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GUEST COMMENTARY

BIOETHICS AND THE FUNDAMENTALIST AGENDA

ROBERT D. ORR, MD, CM

Some time ago I was invited by a professor of bioethics to serve on a panel she was putting together for Bioethics Summer Camp, a meeting of about 75 individuals involved in bioethics to relax and talk shop. The title of this panel was "Bioethics and the Fundamentalist Agenda." She proposed this topic because she had noted a number of "ethics websites" that presented a generally conservative approach to current bioethical issues based on religious presuppositions. She already had three panelists in addition to herself, and asked that I serve as a fifth because I had published material in professional journals indicating I was a person of faith; she had been unable to identify other Summer Camp attendees with strong religious beliefs. Knowing that the professional bioethics community is predominantly liberal and secular, with some clearly anti-religious sentiment, I was reluctant. However, my curiosity trumped my apprehension, so I agreed.

One panelist had developed a questionnaire to be sent to everyone registered for Summer Camp to elicit their views on fundamentalism. The survey listed multiple attributes, and asked respondents to indicate the degree to which they thought fundamentalists demonstrated each (always, usually, sometimes, never). There were a few demographic questions including "How do your own religious beliefs align with how you teach about bioethics? (a) I have no religious beliefs, (b) my religious beliefs do not color what I teach, (c) my religious beliefs color what I teach somewhat, or (d) my religious beliefs closely shape what I teach."

During a conference call, the five panelists agreed to spend five minutes each discussing the following:

- the reason for the panel, including a list of religiously-based ethics websites, and a working definition of fundamentalist (moderator)
- the results of the questionnaire
- the fundamentalist agenda and clinical practice
- the fundamentalist agenda and public policy
- the history and future of the religious voice in bioethics (Orr).

I suggested that when we began the small group discussion, in addition to asking each participant to give the standard name and institutional affiliation, we also ask them to consider including a sentence or two about their own faith pilgrimage.

There were five small group sessions scheduled during each 90-minute time-slot. Over 30 of the 75 bioethicists came to our panel suggesting significant interest in the topic. As we went around the room with introductions, it became clear that the three most common self-descriptions of faith for these professional bioethicists was #1 “agnostic”, #2 “lapsed ...”, and #3 atheist. Almost all of the “lapsed” had been raised in a Christian denomination, a few in the Jewish faith, and several indicated they were now agnostic or atheist. Only a few indicated current adherence to a faith tradition.

The moderator gave a working definition of fundamentalist to guide the discussion: “one whose literal interpretation of religious texts or doctrines affects or determines that person’s choices and actions,” i.e., it might include Christian, Jewish, or Islamic fundamentalists. She also described the results of a web search for sites that advocated a religious influence on education, clinical care, or public policy. Most of the sites that came up in her search came from a conservative Christian perspective; only a few were Jewish and Islamic.

The surveyor briefly discussed his results which he clearly identified as informal and unscientific. The respondents (from the list of all Summer Camp registrants, not necessarily those attending the panel discussion) generally felt that fundamentalists were self-assured, committed, principled, and both religiously and politically conservative, with a strong moral purpose, traditional gender expectations, and low tolerance for moral ambiguity. They were also characterized as generally suspicious of scientific progress, lacking in intellectual rigor, culturally intolerant, homophobic, and not very compassionate. About half of the respondents indicated either their religious beliefs did not color their teaching or that they had no religious beliefs; the other half said their religious beliefs colored their teaching only somewhat.

The panelist addressing the fundamentalist agenda and clinical practice focused on the growing lack of access to women’s reproductive services in small communities following the merger of Roman Catholic and community hospitals. She suggested that healthcare institutions accepting federal funds should be required to offer the full range of services, even those contrary to the moral heritage of the institution.

The panelist addressing the fundamentalist agenda and public policy briefly mentioned legislative and judicial activities vis-à-vis assisted suicide, employment discrimination, status of the fetus, brain death, child immunization, surrogate decision-making, and fetal homicide. There was no specific discussion of the influence of religious bodies in these areas.

