnicity, but some commercial media framed issues as legal accountability for murder.[4] Other public arguments cultivated rival understandings by privileging false dilemmas rather than more complex explanations.[5]

But everything isn't conflictual, and all conflicts aren't intractable. Furthermore, many practical problems invite functional answers. On the one hand, it was not hard to see why. Coroners listed 140 hospital and nursing home "Katrina-related" deaths that provoked legal investigations of six Louisiana hospitals and thirteen nursing homes.[6] Arrests were made on four counts of second-degree murder in "strongest cases" based on excess levels of pain-killers.[7] Yet on the other hand, subsequent grand jury investigations declined to indict.[8] Formal charges were never made. Allegations were dropped, expunged, and accused (Dr. Anna Pou) eventually had legal fees paid.[9]

What raised questions? Of forty-one deaths at Memorial Medical Center, investigators probed toxicology findings in some two dozen cases. Dr. Sheri Fink's detailed interviews disclosed more than one hundred and fifty heroic evacuations as well as contested shifts from triage on Tuesday morning to "reverse triage" (sickest go last) on Wednesday in a hospital with power outages, flooding, and feared civil unrest.

> Those who were in fairly good health and could sit up or walk would be categorized "1's" and prioritized first for evacuation. Those who were sicker and would need more assistance were "2's." A final group of patients were assigned "3's" and were slated to be evacuated last. That group included those whom doctors judged to be very ill and also, as doctors agreed the day before, those with D.N.R. orders….[The difficulty or impossibility of evacuating patients was one factor; some patients were perceived as] too heavy to be maneuvered [up and] down the stairs, through the machine-room wall [hole] and onto a helicopter.[10]

Some might not have survived evacuation. Others were non-terminal. Some un-evacuated elderly whose sedations resulted in death were not even being treated for pain prior to Katrina. According to Fink's detailed interviews, exhausted caregivers ascertained patients as either immobile or unlikely to survive long as well as demanding needed nursing care from limited resources.

> [J.B.] [was] a 79-year-old woman with advanced uterine cancer and kidney failure. She was being treated for comfort only and had been sedated to the point of unconsciousness with morphine. She was so weighted down by fluid from her diseases that [Dr.] C sized her up at 350 pounds….'Do you mind just increasing the morphine and giving her enough until she goes?' [Dr.] C told me [Fink] he asked [J.B.]'s nurse. [Dr.] C. scribbled 'pronounced dead at' in [J. B.]'s chart, left the time blank and signed the note with a large squiggle. Then he walked back downstairs, believing that he had done the right thing for [J.B.]..…
>
> [Dr.]T., a 53-year-old pulmonologist] practiced palliative-care medicine and was certified to teach it. He told me [Fink] that he knew that what they were about to do, though it seemed right to him, was technically 'a crime.' He said that 'the goal was death; our goal was to let these people die.' [Dr.] T gave other patients a shot of morphine and midazolam at doses he said were higher than what he normally used in the I.C.U. He held their hands and reassured them, 'It's all right to go.' Most patients, [Dr.] T. told me, died within minutes of being medicated. But the heavyset African-American man didn't. His mouth was open, his breathing was labored and everyone could hear his awful death rattle. Dr. T. tried more morphine. He tried prayer. He put his hand on the man's forehead; [Nurse] W and another nurse manager took the man's hands in theirs. Together they chanted: 'Hail Mary, full of grace. The Lord is with thee.' They recited the Lord's Prayer. They prayed for the man to die.… 'We covered his face with a towel' until he stopped breathing, [Dr.] T. told me [Fink]. He says that it took less than a minute for the man to die and that he didn't suffer. 'This was totally against every fiber in my body,' [Dr.] T told me, but he also said he knew what he did was right. 'We were abandoned by the government, we were abandoned by Tenet, and clearly nobody was going to take care of these people in their dying moments.' He added, 'I did what I would have wanted done to me if the roles were reversed.'[11]

Officials ultimately determined that prosecution would not have succeeded owing to complexities in establishing exact medical causes of death beyond reasonable doubt in cadavers kept for over ten days in 100+ degree temperatures. On the other hand, as one calamity receded, a wake of recriminations surged.

What happened? Amidst everything, Katrina awoke a national debate about palliative sedation and disaster medicine. Disaster sedations splashed in media re-invigorated drowsy discussions about wider end of life sedations. In the forty-sixth largest city in North America that is three centuries old and has tracked hurricanes since 1846, what made nursing homes and hospitals more lethal than levees? Praise and blame telescoped claims about disasters said to be natural, social, and personal with microscopic revelations about disconnections among levees, public services, and personal choices.

How had a perfect storm become so devastating, exposing an entire ecosystem of assumptions? Various efforts to stabilize dependents converged with others aimed at recovery, restoration, and even good (enough) dying. Because vulnerably dependent were not all dying, examples of sustained care using constrained and limited resources did emerge. Some health care providers were similarly situated yet offered different patient care, whether better or not.[12]

Yet comparisons to make analogies trustworthy require assiduous attention to detail. Some fresh appraisals after the event of past decisions offered caustic boundary judgments about what seemed then to participants to be broad swaths of brackishly practical tradeoffs among patient needs and perceived resource limitations. For example, most ventilator-dependent patients were evacuated early. Yet criteria to judge other kinds of constrained care were contested.

But wasn't Katrina's real culprit simply racism? Persistent accusations demanded precise responses to specific charges; what different kinds of racisms played which roles in whose disaster sedations? Serious questions were not whether race played any role, but how different understandings of "race" interacted with which other factors. Sheri Fink's narrative research located race and ethnicity in contexts of class, ageism, and disability.[13] Many persons worked together for one another's benefit and destiny—and larger structures helped and hurt. This was no simple story of victims and villains. Racism was demonstrably transpersonal and structural. But a shift occurred: from telling illustrations of disreputable personal biases evident in discrete examples of individual consciousness to convincing explanations with specific causal connections about social practices of racial exclusion. Urgent and complex questions tracked different macro and micro correlations among morbidity and 1836 mortalities, of which 140 occurred at hospitals and nursing homes that were categorized as "Katrina-related." Furthermore, race intersected questions of class, gender, disability and ageism at Memorial Hospital. Here three accused killers were white women, and three of four victims were black (African American); a black male physician who objected to critical care decisions left the hospital.[14] Were these typical situations, hasty generalizations, or merely unrepresentative samples?[15]

Because mortality data showed that race was neither the only nor the key factor in who received and who died from medicines--data demonstrates a mixture—quantitative measures required additional metrics and qualitative research.[16] Did staffing asymmetries in race, ethnicity and class both reflect commendable altruistic service yet aggravate inadequate advocacy, training, or recruiting?[17] What kinds of understandings of race shaped corporate health care judgments that influenced medical staff decisions? Contested metrics at macro and micro levels, suggested different kinds of racisms played different roles among diverse parties. For example, local, race-specific disaster mortality rates in New Orleans were two and a half times higher among blacks than whites. But three items constrained micro analyses: age, class and gender made it hard to establish strong micro causal correlations among racism as interpersonal or structural reality with specific decisions or patterns of triage and palliative sedation among each of some 140 "Katrina related" deaths.[18] Close scrutiny of micro decisions and issues of gender continue to unfold as litigation proceeds. Most personal narratives remain filtered by risk of legal exposure.

What is known? Palliation in disaster sedations features *ten contributing factors of racism* at *macro* levels. (1) Apart from Katrina, race is a demonstrable factor in *end of life decision-making* in acute, chronic and terminal settings.[19] (2) Asymmetries in the *health status* (morbidity) of pre-Katrina populations by race (3) are aggravated by a multi-generational service economy with *class-based, underdeveloped usage of health benefits* (unlike labor union cultures). (4) These featured *unequal access* to (5) publically *under-supported health services* (6) that became exacerbated by the natural disaster of Katrina in social and personal ways documented in the *catastrophic evaporation of health care* *delivery systems* including behavioral treatment, records, prescriptions and care. (7) Pre-Katrina morbidities, uneven benefit usage, unequal access, and dissolved delivery systems were further complicated by *haphazard evacuations and returns* of patients and caregivers with either inadequate or destroyed records.[20] (8) *Sheer numbers* make simple comparisons *deceptive*; that so called “white deaths” were said to outnumber “black deaths” with respect to each one’s proportion in the overall population was not key for two reasons.[21] (9) In fact, *overall mortality* was reportedly consistent with pre-Katrina race/ethnicity distributions from the 2000 US Census (Brunkard, Table 2 p. 4, 7)[22] (10) Yet, the *effect of age* on mortality *confounded effects of race*. Most who were at risk and who died were older.

