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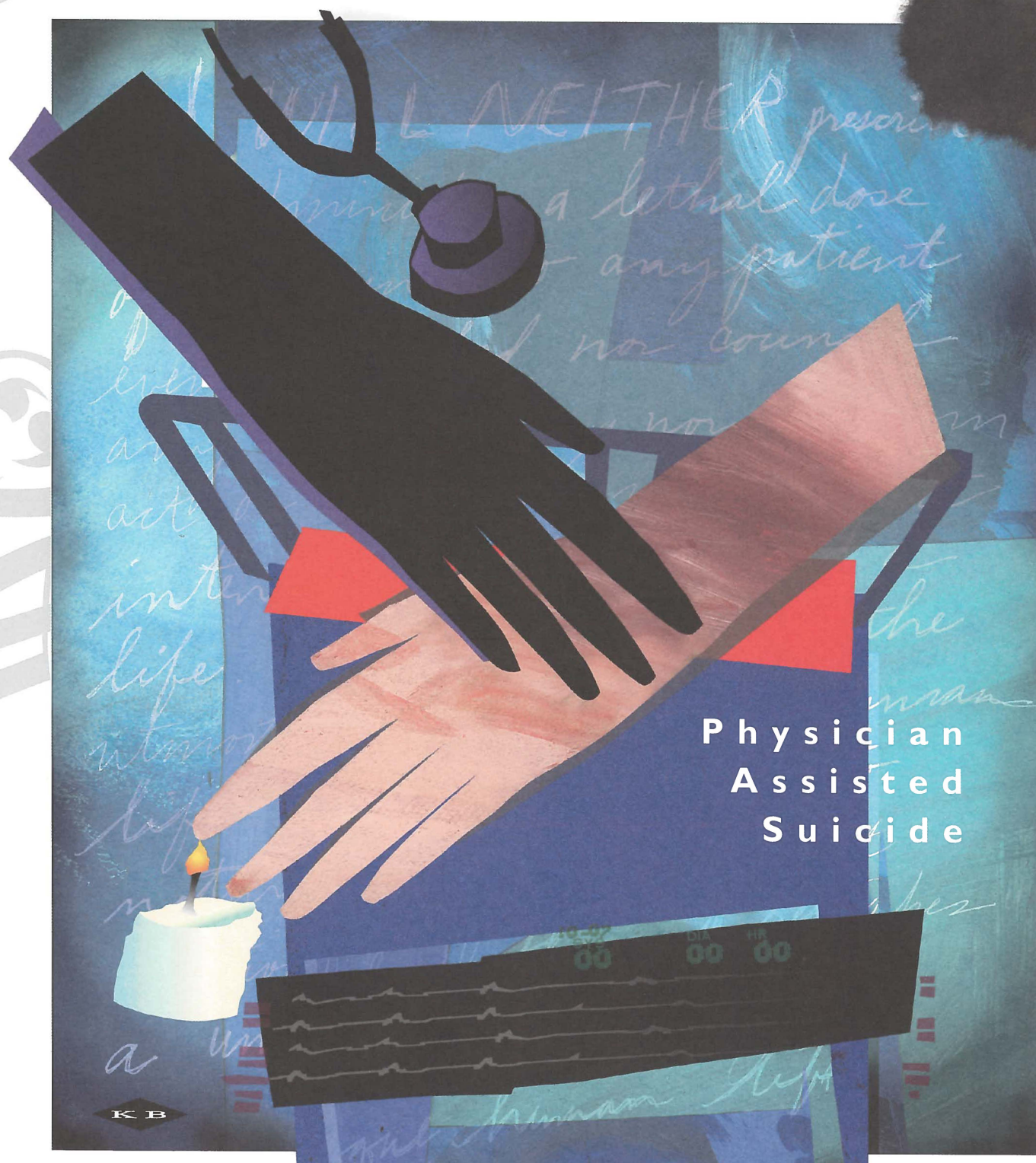
The Park Ridge Center Bulletin, 1997, N1, September/October

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The Park Ridge Center

Bulletin



Physician
Assisted
Suicide

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Issue Number One
SEPTEMBER/
OCTOBER
1997

Artistic Legacy, Ethical Resource

By Laurence J.O'Connell
Publisher

Consider the images on the cover of the new Park Ridge Center *Bulletin*. Aesthetic sensibility, attention to beauty and visual presentation, capture and convey an essential dimension of the Center's mission and philosophy. Since the beginning of our publishing ventures more than 10 years ago, artistic design and visual imagery have played a prominent role. Although we do cherish aesthetic excellence *per se*, we also recognize that human experience, particularly moral experience, is often ambiguous and elusive. Mere words are not always sufficient to expose and illustrate the complexities of human thought or seemingly inexplicable behavior.

So, as we seek to explore the criss-crossing fields of health, faith, and ethics, we

between the powers of darkness and the angels of light. But which is which? Is the dark hand a representation of those who would prevent someone from snuffing out her own life or rather those who would lend a helping hand? Does the black stethoscope against faded lines of the Hippocratic oath suggest a negative view of physicians who assist in suicide? Obviously, you will assign a meaning to the black hand and the black stethoscope that reflects your own moral perspective and ethical posture. If you favor assisted suicide, you will see the intrusive touch of a meddlesome public policy establishment that manhandles free choice; if you reject assisted suicide you might perceive the gloved hand of the surreptitious practitioner of voluntary death.

“Engaging and freely interpreting images that spring from lived experience can stretch the moral imagination and extend our conceptual reach.”

need more than words. The striking

covers of our award-winning journal, *Second Opinion*, underscored the point. And our book, *A Matter of Principles: Ferment in U.S. Bioethics*, concretely spelled it out by explaining our distinctive approach to bioethical issues, describing a method that embraces all forms of human experience and the moral dilemmas that characterize it. The visual arts, for example, can play a mediating role in moral evaluation. Engaging and freely interpreting images that spring from lived experience can stretch the moral imagination and extend our conceptual reach. In short, our handsomely illustrated cover is more than a pretty picture.

In her provocative illustration, Karen Blessen, a Pulitzer-prize winning illustrator and designer, invites us to actively engage the issue of assisted suicide before we even turn the first page. Aesthetically speaking, her haunting images highlight stark contrasts, strong forces moving against one another. The hands, light and dark, suggest a struggle

An artist's work may evoke intensely personal responses. As someone intimately involved in the health-care field, I see in the black-and-white motif an allusion to racial conflict in Blessen's work and the fear that people of color, among others, would be the likely victims of physician-assisted suicide in a cost-driven health-care system. Does Blessen's post-modern collage evoke thoughts of a morally fractured, polarized society where civility and mutual respect are in short supply? Does it portend a chaotic political future as the question of assisted suicide is returned to the states? Will the bond of trust between physician and patient be pulled apart? The artist's use of color and disjointed forms definitely conveys much more than the proverbial thousand words.

Karen Blessen's evocative illustration will set the standard for the new *Bulletin* as a source of spiritual, emotional, and artistic engagement as well as intellectual stimulation. Her work and the content of the *Bulletin* will no doubt elicit many varied responses from our readers. We hope you will share them with us.



Why the Bulletin?

By Philip J. Boyle
Editor-in-Chief

Amidst the onslaught of information on health and ethics, why would the Park Ridge Center contribute to this overload with yet another newsletter? The answer is simple: attention to religion is remarkably paltry. The literature shows little appreciation for faith's contribution to the conversation. The *Bulletin's* aim is to fill that gap by invigorating discussion about religion in health-care ethics.

All the *Bulletin's* columns are meant to accomplish one goal — highlighted in the column entitled “Connect the Dots.” Media and academic coverage of health, faith, or ethics often brings audiences to the cusp of making connections between health, faith, and ethics without ever developing the interrelations.