In my five minutes, I identified myself as a conservative Christian, and said my view of life and the cosmos influences my practice and my teaching. I stated that my understanding of Holy Scripture gives me a commitment to service, especially to the underserved and disabled, and also gives me moral reservations about abortion, euthanasia, embryonic stem cell research, capital punishment, and war. I pointed out that the survey results say more about those surveyed than about “fundamentalists” themselves. I recalled the prominence of religious voices in the early days of the modern bioethics movement, listing many of the pioneers in bioethics who had come from a theological base.¹ I mentioned a dozen or so

currently active bioethicists who I know personally to be individuals of deep faith, most of whom are not active in professional bioethics organizations. Their publications in secular journals rarely, if ever, mention matters of faith, though some are occasionally willing to do so. Most often their allusions to religious belief are ignored, sometimes they are openly ridiculed.

I concluded by asking whether the relative absence of the religious voice in contemporary bioethics discussions and the proliferation of religiously-based websites in bioethics was a result of (a) exclusion on the part of the professional community, or (b) avoidance on the part of those who feel marginalized.²

During the remaining hour of discussion, there was great interest, both brief and prolonged commentary, and brisk interchange, all in a very civil tone. Concern was expressed about the fundamentalist voice having a disproportionate influence in public policy, i.e., “the fundamentalists are trying to force their beliefs on everyone.” When I pointed out that this accusation was very similar to the earlier suggestion that community hospitals resulting from the merger of Catholic and secular antecedents “should be forced” to provide abortion services, there was a moment of silence, then a retort that I was using faulty logic.

By the end of the 90-minute panel, it was clear that we had only begun to explore the issues. Several mentioned that the conversation should continue at subsequent professional bioethics meetings.

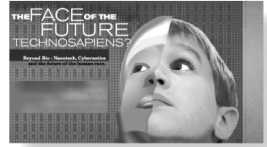
The good news: The US professional bioethics community recognizes there are people of faith who are concerned about bioethical issues, but are outside the mainstream of the profession.

The bad news: Those “fundamentalist” bioethics individuals and centers are speaking primarily to themselves and to each other rather than engaging in public discourse.

The future (?): Either more religiously-based bioethics professionals should join secular bioethics societies, attend professional meetings, present quality papers, and publish in secular journals, or the few of us who have been trying to do this should also retreat and join in the marginalized minority camp. Which of these sounds like the appropriate response to the admonition of Jesus: “You are the salt of the earth. But if the salt loses its saltiness, how can it be made salty again? It is no longer good for anything, except to be thrown out and trampled by men.” (Matt. 5:13, NIV) **E&M**

1 Verhey A, Lammers SE. *Theological Voices in Medical Ethics*. Grand Rapids, MI: Eerdmans, 1993.

2 Lammers SE. “The marginalization of religious voices in bioethics.” Chapter 2 in *Religion in Medical Ethics: Looking Back; Looking Forward*. Verhey A, ed.; Grand Rapids, MI: Eerdmans, 1996.



THE FACE OF THE FUTURE: Technosapiens?

A DIALOGUE ABOUT BIO-NANOTECH, CYBERNETICS AND THE FUTURE OF THE HUMAN RACE.



DISK ONE	INTRODUCTION CHRISTOPHER HOOK (#1) CHRISTINE PETERSON (#1)
DISK TWO	BEN MITCHELL WYRE SENTENTIA RICHARD HAYES
DISK THREE	WILLIAM HURLBUT CHRISTOPHER HOOK (#2)
DISK FOUR	CHRISTINE PETERSON (#2) WILLIAM CHESHIRE DIANE BEESON PANEL DISCUSSION (PT. 1)
DISK FIVE	PANEL DISCUSSION (PT. 2)

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“THE LEAST OF THESE”: A CHRISTIAN MORAL APPRAISAL OF VITAL ORGAN PROCUREMENT FROM “BRAIN-DEAD” PATIENTS

STEPHEN N. NELSON, MD, FAAP

A person is dead when his or her brain is dead.

E.F.M. Wijdicks¹

People have enough common sense to see that a brain dead person is not really dead.