> We identified 971 Katrina-related deaths in Louisiana and 15 deaths among Katrina evacuees in other states. Drowning (40%), injury and trauma (25%), and heart conditions (11%) were the major causes of death among Louisiana victims. The mean age of Katrina victims was 69 years old….Forty-nine percent of victims were people 75 years old and older…whereas their age cohort represents fewer than 6% of both the greater New Orleans and the overall Louisiana population…… Fifty-three percent of victims were men; 51% were black; and 42% were white. In Orleans Parish, the mortality rate among blacks was 1.7 to 4 times higher than that among whites for all people 18 years old and older, indicating that the effect of age on mortality confounded the effect of race….However, stratified analyses evaluating the effect of race within age groups revealed that the dominant effect of age on overall storm mortality masked the differential effect of race in most age groups in Orleans Parish, where race-specific mortality rates were on average 2.5 times higher among blacks compared with whites.[23]

A wary and weary public debate could be advanced by focus on narrow issues (palliative sedation) rather than rehearsing official condemnations of euthanasia (killing by another).

## Methods and Results

### *A Jewish Perspective- Aaron Mackler*

A Jewish perspective enables us to have reasonable confidence about some of the issues regarding the “ethics of palliative sedation and medical disasters.” Judaism affirms the value of life and health. Traditionally, patients and the rest of us are responsible to act prudently as stewards of our lives. Health care professionals are responsible to provide health care that can benefit the patient, and society is responsible to provide necessary resources. As Benjamin Freedman has argued, the informed consent of a patient is important to his or her exercise of responsible stewardship. Appropriate palliative care is crucial to benefit patients, improving the quality of the patient’s life and, generally, the quantity as well.

Medieval authorities, as well as moderns, recognize that all medical interventions entail risk. According to Rabbeinu Nissim, “all modes of therapy are a danger for the patient for it is possible that, if the practitioner errs with regard to a specific drug, it will kill the patient.”[24] Rabbi Moses ben Nahman similarly observes that “with regard to cures there is naught but danger; what heals one kills another.”[25] Furthermore, some traditional sources suggest that severe pain can impose suffering that is even worse than death.[26]

Palliative sedation is justified within this context. A statement of the National Hospice and Palliative Care Organization defines palliative sedation as “the lowering of patient consciousness using medications for the express purpose of limiting patient awareness of suffering that is *intractable* and *intolerable*.”[27] The organization states that “palliative sedation is an important tool” among therapies to help “the small number of imminently dying patients whose suffering is intolerable and refractory.” “Since the goal is symptom relief …, sedation should be titrated to the minimum level of consciousness reduction necessary to render symptoms tolerable.”[28]

A 2009 article in *Annals of Oncology* has a title that clearly summarizes its findings: “Palliative Sedation Therapy Does Not Hasten Death: Results from a Prospective Multicenter Study.”[29] In fact, the use of palliative sedation to relieve refractory symptoms may have led to a slightly longer life, as well as reduced suffering.

In general, palliative sedation requires skill and prudent judgment, but it does not seem to pose radically distinctive ethical questions. Health care professionals should recommend and provide palliative sedation in appropriate cases, when it offers benefit to the patient and is chosen by the patient’s informed consent or the responsible judgment of a surrogate. Jewish thinkers disagree about the question of when life-sustaining treatment should be administered or forgone. Many would say that life-sustaining treatment need not be provided when it would serve only to prolong the dying process, especially when there is little hope for cure and if the patient is suffering. Some Jews express views close to those of Roman Catholics, and more broadly authorize forgoing treatment if it would be excessively burdensome and if it fails to benefit the patient.[30] Despite these differences, it seems that there should be broad agreement to provide palliative sedation in appropriate cases.

How would this approach address challenges posed in medical disasters? It is difficult to generalize, beyond saying that these challenges should be addressed in a thoughtful and prudent manner. Virtues, *phronesis*, and reverence are crucial. The accounts provided by some of our panelists confront us with agonizing questions that demand careful and nuanced attention.

## Palliative Sedation and the Rule of Double Effect- Daniel Sulmasy

I will not attempt judgments about any particular medical events that occurred during Hurricane Katrina. Rather, I will attempt to specify the necessary conditions for a morally acceptable practice of palliative sedation and to distinguish what I will call Proportionate Palliative Sedation (PPS) from what I call Sedation to Death (STD, an abbreviation that has a variety of alternate meanings for a variety of persons). These distinctions do have implications for judgments about cases like the Katrina cases.

In such a brief forum, I will only stipulate, but cannot argue for, my opposition to euthanasia. My remarks are addressed to those who also oppose euthanasia but are uncertain about whether palliative sedation can ever be morally distinguished from euthanasia. For such persons, the Rule of Double Effect (RDE) can be a very useful tool of moral analysis. If one believes euthanasia is morally permissible, then cases like withdrawal of ventilators after complete sedation and/or paralysis are not troubling, and the RDE is not necessary. If one wishes to argue that in pandemics or in natural disasters a case can be made for direct battlefield euthanasia, then the RDE is not necessary to solve such cases. But if the topic of our discussion is whether certain of these practices can be distinguished from active euthanasia (which will be legally relevant anywhere that euthanasia is illegal and morally relevant to anyone opposed to euthanasia), then the RDE is of vital importance. I hold that the practice of Proportionate Palliative Sedation (PPS) is an application of the RDE and can be morally permissible under certain specified conditions.

The Rule of Double Effect, roughly speaking, entails the following:

1. That one's action have two effects that follow from it immediately ("immediate" not in a temporal sense but in the sense that there are no other intended intervening states or other agents)
2. That one's action not be intrinsically wrong.
3. That one foresees but does not intend the bad effect; one only intends the good effect.
4. That the bad effect not be the cause of the good effect that one does claim to intend
5. That one's act is proportionate: that is, that the means are proportionate to the end, and that the good to be expected outweighs the bad in the particular situation.

Typically, one invokes this rule only when other options have been exhausted. It is not a master principle governing all of ethics but a rule to be invoked in cases in which one cannot achieve an important good without risking a side effect.

The use of morphine to treat the pain of dying patients is the classic example of the medical application of the RDE. Morphine has multiple effects, but those that medical ethicists most often consider are its ability to relieve pain as the good effect and its ability to depress respiratory drive and potentially hasten death as the bad effect. Both effects follow immediately from the drug, even by distribution to different subtypes of opioid receptors in the brain. Using morphine is not intrinsically wrong. A physician who uses it in treating a dying patient with the intention of relieving pain can reasonably claim to foresee the possibility of death but not to intend it (this is the logical form of the common medical notion of a side effect). Respiratory depression and death are not the causes of the pain relief that morphine can provide, so the fourth condition is covered. And the use of morphine seems proportionate in this case, since the pain is a kind for which morphine is suitable, the pain is significant, and death is imminent. I fully recognize that morphine is a safer drug than most people realize and that the invocation of the RDE in such cases may itself be disproportionate. However, since many people do worry nonetheless, the RDE can assuage their worries, and it is heuristically useful for everyone thinking about such cases.

I take Proportionate Palliative Sedation (PPS) to be another potentially morally acceptable application of the RDE. Take a case such as that of a patient being treated chronically with morphine for cancer who, as she approaches death, develops a significant side effect of high dose morphine called myoclonus, in which the muscles of the body twitch uncontrollably and often violently. If the patient were still in pain, her physician might need to increase the dose of morphine to treat the pain, but this would only make the myoclonus worse. In such a clinical situation the physician might engage the patient in an informed consent discussion, stating that she could add a drug like valium to the patient's treatment regimen as well as increase the morphine. In such a situation, the valium might stop the myoclonus, but there would be a high likelihood that the dose needed to stop the myoclonus would result in the patient becoming sedated. Would the patient prefer to have the pain controlled and myoclonus stopped, even if it meant sedation and possibly dying somewhat sooner? Certainly, on independent grounds one could decide not to use tube feedings, or IV hydration, or CPR, or ventilator support to prolong the inevitable. But would the risk of sedation be acceptable to the patient?

If so, then the physician would have provided morally justifiable PPS. Valium would have two immediate effects – stopping the myoclonus and possibly sedating the patient. Sedating a patient permanently until death is something bad— something towards which a physician ought not aim. Sedation in any dying patient is not something good but something harmful. Sedation is a harm one might tolerate as a side-effect of treating other symptoms such as pain or nausea, but one ought not *aim* to rob patients of the opportunity to say goodbye to loved ones, to pray, to reconcile themselves with others, or to grow as persons even as they are dying. Sedation could be considered a foreseen but unintended harm that one might risk for some other serious reason. In keeping with the RDE, it is not intrinsically wrong to use valium. So, stopping the myoclonus is the good effect, and sedation is the bad effect. The physician's intention is to relieve the myoclonus, not to sedate the patient. Valium works independently to relax muscles and would not normally sedate a patient to unconsciousness but for the concomitant use of high dose morphine, so the bad is not the cause of the good. Valium is a suitable treatment for myoclonus, and the symptoms are severe enough and death close enough that one would have a proportionately grave reason to administer the drug. This practice is consistent with the RDE.