In the recent coverage of the Supreme Court's decision on assisted suicide the media covered the religious perspective by highlighting religious objections but without ever connecting the dots about how faith communities would be challenged to offer viable alternatives to assisted suicide. Our *Bulletin* —and Center— are as much concerned with what is not said, as with what is said. In “Media Rx” for example, we will identify what coverage is overlooked and imagine what insights would have enriched public discussion of the issue.

Our preoccupation, however, is not simply with the void. Rather, advances in health science often challenge faith perspectives and compel a rethinking of core beliefs. Conversely, frequently overlooked values found in faith communities can offer a poignant critique of prevailing views of medicine, health, and healing. The *Bulletin's* lead story on Lon Priddle provides a narrative of the complexity of dying well — one idea that is frequently overlooked in a press that simply frames the issue of assisted suicide as pro and con debate.

If you feel that the coverage of health and ethics is monochromatic, we hope that you will read the *Bulletin* for its ability to communicate the texture, tone, and depth that a faith perspective can bring. Each part of the *Bulletin* —the narrative lead story, the use of images, or offbeat essay reflects our goal: to enrich health and healing by illuminating the faith dimensions. We look forward to promoting this conversation and welcome your opinions.



Dying Cardinal Bernardin's Way

By Martha Holstein

Many Others, Alone and in Pain, Want Help in Dying Well

Like many Americans, I watched with deep admiration as Cardinal Bernardin lived his last months. His humble honesty, his courage, and his ability to touch other suffering people moved me greatly. In life and in death, he reflected much that we value, even for people of other faiths. But admiration alone can easily convert his death last November into a cultural ideal against which we indict ourselves and those we love for lacking his grace or gentleness.

Because he was so public in his dying, Bernardin opened a moral space that encourages us to reflect about the preconditions for a good death. With all the attention now focused on physician-assisted suicide, we easily forget that most people do not ask their physicians for assistance in dying. Rather they want help in dying well, relatively free of pain and suffering, and with their dignity intact.

The cardinal's dying and death tells us much about reaching that end. Although we cannot control all the medical factors that shape our dying process, we can learn from him about the social and personal conditions that make a good death possible.

The cardinal had the best that technological medicine could offer. Physicians, nurses, and other health-care workers, I suspect, treated him with the utmost respect while addressing his medical condition. They cared for him not as a body in a bed but as a fully embodied, richly complex, honored man. When "rounding," his attending physician, the residents, and medical students did not talk about him but to him. He did not have to worry that his physicians would not respect his wishes, not tell him the truth, or abandon him emotionally, if not practically, as beyond cure.

In contrast, most of us die in the hospital separated from intimate relationships by bright lights, incessant noise, bed rails, and often pain and existential anguish. We may receive

treatment we do not want and are powerless to halt, despite the legal rights we have gained. The care the cardinal received should be available to each of us.

Once home, he also had all the medical and comfort care he needed, not from a spouse or child—whose love is often tempered by day-to-day burdens, concerns about finances, and the needs of others—but from individuals for whom his care was paramount. He was also able to die at home surrounded by loving affection, attention, conversation, and a sense that he still was integral to the life around him.

Bernardin had other blessings. Clearly his abiding and lifelong faith was central to his dying. But even without his strong faith, we too can turn to our traditions for help. Faith can help us talk more openly about death, what we fear, and how we can imagine a good death. Facing our finitude can profoundly influence how we live. Faith can also encourage us to practice the teachings of our traditions in everyday life, encouraging us to live a life that will comfort

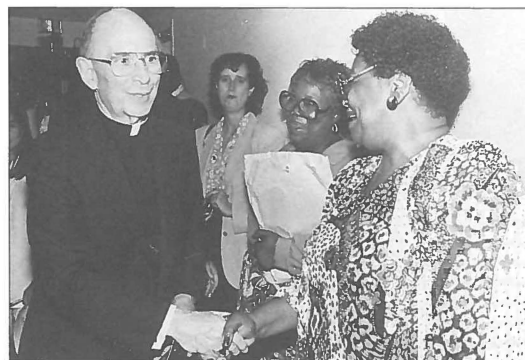


Photo by Sandy Bertog

Cardinal Bernardin visits a senior citizens' home about two months before his death.

late." Days before his unexpected death (he was only 49 years old), my friend said, "I've lived my life as I've wished; though I have much I want to do, if I died tomorrow I would die content." This message is very different from one that encourages us to prepare living wills or durable powers of attorney.

We can never eliminate all suffering. Nor can those who see suffering as ennobling ask others, who may not share this view, to suffer as exemplars for the rest of us. Yet, we can hope to have some of the blessings that made it possible for Bernardin to die as he did.

The fundamental conditions for a

"The Cardinal nurtured in us the courage to think about a good death for ourselves and those we love, and for holding out the hope that dying well is truly possible."

and not burden us at death.

Bernardin also knew the priests in the Chicago Archdiocese, his fellow bishops and cardinals, and many others held him in the highest esteem. From the most intimate to the widest circles, love and respect nourished him. Courage thrives in these circumstances.

The cardinal's death thus taught that living and dying are parts of a whole. Some years ago, upon the sudden death of a close friend, the emergency room physician said to me, "Remember what the Orthodox Jews say, live each day as if it were your last." My daughter, then 16, said, "You need to tell a person often how much you love them—before it is too

good death should be within our grasp. We need competent, respectful, and truthful medical care and loving attention. If possible, we should have the choice of dying in our own home.

Bernardin's death also asks us to attend to how we live—to be open to giving and receiving love, and to understand that the choices we make affect not only our life but also our death. Thinking about the meaning of our lives is not a task for its last moment. The cardinal nurtured in us the courage to think about a good death for ourselves and those we love, and for holding out the hope that dying well is truly possible.





When Suffering is More than Physical Pain

By Dan Dugan

Efforts to Control Emotional Trauma Show Dark Side of Palliation

Mr. Murphy, the 76-year-old patient with lung cancer, died about 1:45 pm in his room on a medical floor at Montrose Memorial Hospital. His wife of 51 years, Lynette, threw herself on her husband's chest, and shuddered, moaned, and wept. The nurse, entering the room, saw Lynette's suffering, and saw that her two daughters were holding each other, sobbing. "Would your mother like something to help her with her pain?" the nurse asked the eldest daughter. The daughter stared blankly at the nurse. Two minutes later the nurse returned with six physician-authorized tablets for the Murphys, along with the necessary forms regarding personal belongings and mortuary designation that would need the family's signatures.

This nurse is "medicalizing" the emotional pain of Mr. Murphy's family, treating their suffering with drugs and serving the interests of institutional efficiency. On the surface, the nurse seems to be providing good palliative care, managing the pain and symptoms of Mrs. Murphy and her daughters. In the current context of escalating demands for health-care providers to provide more pain and symptom control to suffering persons, however, this nurse's welding of compassion to the medical model shows the dark side of palliative care.

Palliation — the art and science of alleviating the suffering of the sick — is a central goal and duty of medicine. Medicine's primary mission is to cure the sick, and

restore their abilities to function. When the disease or injury is incurable, medicine's sole mission is palliation: mitigating pain and suffering as much as possible.

The term "palliation" comes from the same root as "pallor" and "pall-bearer," connoting the act of "covering over" or "making palatable" on the surface that which, beneath the surface, is beyond human control. The World Health Organization defines palliative care as "active, total care of patients whose disease is advanced, irreversible and non-responsive to curative treatment," and "the management of physical and emotional symptoms, as well as the provision of social and spiritual support for both patient and family during the course of progressive illness that is beyond the reach of cure."¹

Palliative care initiatives — supported by foundations, professional medical associations², and federal agencies — are proliferating in hospitals and health-care systems nationwide. The federal government is preparing to approve guidelines for Medicare to reimburse physicians and hospitals for palliative-care treatments. For terminally ill persons and the fragile elderly, the re-emergence of palliative care represents a viable alternative to the options of high-tech rescue medicine, and physician-assisted death. Palliative care has

eliminating grief's symptoms. Grief is not a sickness to be "fixed," but a healing process to be acknowledged and nurtured.