Peter Singer²

Western society seems to be rapidly approaching a stage where the moment of death will be determined not so much by objective bodily changes as by the philosophy of personhood of those in charge.

D.A. Shewman³

Introduction

Historically, controversy has surrounded human dissection because of the potential for exploitation and objectification of the body. In traditional society, death was established by pulselessness, apnea, and coma. Although human cadaveric dissection was legalized in the nineteenth century, contemporary society would have considered the removal of organs by sharp instruments from a person with a beating heart an unspeakably evil abomination.⁴ Subsequently, medical advancement, the concept of “brain death,” and changes in the law (notably the Uniform Anatomic Gift Act and the National Organ Transplantation Act) have largely overcome the historical aversion to human dissection and organ procurement, such that organ donation (“the gift of life”) is firmly entrenched in western society as a virtuous act of communitarian altruism.

Christian defense of the human embryo, the fetus, the cognitively impaired, the terminally ill and the aged against utilitarian assault and destruction presently addresses the philosophical interpretation of “personhood,” or, “what it means to be one of us,” informed primarily by a particular Christian worldview.^{5, 6, 7, 8} Additionally, a critically related philosophical concept concerns the implications of our understanding of “death,” (viz., “What distinguishes the

living from the dead?”), since our obligations to the dead differ in significant ways from our obligations to the living.⁹ Against this backdrop of the Christian understandings of “death” and “personhood,” the morality of vital organ procurement for transplantation from “brain-dead” patients remains largely unexamined in the Christian ethics literature.¹⁰ If it could be determined from the prevailing pro-life Christian worldview and empirical evidence that a “brain-dead” patient is a *person* who is not *dead*, it would follow that there would be no morally relevant difference between such a patient and any other vulnerable human being. If the intentional taking of innocent human life is immoral in the Christian worldview, thereby rendering embryo stem cell research, abortion, physician assisted suicide (PAS) and other forms of euthanasia immoral, then procurement of vital organs from “brain-dead,” biologically alive persons would be equivalently immoral. In each case, this immorality necessarily extends to proximate participation, including consenting for the procedure, counseling in favor of the procedure, or deriving benefit from the procedure. The implications of this position, if argued successfully, would be noteworthy given Western society’s warm embrace of organ donation.

In this paper, I will argue that because removal of vital organs (including the heart and lungs) from living patients kills them (in that the procedure, by definition, results in death as traditionally understood, viz., the permanent cessation of cardiorespiratory function), procurement of vital organs for the purpose of transplantation from “brain-dead” patients who are biologically alive constitutes intentional killing of innocents for utilitarian purposes (euthanasia). Furthermore, I will argue by analogy that like the human embryo, the human fetus, the cognitively impaired, the terminally ill and the aged, the “brain dead,” biologically alive human being, by virtue of biological taxonomy, reflects the image of God and thus must be considered a “person,” without relevant moral distinction, and with the entitled right not to be harmed unjustly. Therefore, proximate participation in the organ procurement procedure in the “brain-dead,” biologically alive patient in any manner is immoral.

A Brief History of the Determination of Death

When is a human being dead? The ability to distinguish living human beings from dead human beings has important medical, legal, social, religious, metaphysical, and metaphorical implications. After all, the dead are suitable for burial and the living are not.¹¹ To begin to answer this question, the concept of clinical death must be examined at three distinct levels:^{12, 13} (1) the *definition* of death (2) the operational, medical *criteria* for determining that death has, in fact, occurred (or, has the definition been met?) and (3) medical *tests* to determine that the criteria have been fulfilled. It is important to note that these conceptual levels are *not* conterminous; however, ideally the tests must fulfill the criteria and the criteria, in turn, must satisfy the definition.¹⁴

The definition of death (i.e., the permanent, holistic dis-integration of the body’s vital functions, and the distinction between the living and the dead), ought to be straightforward, since life and death are *prima facie* mutually exclusive.¹⁵ However, because death in a non-legal sense is a process rather than an event,¹⁶ the criteria by which the definition is satisfied (i.e., *under what*

circumstances is the dis-integration complete) are philosophically informed, worldview dependent,¹⁷ and context dependent.¹⁸