Note that in all these cases the dosage matters. Intentions are difficult to discern, but human beings are experts at reading each other's intentions. For instance, this is what juries do regularly. One who slowly titrates up the valium or the morphine until the symptoms have abated would appear to have a different intention from one who administered two grams of morphine and 500mg of valium by rapid IV push in an opioid and benzodiazepine naïve patient. The valium might stop the myoclonus without sedating the patient. One would then not have failed in one's intention, even if surprised by the result.

Now let us consider the case of a patient with lung cancer who is suffering from significant pain at the end of life, pain that is only partially treated by his morphine, who is also troubled by a depressed mood (although he does not meet diagnostic criteria for major depression), and who is terribly fearful of dying. His physician offers him the possibility of increased morphine or changing to another, more potent drug to treat his pain, even to inject or cut the nerves in the worst areas of pain. He also recommends a psychiatric consult and a pastoral care visit to deal with the patient's mood and fears. The patient refuses all of these interventions saying he "has had enough" and "I read in the newspaper that while assisted suicide is illegal in this state, that you can sedate me to total unconsciousness. I want you to knock me out now, and just let me die." The patient has intact decision making capacity by standard criteria. While prognostication is not very accurate, his doctors estimate that he has a month or two to live. On the grounds of medicine's duty to relieve suffering, and having assessed the patient as experiencing total suffering, the ethicist on call, Dr. Q, advises that this would be morally permissible under the Rule of Double Effect (RDE).

This is a request for what I have called Sedation to Death (or STD), and it is not justifiable by the RDE. Let us examine why. The physician could administer a barbiturate like secobarbital for this purpose. In a high enough dose, this would end the patient's suffering (the good effect) but would also make the patient unconscious and die more quickly (the bad effect). Secobarbital is not intrinsically an immoral drug. It has a small range of established medical uses. But what is the physician's intention here? It is to aim at making the patient permanently unconscious, and I have challenged how anyone could call that a good at which to aim. So, on this ground alone I would discount this practice. Even granting that the physician does not aim at unconsciousness, however, how is the patient's total suffering to be relieved? It is to be relieved by means of the unconscious state. Thus, the request violates the fourth condition of the RDE as well. Is it proportionately justified? Well, perhaps one might suggest that the suffering is disproportionately grave compared with unconsciousness and early death, but, even if the intervention were end-end proportionate, it would not be means-end disproportionate. Secobarbital is not an appropriate drug for pain, depression, or fear of death. The means is not proportioned to the end. "Fear of death" is not an indication for sedation to unconsciousness in any pharmacopeia. Perhaps one could think about this almost as a matter of comparative justice. If the drug would not be indicated in a person who was not dying, how is it that it suddenly should become indicated when a person is dying? Finally, one must question whether in the case described the invocation of the RDE was justified in the first place. Remember that one invokes it when other alternatives have been exhausted. One could ask whether sufficient efforts had been made to treat the pain and depression in the usual ways. Might the depression and fear have eased if the pain were better controlled? Could the patient have been convinced to see a therapist?

One might try to argue that sedation to unconsciousness is not a bad outcome, and that the RDE does apply in this case because the bad outcome to be avoided is death, not unconsciousness, and that, therefore, the RDE still applies. This might seem right to some, but when one thinks about this case carefully, one notes that the proper conditions for the application of the RDE do not obtain even under this construction, because the bad effect of death is, in classical language, mediate and not immediate. Death does not follow from secobarbital itself, at least not in the case in which one is claiming to not be aiming at death by respiratory arrest but only to be aiming at sedation. Death follows mediately from the sedated state and the subsequent cascade of medical decisions it engenders, not immediately from the drug. Thus, while other arguments I have made that STD is not justified by the RDE are still applicable, the RDE cannot be applied to STD even under this construction because the effects are mediate and not immediate in the technical sense of these terms.

How might this analysis be applicable to cases of discontinuing ventilator therapy, whether in the setting of natural disasters or not? Provided the patient is not in pain but is suffering from respiratory compromise, under the RDE one could justify a low dose of an opioid drug like morphine aiming at one of its other salutary effects, diminishing the sensation of breathlessness from which dying persons suffer. This would not typically be high enough to sedate a patient but might, outside the sphere of one's intentions, conceivably hasten death since the patient on the ventilator might be on the machine precisely because of low respiratory drive. This could be justified under standard uses of the RDE along the lines I have already explained. If a patient were suffering from co-morbidities that called for other indicated drugs with sedating side effects, a case might even be made for PPS, but STD would not be justified under these circumstances for reasons which I hope I have already made clear.

## End of Life Decisions from an Islamic Perspective- Aziz Sachedina

Islam, the youngest of the three monotheistic faiths, shares its basic doctrines about God, the necessity of prophets to guide humanity, and the final Day of Judgment to account for one's performance on earth with Judaism and Christianity. Muslims believe that God, the Merciful and the Compassionate, created human beings with the purpose of intimating them to discover God's work in the entire universe and in their own being to appreciate and to serve God's ends for the creation. To overcome a tendency to forget this purpose, from time to time God appoints prophets as reminders and guides to lead people to the right path of prosperity in this and the next world. Prophet Muhammad proclaimed the message about the Unity of God and the necessity to build an ethical order on earth as a fulfillment of one's "submission" (lit. meaning of *islam*) to the will of God.

### *Withholding or Withdrawing? Who Decides?*

All persons will face death. The manner in which this occurs for our loved ones and ourselves is of critical importance to each one of us. The meaning of human life is grounded in the fact that it is sacred because God is its origin and its destiny. Death does not occur except by God's leave, as the Qur'an reminds humanity. At the same time there is recognition of the fact of diseases or trauma that cause death. Health care providers have an obligation to do all that is possible to prevent premature death. Is the goal of health care professionals to maintain life at any cost or merely to provide comfort so that death may come as quickly and comfortably as possible? On the one hand, there is the obligation to save and prolong life; on the other hand, there is a call to exercise limitation in life-sustaining treatment as required by the principle of distributive justice in resource allocations.

Nevertheless, the real question is that of the authority who can make such decisions. The role of religious guidance in these and other matters related to most critical care decisions is to speak authoritatively about death and about self-imposed limits at the professional level regarding such matters. The Qur'an puts forward a harsh reminder to human beings that there are times when they need to recognize their own limits as human beings and entrust nature to take its own course (Q. 39:42). Refusal to recognize the inevitability and naturalness of death leads to more aggressive life-saving interventions. At the same time, to withhold specific interventions at the most critical time leads to deliberate avoidance of responsibility in administering right treatment to save the patient's life.

For the past three decades, people in different parts of the world have struggled to identify the proper circumstances under which life-sustaining medical treatment should be limited. The phenomenal advancements in the field of medical technology have not allowed for the development of adequate procedures and processes to regulate their introduction and use in critical care settings. Authorities have debated many factors: brain death and organ retrieval, the location of the soul at the time of death, cardiopulmonary and neurological criteria for death, medical paternalism directed to family well-being, third-world resource limitations and social constraints on futile interventions. Family members and health care professionals make challenging decisions about withholding life-saving medical interventions, or aggressive and invasive treatments to prolong life, that intimately connect an individual's welfare with his or her family and community, rather than using a principle of autonomy based primarily on the patient. There are instances when the matter is referred to the religious leaders who provide prescriptive rulings connected with terminally ill patients.

## *Right to Die?*

The ground of a doctor's limited obligation to cure and care is that health is God's blessing and one's fortune. To "How are you?" (lit. "How is your health?") one responds: "All praise is due to God!" During a funeral ritual, the Prophet exclaimed, "How fortunate you are that you died while you were not afflicted with illness!" God has not created a disease without creating its cure. Decisions about ending the life of a terminally ill patient at her or his request are beyond his moral or legal obligations. The Qur'an states "it is not given to any soul to die, save by the leave of God, at an appointed time" (Q. 3:145). Moreover, "God gives life, and He makes to die" (Q. 3:156). And hence, "A person dies when it is written" (Q. 3:185, 29:57, 39:42).

Death, then, comes at the appointed time, by God's permission. General questions about meaning and value of suffering should lead us to appraise the suffering caused by prolonged illness to an individual's personal and family life. Closely related to such a consideration on the part of the sick person is whether the unbearable circumstances caused by one's interminable illness make existence worthwhile at all. Beneath these concerns remains a deeper question about the quality of life that individuals and society regard as worth preserving.