Modern hospitals, employing scientific medicine and institutional efficiency, often view grief as a threat and disruption. When other forms of eliminating expressions of grief fail, tranquilizers and sedatives are frequently employed as a way of maintaining order and control. The pain of loss is quickly covered over, the symptoms reduced and eliminated. This type of palliation is inappropriate.

Sufferings of the soul cannot be addressed nor ameliorated by chemicals and distractions. In fact, mourning is the beginning of an inner restorative and healing process. Instead of using more appropriate curative or therapeutic measures, attempts to palliate inner suffering can actually disconnect the sufferer from pain and from the healing process of grief.

Dosing grieving family members with tranquilizers numbs their perceptions, and postpones pain and grief. This type of palliation may even intensify the grieving process by delaying it to a time when family and friends may no longer be available for support. In this way, the "successful" palliation of patients' and families' can amount to inflicting

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been neglected for too long.

Not all pain is physical, nor is it confined to the sick. For family members and professional caregivers, the universal human experience of pain and suffering associated with significant loss — especially when patients die — is more of the soul than the body. Alleviating this suffering calls for something more than "covering over" or enshrouding the pain, and

unnecessary pain upon them, which violates the ethical duty to prevent or minimize unnecessary harm.

Religion, like medicine, embodies a deeply human drive to wholeness, which pain and suffering fragment or diminish. All religions provide a wealth of resources (wise counsel, stories, rituals) to endure suffering. For instance, the "noble truths" at the foundation of

Buddhism acknowledge: (1) Existence is pain. (2) The cause of pain is attachment to that which passes. (3) Release from pain consists in detachment. (4) The middle way between the extremes of self-indulgence and self-denial is the path to bliss.

Similarly, the central symbol of Christianity — the death and resurrection of Jesus — clearly presents an image of spiritual well-being that acknowledges the universality and centrality of suffering. In many religious traditions, the potential for expanded self-understanding, deepened relations with others, and even intimacy with God are all affirmed as possible with suffering.

“Instead of covering up symptoms, compassion seeks connection with the sufferer, without seeking to negate the suffering.”

The great world religions emphasize that compassion helps cure the suffering soul. Compassion or “suffering with” is fundamentally different from palliation. Instead of covering up symptoms, compassion seeks connection with the sufferer, without seeking to negate the suffering. Compassion aids in the genuine healing that comes from grieving and mourning. Palliation is a caring, appropriate response to the suffering of the sick. Compassion is a caring, appropriate response to the emotional and spiritual suffering of persons that accompanies human experiences of significant loss.

Faith-based hospitals, medical centers, and health-care systems embody both medicine’s commitment to palliation, and religion’s support of the natural healing process of grieving. That means accepting its expressions — beginning with tears. Crying is the body’s most effective means of excreting toxic chemicals and alleviating the emotional tension and pain accompanying such loss. Tissues, not tranquiliz-

ers, fulfill the ethical obligation of health-care professionals to alleviate suffering. Making room for crying and other forms of grieving behavior (e.g., compassionate listening, assistance with practical needs, arranging space for families to be with one another) assist the healing process. In a word, pastoral care, not palliative prescription, is the best medicine for the pains of the soul.

Health-care professionals who attend churches, mosques or synagogues might well experience disso-

nance at work if they succumb to institutional pressures to tranquilize patients’ and families’ experiences of loss. The wisdom of their religious traditions (e.g., “Happy are those who mourn, for they shall find comfort”—Matt. 5:4) is at odds with our widespread current scientific-medical ethos. A hospital, medical center or health-care system interested in keeping palliation in its place will sustain a vigorous and present pastoral care team, whose staff bring the compassion that heals to those experiencing loss.

If Mr. Murphy’s nurse is too uncomfortable or too busy to sit with his wife and daughters, to accept their tears and listen to their stories and give them tissues and time, she should ask pastoral care staff to offer this kind of support to them. Time, validation, and compassion, not palliation in service of a quick fix, help suffering souls begin their healing.



1 D. Doyle, G. Hanks, and N. MacDonald, eds., *Oxford Textbook of Palliative Medicine* (Oxford: Oxford University Press, 1993).

2 C. Cassell C. and B. Vladeck, “ICD-9 Code for Palliative or Terminal Care,” *New England Journal of Medicine* 335 no. 16 (October 17, 1996): 1232-3; and American Board of Internal Medicine, “Defining and Evaluating Physician Competence in End-of-Life Patient Care—A Matter of Awareness of Emphasis,” *Western Journal of Medicine* 163 (Sept. 1995): 297-301.

3 Rem B. Edwards, “Pain and the Ethics of Pain Management,” *Social Science Medicine* 18 no. 6(1986): 519.

The High Cost of Death

“Most Americans can’t afford a comfortable death. More than likely, their savings accounts won’t hold up after intense hospitalization. And, as the insurance system now works, benefits will cover ample surgeries and procedures, but once those limits are met there is nothing left for palliative care . . .

“At least three barriers block the way for a more comfortable death . . . (1) The health-care system fails to offer an institutional structure to support appropriate choices for dying patients. (2) Insurance mechanisms fall short of providing adequate support beyond high-tech care. (3) American culture embraces high-tech medicine while harboring an overwhelming fear of painful death. Discussions of palliative care rarely enter into the picture.”

— from the September 1996
Medical Ethics Advisor



A Matter of Death and LIFE

By Daniel Cattau

On a clear night from the front porch on Gwendolyn's Farm, located high on St. Mary's Ridge above the dairyland town of Norwalk, Wis., the yardlights on dozens of neighboring farms create a 360-degree constellation of stars.

During daylight, the view westward resembles a miniature Grand Canyon — the distant hills form a full-color horizon that looks far beyond Sparta, a nearby town. It's a muggy, windless summer day in Norwalk (population 564), but atop these lush west-central Wisconsin hills there is always a welcoming fresh breeze.

Gwendolyn's Farm — named after the more rambunctious of two resident Great Danes — is where Lon Priddle, knowing that he was dying of colon cancer, came to live.

He embraced the farm, its Amish neighbors and its possibilities as a refuge from his troubles, mainly a 10-year fight over enforcing visitation rights to his three children. In particular, he saw it as a place where he and his youngest son Wyatt could be together. Lon's second wife Soma says, "The essence of Lon's life was to be a father to his children."

In spring 1996, Lon (a travel industry executive) and Soma (a United Airlines pilot) bought a 104-acre dairy farm in which he eventually planted a garden with basil, parsley, rosemary, organic vegetables, and heirloom tomatoes. He also devoured books on farming, maple syrup, cross breeding, and pollination. She says, "He understood the difference between substance and style. He was

Lon Priddle Wanted Assisted Suicide, but Found Reasons for Living



Son Wyatt and Lon share some good times.

a substance guy."

His love for the farm was such he told Soma that, after he died, he would signal his presence to her by rustling the pine trees outside the house.

"Lon knew that life and death are merely normal phases in God's astounding natural system," said John Dreier, a Norwalk banker and friend who spoke at Lon's memorial service. "Lon knew the meaning of life, as revealed on the farm. Lon's body ultimately yielded to disease in Chicago, but his soul still resides on his beloved farm."

In recent months, much national attention has been focused on death. Certain well-known figures such as the late Joseph Cardinal Bernardin and Dr. Roger C. Bone, a nationally known pulmonary physician who died in June, gave the public a fuller appreciation of courage under fire and how to die well.

But a darker image of death comes from the spectacle of Dr. Jack Kevorkian's "medicides" and the physician-assisted suicide debate. The U.S. Supreme Court on June 26 overturned two federal appellate court decisions that permitted assisted suicide. But the issue is expected to be picked up again by the states.

Usually the media frame the assisted suicide debate in terms of polar opposites. Civil libertarians advocate the right to die; religious traditionalists bitterly oppose it. But the legal and political battles rarely touch upon the qualities inherent in a good death, where waiting for the "right time" is more important than managing death.

Yet given some proposed legislative guidelines for assisted suicide — still illegal but under consideration in numerous states — Lon fit some proposed criteria. He was alert, mentally competent, and not clinically depressed. And he wanted to die.

Lon Priddle was not nationally known, but his death is instructive on many levels. Lon's story says a lot about the importance of relationships, living for others and the role of faith at the end of life — even for a confirmed skeptic.

In his last weeks, he raised the most basic of questions faced by the dying: Is there a point to the suffer-



Gwendolyn's Farm, near Norwalk, Wisconsin, was a working dairy farm before the Priddles bought it.

ing? Is assisted death an option? What might be the consequences for himself and those he loved? Through the darkness, he learned that if there is a choice in death, it stems from deciding not when to end a life but how death should be faced.

John Dreier says, "From Lon, I really gained some appreciation for patience . . . and perseverance under fire. It's not what happens to you. It's how you handle it."

In late January, Lon and Soma for the last time visited the farm — Jan. 26 was her 38th birthday and his present to her was a hand corn grinder. At 5-foot-8 and 160 pounds in his prime, Lon was now very weak and he was losing weight. On Feb. 6, he was readmitted to Northwestern Memorial Hospital in downtown Chicago.

Eight days later — on Valentine's Day — Lon Priddle, age 50, lost all hope.

Lon's three children live with Lon's former wife in upstate New York. Soma says Lon, after a divorce, gave up his career as a U.S. Air marketing executive and "all his assets" for what he thought would guarantee his visitation rights, but these rights proved difficult to enforce. Gradually, Lon's hopes and a custody battle centered around Wyatt, then 13 years

old (Wyatt has an older brother and sister; attempts to reach Wyatt and his mother Adair in suburban Rochester, N.Y., were unsuccessful).

Lon was not expected to live long. So he had high hopes for a visit from Wyatt, but was devastated when parental politics foiled the court-ordered visit. At the same time, Lon

had met with a team from Northwestern's acute palliative care unit (or its hospice), where he was about to be transferred. Barbara Camden, a registered nurse with the hospice unit who also has a master's in pastoral counseling, recalls that in a preliminary meeting, "Lon asked if there was anything we could do to help him die."

The hospice team, in denying the request, realized Lon's suffering was in the "other realms of his existence," namely the need for reconciliation with his children and more time with Soma. Camden counseled patience: "Sometimes the waiting is not about you, but rather someone you love."

Soma remembers vividly the "awful" Valentine's Day. She realized the key to Lon's continuing hope was a visit from Wyatt. But Justice Evelyn Frazee of the New York State Supreme Court (the lowest state court) was on vacation and unreachable.

Later Friday night, Soma went to the Regenstein Library at the University of Chicago to track down any information she could find on the judge. Through a computer-assisted search of New York State property records, she found the name of the judge's husband (he has a different last name). Startling bleary-eyed students around her at 3 a.m., Soma let



Lon and Soma at their 1993 wedding shortly before Lon was diagnosed with cancer.

out a gleeful shout that a longshoremen would have appreciated.

A separate search yielded the judge's home phone number. Later at home, Soma called the judge, leaving an apologetic message: Lon was dying and needed to see Wyatt, and the judge was the only one on Earth who could help.

Later Saturday morning, she went back to the library and tracked down a list of 115 matching family names where she thought the judge might be vacationing. Returning to the hospital Saturday afternoon — and much to Lon's amazement — Soma hauled out the long list of names and started making phone calls.

Lon perked up. "It was the most intimate moment in our marriage," Soma recalls. "At that moment we both agreed, 'Let's go on and keep fighting.'" And they reminded each other of a slogan that they had adopted early in their marriage when Lon's cancer was first discovered: "We're not dead yet."

On Sunday morning, the justice, who received the message at home, called Soma and asked simply, "What airplane do you want Wyatt on?" He

arrived in Chicago later that day.

The story of Lon's last weeks shows "how truth and facts are not the same thing," says Dr. Kathy Johnson Neely, associate medical director of the hospice unit. Part of Lon was tired of the battle, she adds, but another part "was open to exploring the mystery of dying and exploring relationships with his wife and kids. It falls into the line of miraculous for me. If we had complied with his request, what a loss."

On Feb. 20, Lon was transferred to Northwestern's ninth-floor hospice unit. With its mauve-colored walls, it is softer in tone and less frenetic than a typical hospital wing. Most of the 12 beds were unoccupied during a recent visit; there are currently 50 hospice patients at home. The unit has two full-time doctors, social workers, nurse-therapists, chaplains, dietitians, physical therapists, a "bereavement coordinator," and about 100 volunteers.

They pride themselves in "listening skills," and the ability to demonstrate what they call the "soul of medicine." The team even allowed Byron, the gentler of the Great Danes, to visit Lon in the hospice. Says Camden, "We don't promise we can relieve all the pain and suffering, but we can promise we will be there for them."

Before entering the hospice, says Neely, Lon received "good, aggressive, go-for-broke treatment." But the colon cancer had metastasized to the liver and lymph nodes. Since December, he also was on total parenteral nutrition (TPN), which means that all nutrients from fats to amino acids were being fed intravenously. With such a treatment, says Neely, the question always arises: "Are you adding to the quality of life or are you simply extending life?"

Under normal circumstances, Lon would have gone home once his pain was under control, but the farm was too remote and Soma, because of her job, felt he would receive better care in the hospice.

Yet Lon continued to live beyond anyone's expectations, and this will to live was renewed in March when the judge granted him custody of Wyatt. (A decision confirmed by a spokesperson for the New York State

Supreme Court.)

Ironically, his body could no longer hold up at the time of a long-awaited court victory. Camden remembers Lon telling her: "I reached a point in my life that could have been the best for us." And he had to let go of all of that."

It had been four years since the Rev. John A. Dally, an Episcopal priest and seminary professor from Chicago, had married the Priddles at the Bond Chapel of the University of Chicago. Now, he heard from Soma again. Lon was dying, would he visit? On a sunny Saturday morning, Dally visited Lon alone. He remembers his voice being "unusually strong," and they talked about God, heaven and dying.

"Lon expressed a mixture of skepticism and hopefulness about what lay on the other side of his death," recalls Dally. "He shared a vision of heaven with me, a place of serenity in which there was much useful work to be done. I remarked that it sounded like the farm in Wisconsin. He thought for a moment and then agreed that, indeed, the farm was as close to heaven as he'd come on Earth."

Dally also remembers a discussion about planning a memorial service in which Lon delivered a stern warning: "Just don't say I'm in the arms of Jesus." Dally adds: "I knew that behind this comment lay not a contempt for popular sentimental Christianity, but a desire that there be no falsehood connected with the final words on Lon's life."

There was even a final meeting — if not a full reconciliation — with his two older children. Around March 20, Lon had taken a "dramatic turn for the worse," says Soma. "He was delirious. He was having flashbacks." Dally administered the last rites from the *Book of Common Prayer*. All three children were there, and Lon at last had a chance to tell them all that he loved them.

From Dally's experience, usually the patient sees the last rites as a signal that it's okay to die. But Lon's will to live regularly confounded his family and the hospice staff. Dally says Lon was especially concerned with Wyatt. "Would his son be all right? Would he remember how his father loved him? These questions

Enduring Courage

John Dreier, a banker and friend from Norwalk, Wis., made the following remarks at Lon Priddle's April 24 memorial service in Chicago.