## *Question About the Quality of Existence*

Suicide prohibitions (in Arabic *qatl al-nafs* = "homicide") in the Shariah and scholarly discussions reflect both cultural and religious judgments. Even an afflicted self is but a temporary owner of a tormented body whose rent will come due for the care and upkeep of an erstwhile dwelling whose purpose enabled human relationships (al-Tawhidi, *al-Muqtabas).*

## *Human Stewardship of Human Body and Suffering*

With God the Creator as his or her real owner, a human caretaker-steward has duties to take all necessary steps to preserve himself or herself in a manner that seeks his or her good in both this world and the next. In light of such a stipulation, the problem of human suffering through illness assumes immediate relevance. The Qur'an provides the essential philosophy behind human suffering by pointing out that suffering can have several dimensions as spiritual-moral trial and as education to expiate for sin in self-purification, for example, as a form of a test or trial to confirm a believer's spiritual station:

> O all you who believe, seek your help in patience and prayer; surely God is with the patient.....when…visited by an affliction, say, `Surely we belong to God, and to Him we return'…. (Q. 2:153-157)

God's trial of the people can be for the cleansing effect of illness. "When God intends to do good to somebody, He afflicts him with trials" (Bukhari).

## *Human Response to Suffering*

Should one take upon himself to alleviate suffering where possible and endure otherwise? In general, Muslims have tended to respond actively to remove the cause of suffering. According to the Qur'an, "surely the good deeds will drive away the acts of disobedience (which cause suffering)" (Q. 1:114). Contrary to this activist posture, there was also an attitude of resignation in some quarters among Muslims who believed that, since God is testing human faith and purifying it through affliction, one must endure suffering. These two attitudes had their justification in Muslim creed. The question that is so central to the present day discussion, namely, the patient's "right to die," cannot be negotiated. This is because in the first place, life is a divine trust and cannot be terminated by any form of human intervention, and, in the second place, its term has been fixed by the unalterable divine decree. The right to be assisted in dying, whether through "passive" or "active" means is also ruled out.

## *End of Life Decisions in Islam*

Islamic legal deliberations contain and ground morality as part of its spiritual response to God in interhuman relationships; hence a patient's own determination and physician assisting him to terminate life are both regarded as acts of disobedience against God. Shari`ah refuses to recognize an individual right in that matter. However, it recognizes the possibility of arriving at a collective decision by those involved in providing the health care, including the attending physician and the family. The ethical principle affirmed in most unequivocal terms by the Prophet states: "No harm shall be inflicted or reciprocated in Islam" (*la darar wa la dirar fi'l-islam*). This also allows for important distinctions and rules about life-sustaining treatments in terminally ill patients. The distinctions upon which ethical decisions are made include the distinction between killing (active euthanasia) and letting die (passive euthanasia). The principle of "no harm" in some ways functions like the principle of nonmaleficence. It raises a critical moral question about the intention of the health care providers in forgoing life-sustaining treatment, whether such a decision can be regarded as a form of killing, and, if so, whether it is assisted suicide or a homicide. There is no immunity in Islamic law for the physician who unilaterally and actively decides to assist a patient to die.

## Pain Relief Treatment and Withdrawal of Life-Sustaining Treatments

There are, however, two situations in treatment that could be interpreted as "passive" assistance in allowing a terminally ill patient to die. Pain relief treatment, which could shorten life but which is administered to relieve physical pain and psychological distress and not to kill, is permitted in Islamic law. Likewise, Islamic law regards it as non-culpable and permitted when death-delaying treatments are withdrawn through mutual and informed decision-making by patient, physician and other parties as part of providing care for the patient; the intention to allow the person to die includes competent judgment that omission of delaying treatment will result in death. Delaying the inevitable death of a dying patient through life-sustaining treatment is against the benefit to the patient. Moreover, the principle of "juristic preference" (*istihsan* = "to deem something preferable") protects the physician in order to avoid any rigidity and unfairness in recognizing the incurable preexisting conditions of the patient. Furthermore, the "juristic preference" serves the ideals of justice and public interest in a better way. Some

Muslim jurists have recognized the validity of a competent patient's informed refusal of treatment or "advance directives" that allow the person to die under circumstances in which there is no medical reason to continue treatment. However, even in the case of such rare recognition of the patient's autonomy in Muslim culture, the law actually takes into consideration the patient's long-term treatment relationship with a physician whose opinion, in the final analysis, serves as the grounds for turning off the respirator. In this case, death is regarded to have been caused by the person's underlying disease rather than the intentional act of turning off the respirator.

The underlying principle in this ruling is that intention alone does not make an act culpable. The person's death is actually caused by the preexisting disease. In other words, the Shari`ah does not regard withdrawal of treatment as the cause of the person's death. In contrast, when a person is given a lethal injection, Muslim jurists in fact and in law regard injection as the principal cause of death.

Pain relief treatment or the withholding or withdrawing of life-support treatment, in which the intent is to allow the person to die when it is certain that the disease is causing untreatable suffering, are permissible as long as the structures of consultation among all the parties concerned about the well being of the patient are in place. In final analysis, besides the exceptions noted in the two situations, there are no grounds for justifiable killing of a terminally ill person, whether through voluntary active-euthanasia or physician assisted suicide in Islam.

## Palliative Sedation and American Common Law- William J. Buckley

Who decides, and why? In American common law, palliative sedation for a terminal condition has emerged from a twentieth century medical model requiring permission for an acute intervention. Seven centuries of Anglo-American common law has punished or disapproved of suicide and assisting suicide (*Vacco v. Quill*, 521 U.S. 793 [1997]). Yet a transition to dying from end stage degenerative illnesses retrieves categories to face new questions. What anticipated dying processes and foreseen death events re-negotiate appropriate interventions or forbearance? How are novel cultural inventions of pain and a "right to pain relief" re-inventing dying and death? What is common yet distinguishes effective palliative care among imminently dying from those terminally ill, having an end stage illness or expected to die? End of life decisions have evolved from medical paternalism to informed consent, now permitting treatment refusal that currently focuses on shared decision-making. Processes bedevil events, clinical and legal. Sheri Fink reports how interpretations of patient and proxy wishes in Katrina were contested. Three connected issues merit concise summary as clinical, ethical-legal-political, and public health arguments about "accompanied rest."

### I. Three Clinical Questions and Palliative Sedation

Palliative sedation poses three clinical questions. First, who decides about treatment? Decades of widespread cultural and legal consensus exists: a patient (or valid proxy) should decide using informed consent (from 1975 Quinlan through 2006 Gonzales). "Best clinical practices" have established cultural consensus for procedures to routinize informed, voluntary consent or refusal of treatment by a patient or a valid surrogate in shared decision making. Frank public debate orbits around contested practices such as demands for futile treatment, sedation that terminates, assisted suicide, and euthanasia.[31]

Second, what criteria about a patient's condition are especially important for treatment goals at the end of life? Cultural consensus in a Presidential Bioethics Commission (2008) has rhetorically framed "futility" to be triangulated among three criteria. What is futile is medically ineffective (objectively incapable of reversing the natural course of a disease), non-beneficial to the patient (subjectively determined by patient), and disproportionately burdensome (inter-subjectively appraised).[32]

How is futility related to criteria for death? Four traditions feature broad agreement, debates, and clinical refinements among a combination of traditional cardio-respiratory standards ("irreversible cessation of circulatory and respiratory functions") with an additional neurological standard ("irreversible cessation of all functions of the entire brain including the brainstem") whether called whole brain death or total brain failure.[33]

Third, health care professionals assist different kinds of dying with competence, patient beneficence, and honest dialogue about mutual expectations for appropriate treatment that ground an ethic of healing when cure is at an end.[34] Resistance to equations of religious scrupulosity with technological virtuosity reframes healing as sharing vulnerability; this recalibrates forbearance based only on autonomy, the evil of suffering, or a loss of dignity.

How do most persons die? Eight of ten annual death events in hospitals are the result of withheld or withdrawn treatment.[35] Yet official "causes of death" demonstrate how experiences of dying persons are complex cultural performances with different meanings. These involve socially negotiated perceptions of terminal conditions and care, imminent dying versus death events, futile treatments, end stage conditions and care that is never futile but diligent about compassion fatigue.[36] Central European and Anglo-American cultures share four major causes of death: heart disease, stroke, cancers, and COPD. In addition, both locales feature eldercare that sociological data reports as occurring in four kinds of binary role relations (is "genderized"): working women provide socially under-supported care for older women who are themselves increasingly intensive users of under-resourced care services.[37] Technological vigilance about end stage natural processes heightens cultural alertness that diseases are socially constructed as infections, factors of environment, genetics, symptoms, lifestyle, ecology, and economics.

First world end stage dying occurs in interventionist medical cultures with procedures to desist care judged inappropriate. Yet "decisionism" valorizes deliberative choices as authorization events and authorial processes. Koenig argues that such choices culturally construct, ritualize, and perform death.[38] On the one hand, discrete Anglo-American protocols safeguard informed consent to desist inappropriate treatments which forestall death events. On the other hand, procedures have adapted to dialogic processes of team-based care for chronic and terminal conditions. Some use double effect reasoning as justifying principles (Beauchamp and Childress), whereas others use them to demarcate forbidden harms from permitted risks in professional-patient relations amidst biomedical goods (Sulmasy).[39] For example, some see dying as an opportunity for religious disposal into shared destiny. Hence some heuristically deploy such categories as tools to calibrate interpersonal goods conducive to dying as a potentially valued experience for the dying person. Some double effect reasoning weighs palliation according to different measures based on "sin-avoidance," (safer "tutiorism"), "feasible goods," (virtuosi ascesis) and "transformative wholeness" (contemporary versions of mysticism). There are contending interpretations of double effect criteria; of what is evil intrinsic (acts, contexts, intentions)?[40] What discriminates for whom? Whose foreseen good is distinct from what kind of bad effects (patients, caregivers, health care professionals)? If death may never be directly caused, might its permission as a lesser evil allow sedation which terminates (Cahill, Farley, McCormick)?[41] Are current conceptual tools adaptive enough to promote practical gains in palliative sedation for end stage dying (e.g. Georgetown "mantra," ERD "principlism," Catholic "double effect," ELCA "situationism," Anglican-Methodist "quadrilateralism," UCC/Presbyterian "exceptionalism")?[42]

What do "best practices" of palliative sedation suggest? First, palliative sedation is a therapy of last resort that distinguishes sedation for terminal patients (sedation of imminently dying) from termination (sedation to death).[43]

Second, "best practices" in palliative sedation show that mandated relief such as effective pain management converts to cost-effective, safeguarded therapy with consultations and monitoring to resolve stakeholder disagreements practically. When "pain relief" and "sedation" are weighed with respect to very specific therapies—as in Dr. Sulmasy's case above—this highlights actual risks and ways to avoid incorrect reasoning among causes and effects (complex cause fallacies). Hence diverse side effects invite discrete ethical calibrations. Contrary to generalizations about "painkillers," this includes thresholds of a maximum, or fiduciary monitoring, and minimum; competent pharmacological administration distinguishes regimens of sedation from kinds of analgesia and sedating effects of opiods.[44]

Third, categories refine palliation most appropriate to those with end of life symptoms that are intractable or resistant to effective relief among different morbidities. These are different than palliation considered most appropriate to those undergoing existential distress without physical symptoms.[45]

Fourth, in each of four traditions, death is not the enemy but reducible suffering is.[46] In clinical terms, suffering is a subjective appropriation and interpretation of a grammar of affliction. Cassell descriptively distinguishes the stimulus response of pain, traumatic events, specific injuries, resulting disabilities, morally and legally blameworthy harm, objective disease epidemiologies that are chronic, acute, terminal, including subjectively perceived sickness and illness, as well as mental wellness.[47] Because vulnerability is wider than pathology, functional delegations of misery are not inevitably reduced to post-industrial medicalizations, professionalizations of care, or technologically managed end of life relief.[48]

## II. How Diverse Audiences Interpret Palliative Sedations as Different Circumstances: Ethical, Legal and Political Frameworks

Common law traditions connect ethical, legal, and political arguments concerning diverse palliative sedation practices.

How does common law interpret pain that shapes understandings of end of life comfort care? Pain is being culturally re-invented: palliation is more than pain relief. Contrary to the implied passivity of their etymologies, few contemporaries agree that that pain is simply "punishment" (poena, Latin and Grk, *poine*)—much less magical or tritely educative—or that a "patient" is merely "one who suffers, endures" (Latin, "patiens"). On legal and clinical fronts pain is understood in terms of different kinds of rights and embodied claims to be "managed" as a "client service" in demand-based knowledge economies. Some clinical questions, "How are you?" are embodied inquiries "Where does it hurt" and "Can you describe the pain?" Yet undertreated pain generally and especially at the end of life remains widespread. This is due to practical not theoretical barriers such as patient misplaced fears of addiction, exaggerated caregiver concerns about lethal risks from competent opiod use, cultures of provider under-prescriptions and fears of regulator sanctions (Ingham, 2009; Smith, Cenzer, Knight, et al., 2010).

But pain relief has emerged as different kinds of rights with guidelines that have developed for complex care. Clinical guidelines and legal cases over the past few decades interpret *pain relief* as one of *five different kinds of rights* with implications for American constitutional law and corresponding political theory of common law. Pain relief is argued to be a *basic human right* (International Association for the Study of Pain, IASP, 2004; Human Rights Watch, 2009), *a civil liberty* (California Pain Patient's Bill of Rights; Pain Relief Network), *a civil right* (Pettus, 2011), *a risk of criminal homicide* (intentions and cause of death in drug dosages, Syme, 2009), and a *civil duty* (standard of care, Tucker, 2004). In 1971 the Controlled Substances Act placed pain medicines under the jurisdiction of the DEA and FDA. In 1976 the International Association of the Study of Pain defined pain as both physical and psychological (Stahl, 2008) and provided recommendations for treatment. In 1986, the World Health Organization proposed a three step pain relief standard for cancer that has been adopted, applied, and modified over the years for pain generally (non, mild and strong opiods in Vargas-Schaffer, 2010). Decades of medical and nursing organisations have given detailed clinical practice guidelines for providing pain *management* as part of routine EOL care (American Academy of Pain Medicine [AAPM] and American Pain Society [APS] 1996; Oncology Nursing Society 2002; American Nurses Association 2003).

Greater precision among categories "pain relief," "treatment," and "management" is ongoing. Clinical professionals, regulatory bodies, and insurance guidelines use some two dozen self-reporting, observational, and physiological pain "pain scales". Pain is interpreted with two key physiological and psychological categories. These metaphors include trauma biomechanics (damage such as "lascerating") and electrico-physiological transmission (pain "sensation-impulses" by neuronal conduction called nociception as thermal, mechanical and chemical) (Melzack and Wall, 1996; Stahl, 2008; 2011). Founder of the modern hospice movement and innovator in palliative care, the nurse, social worker, writer, and physician Cicely Saunders developed the concept "total pain" and concluded "constant pain needs constant control" (Cicely Saunders, 1918-2005).[49] In demand-based health care systems, patients are simultaneously clients, and pain has become embodied pains against which there are struggles using images of war, crime, conflict, game, and industry (Scarry, 1981; Morris, 1991, Baszanger, 1998; Graham and Herndl, 2011).

On the one hand, jurisprudence recognizes that effective palliation permits foreseen lethal risks which are not intended, even with contested key terms (e.g., double-effect, intentions, painkillers, risk, sedatives, 1997 Vacco vs. Quill). On the other hand, advocates and opponents of patient termination by sedation make many contending arguments. It must be voluntary or optional. It is already a congery of standard practices that constitutes assisted suicide or euthanasia in disguise. It is (in)capable of being effectively professionally regulated or legally monitored.[50] Ethical criteria map justifications regarding withholding or withdrawal of treatment, assisted suicide and euthanasia, the excusability of exceptional circumstances, or, alternatively, the ways in which caregiver obligations outweigh abandonment or mercy killing.[51]

Legal arguments about disaster sedations contribute to three kinds of larger public debates (criminal, civil, professional). For example, "painkiller" usage remains contentious evidence in criminal homicide cases. Disputes over types, amounts, rationales, and evidence of "painkillers" inhibited the state from bringing formal charges in Katrina for second degree manslaughter (without express or implied malice).