On the field of battle, courage is defined as the ability to ignore the terrible circumstances of conflict and death, and yet unselfishly lead and protect the persons under your care and command. Lon Priddle did just this with unselfish compassion and love, while fighting desperately to protect his children and defeat the cancer in his body.

Over the past six months, I had the opportunity to observe Lon during his battle with an insidious disease. I learned a great deal from these observations. What I saw was a man of intelligence, character, humor and courage who routinely subordinated his own requirements to the needs of others. This, my friends, is the true character of a man . . . enduring courage under fire. Nothing . . . nothing is more difficult or costly.

kept him alive weeks beyond any reasonable expectation."

By April, Lon was doing a lot more sleeping, the intravenous nutritional treatments were cut back, and he was a little confused, "Why am I so weak?" he asked. He was receiving a low dosage of two milligrams of morphine an hour to control the pain. Neely says: "It was clear on the day before he died he was too weak to get physical or occupational therapy. . . . He did not want to eat."

But he seemed at peace. He had received a phone call from Soma and Wyatt saying they had just arrived in Hong Kong. It was a last act of sacrificing for others, according to the family, because Lon had long promised Wyatt the trip to the former British colony before it was turned over to China. Lon, of course, was too ill to make the trip.

Across the world, as Lon was dying, Soma and Wyatt had dinner with friends, then took a starlight walk along Repulse Bay in Hong Kong before retiring to the friends' house.

Soma called Northwestern hospital; Lon had died on April 16. He was alone, but in a place he felt safe and cared for. It was, finally, his time to die.

"Lon's memorial service was exactly what he wanted it to be. No platitudes, no false sentiment, no claims about Lon's new location," says Dally, who officiated at the Bond Chapel service on April 24. The words of the Beatitudes — "Blessed are the poor..." wrap around the walls of the chapel.

Lon embodied the text, "Blessed are the pure in heart, for they shall see God," says Dally. "Throughout his life, he willed the good of those he loved, not in a possessive, cloying way but in a way which set them free."

•

After the memorial service, Wyatt went back to upstate New York to live with his mother. Two months later, Soma and friend John Dreier show a visitor around Gwendolyn's Farm. A meatless pasta dinner is served with fresh vegetables and loving care. After dinner, they go outside to the front porch, and there's a fresh breeze tussling the branches of the pine trees.

"That's Lon," says Soma softly.



The Supreme Court and Physician-Assisted Suicide

By David Sinacore-Guinn

The Supreme Court has wisely decided to allow, rather than stifle, public debate on physician-assisted suicide. In a long-awaited ruling on June 26 involving two cases — *Washington State v. Glucksberg* and *New York v. Quill* — the Court held that there was no such constitutional right under either the due process or equal protection clauses of the 14th Amendment. While the concurring opinion of Justice John Paul Stevens suggested that the Supreme Court could subsequently revisit the issue as a matter of constitutional law, the thrust of these two opinions is to hold that it is an issue for the states and the public to decide.

As noted by Chief Justice William Rehnquist, "Throughout the nation, Americans are engaged in an earnest and profound debate about the morality, legality and practicality of physician assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."

We should all be grateful for the Supreme Court's ruling since public debate offers the hope of consensus. To have decided otherwise would have invited the same acrimony and political turmoil that now exists in the abortion battle.

Yet there are many similarities between the issues of abortion and physician-assisted suicide. There are significant unresolved moral and religious questions about our understanding of the nature of human life and our obligation to its protection and preservation. There are profound political questions regarding the relationship of the individual to the state, the role of the state in legislating morality, and the role of the Court itself.

Proponents of physician-assisted suicide stress the constitutional rights of the individual, but there is no such unambiguous right set forth within the Constitution to physician-assisted suicide. Moreover, it is not a right which is necessarily implied by other decisions of the Court regarding the refusal of life-saving treatment or the abortion decisions.

In our attempts to resolve the morality, legality and practicality of physician-assisted suicide, the courts are an inappropriate forum. They cannot bring

people together or create a moral consensus. This is especially true in the physician-assisted suicide debate, which is still highly controversial and emotionally charged. While many polls report significant levels of popular support for assisted suicide, where the issue has been subjected to public debate and public votes, it has either been defeated (California and Washington) or passed by a narrow margin (Oregon). Moreover, the Oregon initiative has been subsequently challenged in court as unconstitutional.

It is only through an on-going conversation that we can hope to reach a consensus and, as noted by Chief Justice Rehnquist, one of the problems of the law is its tendency to end debate and discussion. "By extending constitutional protection to an asserted right or liberty interest, we, to a great extent, place the matter outside the arena of public debate and legislative action."

Arguably, one of the reasons the abortion issue remains so heated to this day is that the Court in *Roe v. Wade* ended the debate too soon. Instead of allowing the discussion of abortion to proceed through normal political channels, it was short circuited along the lines drawn by the Court. The issue was framed in black and white, whereas the reality for most of us, as in any other area of moral concern, is that there are enormous gray areas.

The issue of physician-assisted suicide will raise very difficult and potentially painful questions and the discussion will at times be heated.

Nonetheless, when the questions are fully debated and resolved by the political process, we should not be left with an on-going cultural war. While we cannot simply assume that the political process will automatically lead to a just moral resolution of this dilemma, public debate may lead us to new ways of viewing this problem and affording us new answers. The issue here is not simply about an individual's right to assistance in killing themselves, but rather about our relationship to each other, to life, and the inevitable process of dying.



Studies Say Marriage is Good for You

Earlier this spring, The Park Ridge Center hosted an evening conversation with Don and Carol Browning on "Health, Faith and the Family: Should Professionals be Interested in Strong Marriages and Families?" Dr.

Browning, the Alexander Campbell Professor of Religious Ethics and the Social Sciences at the University of Chicago Divinity School, directs the Lilly-supported Religion, Culture and Family Project. Carol, a musician and piano teacher, serves as research associate to the project. This is an edited version of their remarks.



Carol Browning



Don Browning

Don: In the popular mind, marriage and families are generally identified as religious values. However, a new discourse — a new kind of language game — has entered the public conversation about marriage and family. This is the language of public health and the language of the common good.

Marital disruption and unhappiness correlate with a whole range of unfavorable consequences for men, women, children, work place, and a host of other social ills. Marital disruption costs taxpayers and damages the health of both adults and children.

The recent federal welfare reform law acknowledges that strengthening marriage and families is the major motivation for this legislation. Several states are considering requiring marriage counseling and one of the new marriage compatibility inventories before granting marriage licenses. Some states are instituting mandatory couple and family counseling at the time of divorce.

Carol: A couple of years ago, a group of legislators in the state of Washington wanted a warning added to marriage license applications suggesting that marriage might be dangerous to the couple's health. Today, they would need to add a further sentence to the effect that, absent abuse, marriage seems to be very good for your health:

■ People who are married live longer (and this is true worldwide) than single, widowed or divorced people.

■ Widowed women are better off than never-married or divorced

women but still disadvantaged when compared with married women.

■ Married men are much more likely to live longer than any of the other categories.

Why? First, marriage appears to reduce risky and unhealthy behaviors. Second, marriage increases material well-being — income, assets and wealth — to purchase better medical care, better diet, and safer surroundings. Third, marriage provides people with a network of help and support. Fourth, marriage provides adults with a readily available sex partner, something most people consider a great human good.

Married couples have two extended families, and they build up good social networks. They also have each other as confidantes. This is good for their own psychological well-being, as well as for their children. Their own good mental health enables them to do a better job of raising their children. Children do better with intact, two-parent families.

A 1992 study showed that depression is now a major health problem in the United States, costing about \$16 billion and leading to 30,000 suicides annually. Depression is on the rise worldwide, particularly in younger people. Explanations for the causes include doubling of the divorce rate, drop in parents' time available to children, and an increased mobility.

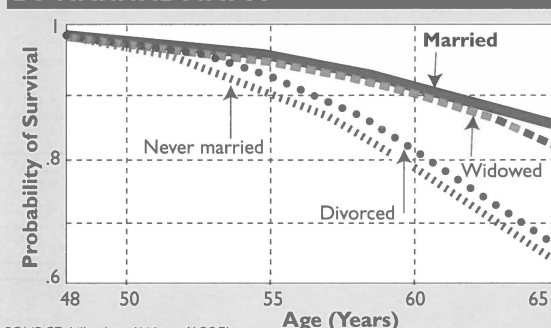
Other explanations have to do with the ascendance of

individualism, a waning of beliefs in religion, and a decline in community and family support that can buffer you against setbacks and failures

Why has marriage, with all its benefits, declined? Linda Waite (University of Chicago) offers the following reasons: More women are now employed; high divorce rates decrease people's certainty about the long-run stability of their marriages, and thus may reduce their willingness to invest in it; and changes in divorce laws have shifted much of the financial burden for the breakup of the marriage to women, making investment in marriage a riskier proposition.

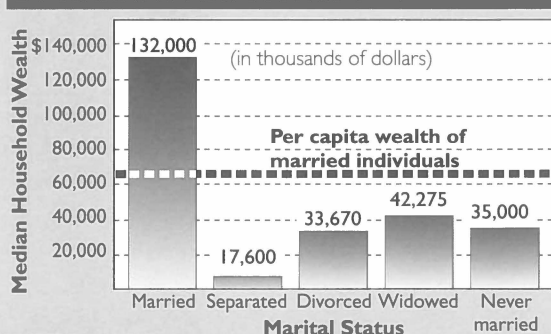
Men, in turn, may find marriage and parenthood less attractive because they face the loss of contact with their children if their marriage dissolves. Women are now less dependent on men's financial support. Public policies that support single mothers and changing attitudes toward sex outside marriage, toward unmarried childbearing, and toward

PROBABILITY OF SURVIVAL TO AGE 65, BY MARITAL STATUS



SOURCE: Lillard and Waite (1995)

MEDIAN HOUSEHOLD WEALTH BY MARITAL STATUS AGES 51-61



SOURCE: Smith (1994)

divorce have all been implicated to explain the decline of marriage.

Don: The language of health is riddled with what moral philosophers call teleological language. It is the language of goods — the goods of bodily health, the goods of mental health, the goods of pleasure, the goods of material wealth, and the goods of agency — the capacity to act with confidence and dispatch in the pursuit of other goods such as jobs, education, and friendships.

It is a language that plays down obligation and commitment and plays up individual and social benefits and consequences.

The language of religion is often thought to have little to do with the teleological language of relative goods. The language of religion sounds more like the language of love, obligation, commitment, loyalty, ordinance, law, and judgment. It would seem strange to hear in a wedding ceremony the words, "I, Jim, take you, Mary, to be my lawful wife because I know that in so doing, I will live longer, get richer, have a better heart, learn to give up smoking, and get more really satisfying sex than if I remain single."

Those using the language of health to support marriage almost always at some point require the language of commitment, but often have difficulty explaining it, grounding it, and showing how it fits with the good of health.

On the other hand, religious people who specialize in the language of commitment, covenant, or sacrament almost always invoke the language of health and the goods it represents.

Our quest for a genuine public good and our quest for a more authentic religious language will be most completely realized when we learn how to reconcile these two languages. I believe that can happen best when religious language is seen as the most encompassing and inclusive.

It is easier to show how the language of commitment has within it a consideration of the goods of life than it is to show why, in the pursuit of individual health, we should commit ourselves to another person.



THE PRESIDENT'S COUNCIL

Members of the President's Council, which held its first meeting July 22, are concerned with developing and interpreting the Park Ridge Center's vision. They provide guidance in long-range plans and projects, and secure philanthropic support. Members include:

William J. Arnold: executive vice president, medical director and board member of Advanced Bio-Surfaces, Inc., a company that designs and develops polymers for joint resurfacing.

José Barzelatto: vice president, the Center for Health and Social Policy, a non-governmental organization for the improvement of world health.

Robert W. Beart: executive consultant, Illinois Tool Works, a multinational manufacturer of highly engineered components and systems.

B. Frederick Becker: chairman and chief executive officer, MMI Companies, Inc., an international health-care risk management company.

George B. Caldwell: chairman, The Collier Company, a health-care consulting firm.

Margaret Corbett Daley: president, Pathways Awareness Foundation, which promotes awareness about detection, intervention and inclusion of children with physical challenges.

Alan M. Hallene: retired president, Montgomery Elevator International, a manufacturing company.

Martin E. Marty: University of Chicago Divinity School historian and George B. Caldwell Senior Scholar-in-Residence, the Park Ridge Center.

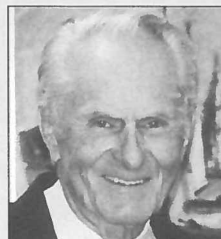
Catherine E. McDermott: president and chief executive officer of the National Committee for Quality Health Care, a nonprofit coalition of health-care related organizations.

Warren R. Rothwell: retired chief executive officer, General Binding Corporation, a manufacturer of office machines.

SHARING THE VISION

I was first attracted to the Park Ridge Center while playing golf with George Caldwell, one of the Center's founders. George shared with me his dream to form a group to study and to research the relationship between health, faith and ethics. His desire began in his hospital experiences where he witnessed patients repeatedly reaching back to their basic faith to try and find aid and solace when faced with life-threatening health problems.

As the Center took shape I was attracted to the work they were doing not only in the field of health-care but in the over-all context of strengthening and restoring this country's ties to its religious



Rothwell

roots, which are so severely challenged these days.

As time went on and my ties to life in Naples, Fla., grew stronger, I recognized the importance of the Center's work with the "aging" part of our population, particularly as it would apply to the retirement community.

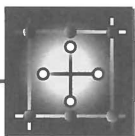
All of these factors seemed to converge and lead us to initiate the annual "Naples Symposium" where the various health, faith and ethical issues relating to the older generation are discussed, in addition to cloning, transplantation, and physician-assisted suicide.

—By Warren R. Rothwell

Rothwell, retired chief executive officer of the General Binding Corporation in Northbrook, Ill., is a member of the President's Council, and a strong supporter of the Center. Now a resident of Naples, Fla., he is founder of the Center's annual Naples Symposium.

VISITING SCHOLAR

Murray L. Manus, a Chicago lawyer currently a scholar-in-residence at the Center, is working on an article on how "virtuous behavior" in a health-care system can provide improved medical treatment and "reduce the likelihood of malpractice litigation." He is using the Jewish concept of "mensch" — a German and Yiddish word which connotes a person of decency and honesty — and the Golden Rule.



Nurses and Assisted Death

A Year After Two Controversial Reports, Issue Still Ignored

David A. Asch, "The Role of Critical Care Nurses in Euthanasia and Assisted Suicide," *New England Journal of Medicine* (1996): 1374-79; Nessa Coyle, "The Euthanasia and Physician-Assisted Suicide Debate: Issues for Nursing", *Oncology Nursing Forum* 19, no. 7 (1992 Supplement): 41-46.

More than a year ago, a *New England Journal of Medicine* report sent tremors through the health-care community by claiming that up to 20 per cent of critical-care nurses had "performed" euthanasia or assisted suicide. In the extensive discussion

"Is there still a sense that meaning can emerge in suffering, or that there may be some good reason to live despite suffering? Are there traditional resources that might help the faithful develop a different perspective on suffering and its place in our lives?"

of the physician's role, it is ironic that the question of nurses' involvement — or that of any non-physicians — has receded into the background.