Yet, a "right to aggressive pain management" continues to be litigated wherein most cases involve end stage cancers. Standard of care discussions about pain are part of larger tort reform debates. Accountability comes through civil courts, professional organizations (State Medical Boards), regulatory agencies (e.g., Medicaid Services), and the private sector (pharmaceutically proprietary pain management). Some pursue tort exposure through liability such as medical negligence. "Pain and suffering" are legal categories a plaintiff may use to seek compensation for stress from blameworthy harm (e.g., injury and or death). States vary as to whether pain and suffering damages survive a patient's death under a state's medical negligence laws; in California they do not, in Louisiana they do. Others pursue applications of statutes governing elder abuse; litigation has been successful in meeting this additional proof of recklessness.[52]

Were Anna Pou and medical colleagues guilty of civil negligence during Katrina? That is, was a standard of care violated? Some 200 civil cases alleging poor preparedness and response are outstanding. Not all involve end of life decisions.[53] Answers must come from Dr. Pou's own understanding of specific treatment decisions, in unfolding litigation and commentary. Macro and micro questions intersect. How prepared must health care professionals and hospitals be for the worst possible circumstances? Civil litigation (i.e., "medical malpractice") seeks monetary redress for negligence. In order to prevail in such a lawsuit, a plaintiff must prove four elements: (1) Existence of a duty to care (between a specific doctor and a specific patient), (2) negligence (i.e., a breach of the duty to provide reasonable care), (3) resulting in blameworthy harm (injury and/or death), (4) which was directly foreseeable as a consequence of that negligence (not too remote).[54]

A wide public debate continues on this very issue. Many see either medical malpractice as key to health care problems or tort (liability) reform as essential to effective health care reform.[55]

Political arguments reviewed responsibility during the disaster or previewed a finite set of rules for competent responses as an algorithm of precipitation peril for elected politicians facing natural disasters. Successful leaders are those perceived as actively in control yet effectively battling and coordinating bureaucratic hurdles.[56] Effective "palliative care" assists health care reform.[57]

Public health arguments appraise macro preparedness. Retrospective questions focused on whether and how well different kinds of training were either aggravating conditions that accused those deemed blameworthy or mitigating circumstances that excused some of the responsibility such as effective evacuation,[58] understanding disaster triage, and effective training,[59] as well as medically managing vulnerable populations with limited resources.[60] Prospective questions examine "readiness" given known comparative data and anticipated natural events.[61]

What ethical lessons about palliative sedation come from disasters at once natural, personal, and social? Diverse questions yield different answers about embodied character, caregivers, exceptions, obligations, best practices, key features, factual assumptions and established maxims. What most adequately describes the embodied selfhood of a vulnerably dependent who is dying? Some traditions have parallel debates: Rabbi Reisner's "goseis" (last stage of life) versus Rabbi Dorff's "tereifah," (terminally ill) are akin to Catholics whose experiential focus on dying agents connects the body (Kelly) with the whole person (Pellegrino, Sulmasy, O'Rourke, McCormick, Cahill, Farley) as well as Muslims who connect body and soul through kinship (Sachedina).[62] Some find in Katrina and its sedations a unique "type case" or "selected paradigm" such as disaster medicine that generates particular scopes of permissible exceptions, e.g. triage, emergency evacuation, managing medically dependent patients. For others, urgent conflicting obligations demand prioritizing forbidden harms, obligatory cares, and permitted risks, for instance, no PAS, non-abandonment, palliation, manage resources, accompany yet not assist humane dying (Sulmasy, Sachedina). For still others, a return to best practices brings confidence to engage exceptional features, viz., "seek informed consent/refusal," palliate, sedate, apply learned wisdom (Mackler). Ongoing work explores underexamined features like class, ethnicity, and gender (Fink). Some find new factual assumptions about end stage dying in proxy consent, threefold futility, brain death criteria, pain criteria, integrated palliative care standards. Others ask whether new facts—or even emergencies—shift meanings or applicability in older, established non-malfeasance maxims such as "do no harm," seek patient beneficence, alleviate pain, seek informed consent/refusal.

Palliation burdens dying with three choices, two skeptical and one practical. Do evolving criteria in a person's end stage dying unnecessarily complicate practical decisions with cultural messiness?[63] Are distinctions of effective pain relief that are related to complex morbidities asking wrong questions? Are assertions that terminal sedation is maltreatment really poorly understood debates over contested boundaries of palliative mistreatments?[64] Or, do practical guidelines assist end of life decisions that nourish careful expectations for good dying as accompanied rest?[65]

Had disaster sedations created a new plea for the importance of circumstances in end of life decisions?[66] For whom were which palliative sedations what kind of circumstances? That is to say, did circumstances of disaster or triage permit or commend palliative, if not terminating sedations, or qualify, if not exempt, ordinary moral bans on killing? Contemporaries who claim "never deliberately" while others counter "perhaps exceptionally" retrieve centuries of discussions between what is said to undergird action ("sub-stans") versus what borders it ("circum-stans").[67]

Why did end of life palliations require a retrieval of a three-part "rhetoric of circumstances?" One had to make *convincing* arguments based on consensus about key evolving categories such as triage, informed consent, and dying as accompanied rest, no less than *justifications* that appealed to convictions about what ought (not) to be done. For different cultural traditions, three distinct audiences (past, present, and future) debated how widely "circumstances" for palliative sedation were understood. In other words, three rhetorics of circumstance shaped future deliberative decisions in triage and weighed counter-claims about what was just in past human experiences and legal conditions. They also praised as honorable certain current performances of dying circumstances in contrast to forms judged less commendable or even blameworthy.[68]

Decisive for palliative sedations, these three historic kinds or rhetorics of "circumstance" shift meanings. Circumstances change from sheer uncontrollable "catastrophies" (complete breakdown) or "disasters" (discrete events) to specific situations or contexts shaped by human action (agency).

First, clinical discussions of palliative sedation in Katrina focused on how "triage" was its own unique "circumstance" by focusing on *future or prospective* deliberative decisions by health care professionals. Some nine mass casualty triage systems are currently used around the world, whether as event, process, or outcome.[69] Debates are not merely theoretical about number of saved lives, or years of life saved, or quality of life but about contested practical issues. At Memorial Hospital, [un(der)]trained assessments first triaged then reverse triaged patients into categories (sickest evacuate last) that blended three criteria estimating healthy-survivable, treatable, and (un)transportable.[70] Were judgments inexact ("treatable"), biased ("nontransportable") or open to re-assessment ("survivable")? Palliative sedations that defenders argued were necessary for comfort, critics charged in fact carelessly or deliberately killed some who were not dying.[71]

Katrina triage decisions now revealed what everyone knew but few explored: technical questions demonstrated that wider cultural understandings of circumstance were also at stake.

What were these additional understandings of "circumstance?" Succinctly put, there were two. A glance backward and forward showed what they were. A second understanding of circumstance combined general anthropological descriptions of human action with legal appraisals to weigh *past claims about justice*. A third type appraised meanings of *praise and blame in the context of dying as a current cultural performance*.

Historically, this second or "backward"-looking account of circumstances weighed what was just by reviewing what was true for human experience by describing human action in general categories about existence called metaphysics or knowledge termed epistemology, historically called "natural law." An internal or external feature of human action was selected as pivotal to what counts as "circumstance." For example, with respect to Katrina sedations, some asked as an internal condition of human action, "Was informed consent given or offered by a valid proxy, who followed correct standards of 'best interests' or 'substituted judgment'?" Disputes in disaster sedations over interpretations of otherwise clinically useful tools (DNR), amplified cultural apprehensions about limits in end of life pre-commitments.[72] "Externally, was diagnosis and prognosis of patient conditions competent and revisable pending any change?"

Globally, such questions were hardly peculiar. Reasonable questions for anyone concerning particular circumstances of palliative sedation came to be seen as universal to human experiences. Many oral discourses of vernacular cultures, literary texts, and practices connected general with particular experiences.[73] Lists of questions emerged requiring non-binary (non-disjunctive) answers of who, what, when, where, why, in what way, by what means.[74] For example, who (is triaged, dying), where (disaster, hospital, hospice), what (disease), when (timely assistance), how (informed or proxy consent, with-holding or withdrawing treatment, lethal self-administration), why (transition, transformation, accompanied rest, journey). In the west, from Greek and Latin rhetorical traditions interested in justly adjudicated praise and blame, later thinkers such as Cicero sorted out attributes of persons (name, nature, manner of life, fortune, skills, feelings, interests, purposes, achievements, expression) and action such as place, time, occasion, manner.[75] In the early middle ages, pastoral interest evolved a hexameter with a memory device (mnemonic) in various forms that influenced medieval discussions.[76] Its Aristotelian tradition focused on the moral problem of the imputability of actions to agents. Another layer came through penitential books and canon law that sought to determine whether a law applied and whether sin occurred (weighing rank, wisdom, and age). Aquinas drew together Aristotle's metaphysics (separating acts into types called species and genus) with a psychology of human action (*Summa Theologiae* I-II,7) and, finally, the moral evaluation of actions (I-II, 18). Hence, the Ciceronian hexameter of circumstances are like accidents to the essence or form of an act. They touch the act by influencing its seriousness and weakening or amplifying its blameworthiness. They may also change the nature of the act. "The human act ought to vary according to diverse conditions of persons, time and other circumstances: this is the entire matter of morality."[77]

For example, ongoing Catholic understandings of "circumstances" shaped interpretations of "palliative sedation" as well as disaster and triage within this framework of judgments about injustice—as commendable or blameworthy acts. In that branch of applied Christian theology treating human character and action called moral theology, "circumstances" are one of three elements called "sources" according to which a human action is judged good or bad (object, end, circumstance).[78] For Christians, only God judges interior qualities of actions (goodness of the will and conscience).[79] However, qualities of exterior action are defined with reference to different "causes" that are materially specific objects, final purposes called ends, efficient powers of the will, and accidents called circumstances, or "[w]ho, what, where, by what aids, why, how and when?"[80] Actions are categorized in even contested ways; for example, they have an external material object (palliation) and by species (sedation), a formal end or interior act of the will as purpose (care for dying) and circumstance (triage, disaster, dying).[81] Wide borrowing has characterized philosophical and pastoral understandings of "circumstances" even while later scholastic terminology coined terms for the relation between an "object of the action" (finis operis) and the "end" or "purpose of the agent" (finis operantis).[82]

But not everyone agreed—and counter-arguments shaped many clinical realities of end of life decisions of palliative sedations. Three "circumstantial" objections emerged to understanding palliative sedation through this general interpretation of human action with its focus on justice in natural law categories. Did the focus on discrete actions (object-end-circumstance) adequately account for social circumstances of decisions or assume dying patients (or proxies) are ideal decision-makers? Did moral self-scrutiny using justice paralyze decision-makers with "sin-avoidance" ("Don't kill.") or pander to scrupulous guilt ("Avoid shame or blame, hence suffer unto death…")? Did this effectively obstruct lived circumstances in which dying was performed "well-enough," or unduly restrict comfort from religious truths about shared post-mortal destiny (resurrection)?[83]

With respect to disaster and palliative sedations, common (case) law distinguished four kinds of unjust circumstances. Two described facts external (attending) or internal (exigent) to a case and two evaluated blameworthiness as extenuated (mitigated) or increased, that is aggravated. Some find a disaster or a hurricane to be an external (attending) circumstance permitting/requiring an exigent circumstance, suggesting a kind of warrantless "knock and announce" of triage to save lives, in which particular circumstantial decisions are weighed as less (mitigating) or more aggravating.[84] Extenuating or mitigating circumstances decrease guilt including facts beyond the control of parties like a hurricane, termed by some an "act of God," or a related category, *casus fortuitus* (Latin) or "*Force majeure*."[85] Aggravating circumstances increase the blameworthiness of a crime or civil injury because of the intent (murder, manslaughter), the extent of injury (inadequate appraisals of pain), or deliberately misusing hence weaponizing therapy (overdosing sedation or palliation).[86]

A third kind of rhetoric of circumstance argues that triage or palliative sedation can only be commended as praiseworthy or blameworthy in relation to dying as a cultural performance. Life can be advantageous, but death might be honorable when dying is well performed.[87] What were the grounds of these appraisals? Improvements in effective palliation and end of life healthcare literacy are feasible desiderata rather than reality. Emerging USA cultural consensus about relinquishing futile treatments that provide no benefit, are medically ineffective, are non-beneficial, or are disproportionately burdensome at the end of life are counterposed by widespread cultural confidence that technology can always rescue one who is dying (Callahan, 2008). Contrary to claims about criminal "euthanasia" or pathologically self-inflicted harm called "suicide" (DSM IV, Durkheim), some argued deaths from desisted treatments could be defensible as ideally heroic relinquishments in the face of adversity called merciful self-denial (Grisez, 1997; Thomasma, 1998; Droge and Tabor, 1992).

Some narrow the descriptive category of disastrous natural or social events to personal "circumstances" such as amyotrophic lateral sclerosis (ALS) and conclude that a request to end life can be reasonable.[88] Others widen "circumstances" as referring to disabled health care delivery systems and ask, "Can conditions in a collapsing health care delivery system be circumstances that ever excuse euthanasia?"[89] They ask: Are situations of intractable suffering or forced abandonment (forced retreats, civilian disasters) those in which beneficent killing is not only excusable but justified provided "yellow light" objections (warranted safeguarded "cautions") are distinguished from "red-light" admonitions to stop (e.g., impermissible thresholds)? To rebut any equations of circumstances with widening exceptions or moral permissiveness, some sought to rescue circumstances permitting sedation from objectionable synonyms for subjectivism, situationism, contextualism, or relativism.[90]

Apart from Katrina, a least three interpretive frameworks intersected. One historically weighed different triage systems, a second involved particular cultural traditions (Jewish, Christian, Muslim, secular, legal). Yet a third used different ethical systems. For example, Jewish traditions counter-balanced sources against wise practical decision-makers of triage.[91] Muslim sources sought to unite non-utilitarian, principled triage considerations with historic religious convictions about divine prerogatives.[92] Christian and secular traditions weighed virtue-based systems, or contrasted diverging understandings of justice versus common good with religious systems offering practical maxims of guidance.[93]

But previous discussions had not specifically addressed key questions at issue in Katrina about palliative sedations. Were choices based on a professional ethic of character ("non-abandonment"), or a utilitarian ethic of most benefit-least harm (diminish suffering), or some more than utilitarian framework (duty-obligation to survivors, principles of autonomy, beneficence, non-maleficence, justice, ethic of gender, ethic of care)?

None of these could be assessed alone without some account of dying as a cultural performance.

## III. Cultural Performances of Dying as Accompanied Rest

How should we judge meanings of palliative sedation beyond effectiveness for a particular patient? Participants used narratives or stories that observer-outsiders interpreted as contextual explanations: palliative sedation demands wider social contexts of meanings in relation to care and dying. One key to such frameworks was how dying culturally performs a social identity of "accompanied rest." Some Katrina disaster sedations were ritualized as stage-coached "rest." A few included prayers. Connections among dying customs and social identities are ancient. Contemporary understandings, called social imaginaries of dying and death need not be merely religious supercessionisms (ideologized replacements). For example, Jewish retrievals of second temple discourses about genderized embodiment as well as Jewish and Muslim explanations of divine justice in relation to human affliction and death, have common ground with Christian accounts of "proportionate" care and shared communal memory (e.g., Durkheim, Hertz, Wandrey, Ilan, Kraemer, Levenson, *Sachedina, Halevi, Asad).* Furthermore, there has been change. Within a century, western Christian cultural imaginaries have dramatically shifted from Good Friday to Easter Sunday. Eras of pandemic and acute deaths were contexts for historic "arts of dying well" called "ars moriendi" that patterned themselves after ritual texts depicting the passion of Jesus for cultures vigilant about post-mortal individual judgment. Ritualized transitions through a social order were linked to seasonal-calendrical cycles and enacted in burial practices, such as separation, transition, and re-incorporation (van Gennep, Eliade, Bell, Reinis). Idealized dying re-enacted liminal ordeals.

Palliative sedation, end stage dying, its medicalization-professionalization, the genderization of eldercare, and entrepreneurialized mortuary practices continue to culturally re-invent dying and death. The new epidemiology of delayed degenerative diseases and end stage death now frames dying processes and death events as transformations to be accompanied with social care.[94] The professionalization of "care ethics" in Anglo-American worlds distinguishes personal affect, solicitude, skilled competence, and personal regard. These different meanings of care reflect complex evolutions of clinical education in cultures where healthcare has been demand-based.[95] This contrasts with socially supported, communitarian social traditions in central Europe of medical care (Sorge), social welfare (Fürsorge), and pastoral care (Seelsorge) which privilege caregiver paternalism. For example, in barely two generations, a social imaginary of "paschal mystery" in one tradition has become a logic of molding by resurrection for dying, and caregivers understood using a threefold figurative image as enclosure-metamorphosis-emergence (Lincoln, Grimes). Performative understandings of dying have shifted from participation in an ordeal of liminal passages ("passion") to trust in proleptic shared transformation (resurrection as "paschal mystery"). An anticipated shared destiny of post-mortal existence (i.e., resurrection) underscores present-day social obligations for painless accompaniment ("in Abraham's arms, where Lazarus is poor no longer…").[96] Constructive resilience (Bonanno) might make end of life palliation more effectively comfortable than protective bereavement (Kubler-Ross).[97] Exhorting trust in mercy, managing grief in stages can have unquestioned gains over lachrymose apprehension, provided there is vigilance to avoid bouyant optimisms, ethnocentric abuses and anthropocentric misuses. Nor need each foreclose piecemeal gains by sustainable use of shared social capital to dying well as religious practices of accompaniment (e.g., Zion, household, temple/kingdom/Jerusalem, the communion of the saints, ummah, "in Abraham's arms…."). Vast global injustices challenge rich historical resources of social capital to help each dying person perform a "death of her own" as an anticipated cultural memory of accompanied rest.