At the time, the study received sharp criticism, much of it deserved. For example, the report did not clearly distinguish between assisted suicide and euthanasia, or between "hastening" death and commonly accepted forms of treatment withdrawal. The protests' intensity also reflected fears that the study would generate unwarranted mistrust of nurses. Unfortunately, the criticism appears to have stifled further discussion on the issue.

Has the nearly exclusive focus on the physician's role in assisted death been misplaced? If a minority of nurses has actually assisted in suicide or euthanasia, such a possibility demands further examination. Many nurses will continue to be primary providers of direct care for distressed, suffering patients and their families.

Even more than physicians, nurses

will hear patient complaints about pain and discomfort, and about the deeply dispiriting effects of chronic or terminal illness. They will continue to see too many patients who suffer from inadequate pain management and poor palliative care. They will be keenly frustrated by their lack of authority to prescribe more appropriate pain medication.

Some will receive direct requests from patients for assistance in hastening death. Nursing education and its literature help clarify some ethical distinctions between hastening death and generally accepted pain-management practices, and describe interventions that address patient despair. But these alone cannot resolve nurses' distress.

Nurses are people of deep com-

passion, motivated by mercy and kindness. Nursing, like other health-care professions, is grounded in a desire to help those in distress. Nursing shares in the activist tradition of medicine and the other health-care fields; health-care personnel are typically conditioned to favor action — doing something — over inaction. This activism finds further support in the "can-do" attitude and expectations of American culture.

The problem is finding effective ways for nurses to express their genuine care and compassion. If they feel unable to provide effective relief of pain and suffering, a small percentage of nurses may find assisting death an attractive option that speaks of mercy and compassion.

The fact that these virtues lie at the heart of the great religious traditions may inadvertently reinforce the attraction of euthanasia and assisted suicide — even if those same traditions also discourage such acts. Nurses who are Christian, for exam-

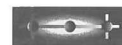
ple, may well internalize their tradition's stress on compassion through the filter of the activism prevalent in our culture. Compassion and mercy can then become duties to make things happen.

Perhaps something from the tradition has been lost in modern Christians' understanding of compassion. Is there still a sense that meaning can emerge in suffering, or that there may be some good reason to live despite suffering? Are there traditional resources that might help the faithful develop a different perspective on suffering and its place in our lives?

There is a fundamental vulnerability, indeed helplessness, that plagues the human condition. The Christian tradition teaches that "waiting upon the Lord" is not only sometimes necessary but is strangely good for the soul. Can these dimensions of traditional faith provide support for nurses and others, including patients and families, who face circumstances beyond their control and feel compelled to "take matters into their own hands?"

Some nurses might be helped by the faith communities' efforts to ask and answer such questions. It might even be that the very effort to do so would be welcomed as a gesture of support and solidarity in matters that, after all, affect not only nurses but all of us.

— By David B. McCurdy



Exceptional Cases

Ezekiel Emanuel, "Whose Right to Die?" *The Atlantic Monthly* (March 1997): 73-79.

In condemning the opinions that the Second and Ninth Circuit Court of Appeals issued supporting a constitutional right to physician-assisted suicide — decisions recently overturned by the U. S. Supreme Court — Dr. Ezekiel Emanuel argues that the courts misread history, misinter-

preted survey data, engaged in mistaken reasoning, and were simply misinformed.

Emanuel, an ethicist at Harvard Medical School, concludes that physician-assisted suicide and voluntary euthanasia ought to remain illegal for reasons that range from the dangers of the slippery-slope — that legalization might lead to unintended abuses — to fears that patients would be blamed for their own suffering if they did not opt for assisted death. He also cites grievous predictions that terminally ill patients would not receive the care they need if death were an option. His position, however, allows for exceptional cases where “acts of desperation” are permissible — where “all other elements of treatment . . . have failed” (p. 79).

Emanuel, in contrast to the appellate court opinions, says most people do not ask for help in dying because of unrelenting pain — the condition for which most Americans seem to support physician-assisted death — but rather because they fear the loss of dignity or control and worry about dependency. Using the Dutch experience with assisted death, Emanuel suggests that legalization of assisted death for competent, terminally ill patients can easily be transformed into comparable policies for incompetent, non-consenting, and even non-terminally ill patients.

The article raises important questions. For instance, will physicians and other health professionals, as Emanuel suggests, opt for the easier course — providing a lethal injection — rather than doing the hard work of compassionate caring? But other questions that he does not raise are equally important.

What is the significance of polling data that show the groups most opposed to legalization are African-Americans, those with low incomes, women, and those over 75 years old? What arguments will count as good arguments for deciding that in certain specific cases, an exception to the rule against physician-assisted death is justified? Who is to say that the fears he discounted — the loss of meaning,

fears of dependency and being a burden — are not in the category of good justifications? Who will decide?

How would different religious traditions, which may oppose legalization, respond to the argument that in certain cases, the rule against assistance with dying can be waived? What does his argument say about the medical profession if the legal option to hasten a patient's death shifted blame for suffering onto the patient and reduced efforts to provide excellent end-of-life care?

At a minimum, Emanuel's article is a useful starting place for the discussions that must now take place at the state legislative level. Even the Supreme Court has left open the possibility of having future cases

brought by individual patients. So the issue will not disappear. But as the medical care system becomes more competitive and more cost-constrained, attention needs to be put on providing the terminally ill with compassionate end-of-life care. If such care is now lacking for large numbers of people and is unlikely to be offered in the near future, society needs to respond either through traditional means — faith and voluntary communities or with legislative remedies. Emanuel's “exceptional case” scenario still haunts the debate because no one knows if such “acts of desperation” will include an individual's deeply held wish to close his or her life in a certain way at a certain time.

— By Martha Holstein

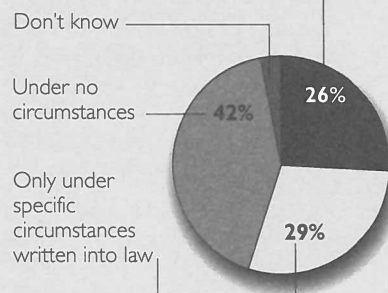
PHYSICIAN-ASSISTED SUICIDE AND EUTHANASIA

PHYSICIAN-ASSISTED SUICIDE

involves a doctor giving a patient the means to commit suicide, such as making available a fatal dose of a drug, knowing that the patient is going to use it to commit suicide. Should it be legal for a physician to help commit suicide?

PUBLIC OPINION

Under any circumstances, as long as the patient and doctor agree



PHYSICIAN OPINION

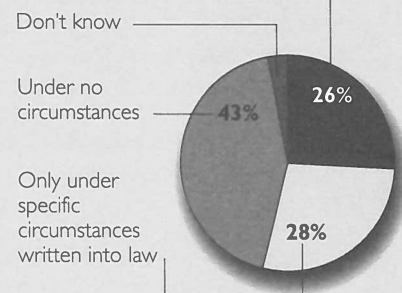
Under any circumstances, as long as the patient and doctor agree



EUTHANASIA involves a doctor taking action to relieve pain and suffering by intentionally causing a patient's death, such as by injecting the patient with a fatal dose of a drug. Should it be legal for a physician to commit euthanasia?

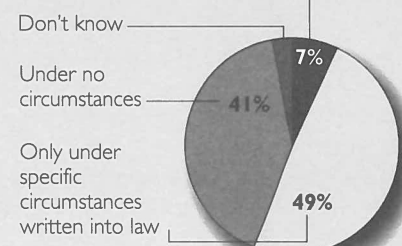
PUBLIC OPINION

Under any circumstances, as long as the patient and doctor agree



PHYSICIAN OPINION

Under any circumstances, as long as the patient and doctor agree



SOURCE: AMA Opinion survey, 1995



When Seeing is Not Enough

By Daniel Cattau

The best news reporting is surprising. It causes the reader to look at an event or person through a different spectrum or lens.