However, disaster sedations contain lessons. These featured neither kin-family, nor official pastoral caregivers, nor religious representatives requested by patients or kin.

## Conclusion

After Hurricane Katrina, despite investigations of numerous deaths related to painkiller usage, formal charges were never made, and allegations were dropped; the state paid legal fees of the accused. Palliative sedation practices raise three kinds of issues: clinical, ethical-legal-political, as well as public health and cultural arguments about accompanied rest (including religious claims). Consensus emerges about palliative sedation among four traditions about three issues: who decides (patient-caregivers), how (futility, last resort, no PAS, right to pain management, safeguarded therapy) and why (accompanied rest). Seven practical maxims emerge: (I) Informed consent in shared decision making processes connects treatment refusals and the provision of palliative sedation (e.g. DNR choices). (II) Futility is collaboratively negotiated with severe, unremitting, refractory symptoms. (III) Palliative sedation is a therapy of last resort. (IV) Palliative sedation does not deliberately terminate terminal patients (it is not PAS/Euthanasia). (V) Palliative sedation enacts rights to aggressive pain management (VI) by converting mandated relief into cost-effective, safeguarded therapy with consultations, monitoring, and practical stakeholder re-assessments (VII) thereby ritualizing dying as an "anticipatory memory" of accompanied transformation. Areas for ongoing clarification of palliative sedation include: Does proportionate pharmacology robustly discriminate misuse from abuse? Should DNR's be required? What defines and who treats existential suffering? Must death be imminent? May valid proxies make decisions for those lacking decisional capacity?[98]

## Endnotes

1. Our thanks for the excellent editorial suggestions of Hannah Wakefield with *Ethics & Medicine*. In addition, thanks are due colleagues Sheri Fink, MD; Michael Cantor MD, JD, Karen Feldt, PHD, ARNP, GNP-BC; Annette Clarke, MD, JD, and many who responded to oral and written versions of this work before and after a panel discussion hosted by the Society of Christian Ethics, January, 07, 2011, in New Orleans, LA, at the Annual National Co-Conference with the Society of Jewish Ethics and Society for the Study of Muslim Ethics. Views expressed here are those of the authors alone.
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# BOOK REVIEWS

## A Matrix of Meanings: Finding God in Popular Culture

Craig Detweiler and Barry Taylor. Grand Rapids, Michigan: Baker Academic, 2003 (fourth printing 2007; Engaging Culture Series).

ISBN 978-0-8010-2417; 351 PAGES, PAPER, $28.00

The thesis of this book is that popular culture is a phenomenon that often demonstrates evidence of spiritual yearning, and it is thereby important for Christian theology to engage with it. The authors express a sincere appreciation for popular culture as a common language that can ultimately impact our theology. In this volume, they explore different forms of popular culture with an attempt to both describe it and explain its relationship to Christian theology. The function of advertising is to foster a particular worldview that emphasizes consumerism. Our current obsession with celebrities rather than heroes has resulted in the creation of the “movie star.” Popular music is often used to convey spiritual ideas. Movies address many religious themes that are not always recognized by reviewers. Television is considered a burgeoning art form that reveals our deepest longings as humans through various genres. Fashion is not only a representation of our identity, but our current emphasis contains almost a sacramental element. Sports have often been associated with the phenomenon of religion, though the younger generation prefers being active in sports rather than being mere spectators. Art – and in particular the art of Picasso, Jason Pollack, and Andy Warhol – emphasizes the relationship between the sacred and the secular. Finally, the authors argue for what they call a “top ten” and “bottom up” theology which takes “the charts” seriously, understanding that God can speak through popular culture and that theology should therefore take seriously its theological expressions and insights.

This book is truly a delightful read. While not postmodern, it takes into account the impact of postmodernity in popular culture. The book is nicely illustrated with interesting pictures and cartoons and is replete with popular culture references that demonstrate a broad knowledge of its different aspects – historically, culturally, and theologically. They do not deal narrowly with only specifically “religious” works but view theological concepts through a broad lens. Most creative is the authors’ explanation of a “top ten” theology, which they outline as post-Christian, post-ethical, post-traumatic, post-human, post-racial, post-sexual, post-scientific, post-literal, post-rational, and post-national. I found myself continually underlining book titles for further reading, movie titles for future viewing, and names of artists for additional exploration. Their breadth and analysis of popular culture is impressive and broadly focused.

This book would be of interest to anyone interested in the topic of popular culture from within the Christian tradition, whether lay persons, students, or scholars. Those who eschew popular culture as in opposition to Christianity would not like this book. Although written from a primarily conservative Christian perspective, those from a more liberal bent should not dismiss it. The authors’ openness to the prospect of popular culture as an important phenomenon for religion to understand, their grappling with postmodernity, and their generous reading of popular culture texts as religious and spiritual should challenge many of us to reconsider the role that popular culture both does and should play in Christian theology.

**Reviewed by Donna Yarri, PhD (Religious Studies),** who is an Associate Professor of Theology at Alvernia University in Reading, Pennsylvania, USA.

# Michael Ryan's Writings on Medical Ethics

Howard Brody, Zahra Meghani, Kimberly Greenwald, editors. London and New York: Springer, 2009.

ISBN 978 90 481 3048 1; 258 PAGES, CLOTH, $139.00.

One of the main attractions of this book is the editor, Howard Brody, a founder and major contributor to modern medical ethics. This book was produced to fill the 19th century gap in the history of medical ethics, and Michael Ryan (1794-1840) is offered for this purpose. Moreover, Brody presents Ryan as an original contributor to research ethics because of his public insistence that the informed consent of a research subject must be acquired. In addition, Ryan created perhaps the first pocket handbook or manual of medical ethics for the convenience of medical students and physicians. Since Brody is not specifically a historian of medical ethics, he surrounded himself with two additional editors and an historian Peter Vinten-Johansen to deal with Latin and the historical medical context of England, Ireland, and especially the Scottish enlightenment. The beginning of this story is summarized within the first seventeen pages of the book. A brief biography of Ryan follows, and the identification of his major writings on medical ethics by page 55 and almost twenty additional pages of notes complete Part One. Part Two gives us the actual selected writings from Ryan plus a short bibliography, along with a substantial and helpful index.

One of the most interesting parts of the book for current students of medical ethics is a short debate Brody sets up with another giant of the field, Robert Veatch of the Kennedy Center, who wrote a fascinating book on the relation of medical science and the humanities titled *Disrupted Dialogue: Medical Ethics and the Collapse of Physician-Humanist Communication (1770-1980).* Howard Brody, et al. (54-55) claim that Robert Veatch considers Michael Ryan to have been a follower of Alexander Monro of the medical faculty of Edinburgh University. But Brody insists that Ryan was more of a disciple of John Gregory and Thomas Percival. The significance of this controversy is to establish whether Ryan leaned toward the Gregory tradition of interpreting medical ethics from the foundation of moral philosophy or the Monro tradition of basing the practice of medicine strictly on medical science. Consequently, Veatch[1] gives us two pages on Ryan in his majestic history, while Brody and colleagues give us a detailed and selected presentation of Ryan's writings on medical ethics meticulously footnoted from massive writings. Nevertheless, Veatch provides an extremely helpful (if not indispensable) history of the time surrounding Ryan and his publication.

The difference between Brody and Veatch might be the difference between an implicit or explicit medical ethics. Does Veatch demand an explicit medical ethics while Brody sees an implicit one, especially in his selections from Ryan's abundant writings? On the contrary, Brody's perceptions are more explicit. This task might be seen most clearly in the way Brody presents Ryan dealing with abortion in his practice and writings. The most extensive writing (228-240) on the conflict between preserving the lives of the infant and mother show implicitly that Ryan is certainly opposed to abortion. There is some evidence of knowledge of Catholic teaching (232, especially) against abortion, but scholars are not aware of Catholic education in Ryan's past. Ryan does show considerable technical medical expertise in the treatment of very complicated issues for women and infants related to his strict adherence to laws, including religious laws, against abortion.

This is just one brief example of the rich historical treatment of medical ethics lived and practiced by Michael Ryan which has been given to us in a very readable form by Howard Brody and his capable collaborators in this excellent book.

**Reviewed by Jack T. Hanford, MDiv, MA, ThD,** who is a professor of Biomedical Ethics at Ferris State University in Big Rapids, Michigan, USA.

1. Veatch, Robert. *Disrupted Dialogue: Medical Ethics and the Collapse of Physician-Humanist Communication (1770-1980)*: Oxford University Press, 2004, pp 76,77.

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