Take the famous neurologist-author Oliver Sacks, who finds stories when nature does the unexpected, goes off the beaten path and turns conventional wisdom inside out.

Writing four years ago in *The New Yorker*, Sacks in "To See and Not See" told of a patient in Oklahoma — given the alias Virgil — who had been virtually blind since birth with what was thought to be *retinitis pigmentosa*, a hereditary condition that slowly eats away at the retinas. An ophthalmologist, however, doubted the official diagnosis and thought a simple procedure to extract the cataracts might lead to partial sight.

When the bandages were removed from Virgil's eyes, all he saw was a mass of confusion interrupted only by the surgeon's comment, "Well?"

What Virgil saw had no coherence. "His retina and optic nerve were active, transmitting impulses, but his brain could make no sense of them," writes Sacks. "He was, as the neurologists say, agnostic."

Seeing, as everyone learned in the case, is not that simple. "When we open our eyes each morning it is upon a world we have spent a lifetime learning to see," writes Sacks. "We are not given the world: we make our world through incessant experience categorization, memory and reconnection."

Virgil's story was miraculous, but it raised a host of unexpected questions. Is seeing enough? What about the role of experience and memory? Is it always better to see than not see? We no longer know for sure.

In using the article in undergraduate magazine classes, I was perplexed by student reactions. They found it boring, overly long, too technical and lacking in detail about the relationship between Virgil and his fiancée (who openly promoted the surgery).

They wanted a conventional ending — the battle to regain sight ends in triumph — and were not interested in the medical history of vision or the fact that the story ended with more questions

than answers. In their desire for a "cleaner" version of the story, I suspect, these future journalists had already learned an important lesson for their own careers: surprise the reader — and future editors — but not *that* much.

At times, the news media seem to act more like the medical experts following the Virgil case than skeptical outsiders. In searching for easy truths, cheap grace, quick fixes, and miracle remedies, the news media think they are giving the public what it wants. But I think what the public really wants is what Virgil's medical team had hoped for — sight and coherence.

As the wire editor at *The Omaha World-Herald* in the mid-1970s, I selected national and international stories for Page One and the rest of the newspaper. As today, there was a constant flood of new scientific and medical discoveries. These new findings were often compelling and surprising — the classic definition of news — but these breakthroughs were often contradicted or even discredited in the following weeks.

These follow-up stories often received lesser "play," meaning they were buried in the inside page, so the original and often inaccurate images lingered. One image did stay with me: that of a cancer patient in a small Nebraska town whose hopes were raised, then dashed, by a series of new discoveries and later stories that debunked the "breakthroughs."

Though science reporting has become more sophisticated in recent years, some things have not changed.

Witness the recent case of Dolly, the cloned sheep. Four months after the initial breakthrough was reported in late February, *The New York Times* carried a solitary article inside its science section indicating that some scientists are skeptical about whether cloning actually took place.

Or take physician-assisted suicide. It was the rare newspaper that carried the issue beyond the normal advocates and opponents of assisted suicide. For instance, David McCurdy's story in this issue of the *Bulletin* (Pg. 12), raises the interesting and ignored question of the

nurse's role in assisted death, yet very few articles have been written on the topic.

In addition, the larger question is not so much about the right to die but the quality of one's death. Most polls indicate that people facing death want choices, but of a different kind. They want to die with as little pain as possible, with loved ones and at home, whenever possible.

The story of a good death, however, is beginning to get covered. *The Philadelphia Inquirer* won a Pulitzer Prize this year for its series on death and dying. *The Wichita Eagle* is running a continuing series on what constitutes a good death.

This kind of journalism would appeal to James Carey, a professor at Columbia University's Graduate School of Journalism and a thoughtful critic of the craft. The purpose of journalism, Carey believes, is the development and enhancement of a common life.

Before the Wichita newspaper engaged in an 18-month project to tap into the community's civic life, reporters expressed frustration that they kept covering the same people and institutions. As former editor Buzz Merritt said, real issues are not addressed at city hall or the courthouse, but in the "dark and trackless swamp of public life."

Civic journalism has its critics, but at its center is a concern for uncovering the layers of public life, "framing stories" differently, and writing harder-hitting articles — and still being first with the news. It's also about covering the ignored, forgotten and powerless.

There are many untold stories in healthcare that deal with people's real concerns: finding adequate and compassionate care for elderly poor who are dying, how assisted suicide would affect people with severe disabilities and limited resources, just to name two. There are hundreds more.

"The struggle of people against power is the struggle of memory against forgetting," said Carey. "To make experience memorable so it won't be lost and forgotten is the task of journalism."



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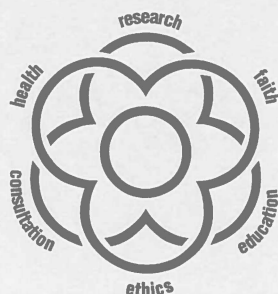
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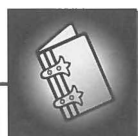
DESIGN AND

COVER ILLUSTRATION

Karen Blessen



The Park Ridge Center's sixfoil portrays the unending and many faceted interaction which takes place among three major areas of human endeavor: health, faith and ethics.



Reading Room

Embracing Mystery, Losing Control

By William F. May

The defining events in life ask us not simply "What are we going to do about them?", but the deeper question "How does one behave toward them?" How does one become and remain whole in the midst of them?

This deeper question goes to the issue of one's core identity — both for the person suffering through such an event and those who help that person heal. Such events do not yield altogether to our problem-solving maneuvers.

No specific policy, strategy, contract, or behavior can dissolve them. As Simone Weil put it, "What could be more stupid than to tighten our muscles and set our jaws about the

solution" of such problems? They must be faced rather than solved. They resemble a mystery more than a puzzle; they demand responses that resemble a ritual repeated more than a technique, as we learn how to rise to the occasion

Such events are tinged with the sacred. Sacred occasions or holy days are set apart from other days. On such days, the ordinary canons of mastery and control do not work. "Take off your shoes: you are on holy ground." You are on turf where you are not in charge. Karl Barth once distinguished workdays from holidays by observing that on workdays we make things happen, whereas on holidays we let things happen. The letting-things-happen of the holiday is not a state of mere passivity, however. By "taking in" the sacred occasion — the puberty rite, the marriage, the public gathering, the day of atonement, the Good Friday service — we let the occasion, in a sense, do the work, as it defines us.

Serious illness and death (and other defining events in life) often

resemble the holiday: They call for decorous response rather than control. And that response in turn calls for an important set of virtues, the first of which is patience.

The dying patient needs patience, but this virtue differs from the buffeted passivity of being a patient — triply passive to the ravages of the disease, the ministrations of the experts, and the regimen of the treatment. Patience calls for a purposeful willing and waiting in the

course of letting be and letting go. As such, the virtue contrasts not only with the obvious passivity of the patient but also with the frantic busyness and the driven agendas of those who hover



about the patients projecting the illusion of activity and control.

Such patience resembles the virtue of courage with its more active mode of attack. Active courage takes on evils and confounds them. We look for that kind of courage in the soldier, in the physician, and in ourselves when dealing with problems that can be solved. But before the insoluble, we need the more "passive" variety of courage that Thomas Aquinas identified as endurance or perseverance. Such perseverance does not mean that the person will outlast the trouble. Sooner or later, she must die. But, armed with courage, she can die without being thrown into panic and scattered by her trouble. She can endure. That is courage, not on the battlefield, but in bed.



Dr. May is the Cary M. Maguire professor of ethics at Southern Methodist University in Dallas. This article is excerpted with permission from *Testing the Medical Covenant: Active Euthanasia and Health Care Reform* (Wm. B Eerdmans Publishing Co.).

The Park Ridge Center

Bulletin

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September/October 1997

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