DeVita, in a succinct review, notes that the determination of death has posed longstanding difficulties.¹⁹ Historically, lurid tales of burial of the living mistakenly thought to be dead has placed great emphasis on certainty in the determination of death. Absent respiration indicative of death was occasionally more apparent than real. Even putrefaction²⁰ as a certain sign of death was discredited because of its similarity to gangrene.²¹

Certain evidence that death has occurred by way of the passage of time (the “death watch”) was largely supplanted by cardiac criteria with the invention of the stethoscope.²² However, by the mid-twentieth century, technological advances gave physicians the increasingly frequent capability to reverse the cardiorespiratory signs of death, albeit on occasion at the expense of devastating neurological injury and permanent, irreversible unconsciousness.²³ In 1959, Mollaret and Goulon reported cases of *coma dépassé* (“beyond coma”) characterized by absent brain stem reflexes, apnea, and flat EEG.²⁴

In 1968, the report²⁵ of The Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death defined “irreversible coma” as absence of responsiveness, movement, and brain stem reflexes (including breathing) with a determined cause²⁶; it was the Committee’s intent to establish this new neurological criterion (“brain death”) as a proxy for clinical death.^{27, 28} In doing so, the Committee made two astonishing assertions, viz., that (1) death is a social construct, and (2) because physicians have traditionally diagnosed and declared death, it is within their purview to change the diagnostic criteria. The latter assertion was based on the Committee’s questionable interpretation of a contemporaneous legal definition of death.²⁹

Given society’s enduring traditional understanding of death, why was a new criterion for determining death needed at all? Clearly, a new criterion for death was not required on the basis of empirical data.³⁰ The Committee’s report was issued in 1968, at the dawn of successful human organ transplantation.³¹ As stipulated by the “dead donor” rule, patients cannot be killed to obtain vital organs for transplant; such organs must be procured only from dead bodies. However, successful transplantation requires viable organs, clearly a problem if cadavers are dis-integrating by definition.³² Thus, without broadening the criteria for the determination of death, the great need for viable transplantable organs would remain unmet by the limited supply of potential donors. Commentators familiar with the behind-closed-doors workings of the Committee have suggested that the new neurological criterion was largely proposed for the strictly utilitarian purpose of increasing the supply of transplantable organs.^{33, 34, 35, 36} In fact, Peter Singer has declared, “The brain death criterion of death is nothing other than a convenient fiction.”³⁷

Because of continued unease over the new neurological criterion, the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research revisited the issue.³⁸ The Commission proposed definitive guidelines of “brain death” as a model legal statute, The Uniform Determination of Death Act (UDDA).³⁹ This act has been either directly adopted or has informed similar legislation in all fifty states and the District of

Columbia.⁴⁰ The UDDA proposes criteria for the determination of death, viz., an individual is dead who has sustained “irreversible cessation” (as determined by “accepted medical standards”) of (1) circulatory and respiratory functions as established by the cardiorespiratory standard, i.e., the traditional tests that document cessation of cardiorespiratory function; OR (2) “all functions of the *entire* brain, including the brain stem”^{41, 42} (emphasis added), as established by the “whole brain” or neurological standard, i.e., testing that documents absent response to external stimuli, apnea, and absence of other brain stem functions, evidence of irreversibility, and the exclusion of confounding factors.^{43, 44} As a result, the definition of death (first conceptual level described above) can be met by either criterion (second conceptual level) if the chosen criterion is fulfilled by appropriate testing (third conceptual level).

Is the “Brain-Dead” Patient Really Dead?

Since its inception, “brain death,” as a utilitarian social construct to broaden the circumstances under which human organs legally can be procured for transplant, has been subjected to withering criticism from secular commentators.⁴⁵ That the definition of death, criteria for death, and testing to determine if death has occurred are not conterminous but are used (mistakenly) interchangeably is the root of the problem. Weaknesses of the neurological criterion for death include arbitrariness, the obvious fact that the “brain-dead” patient is not a corpse, the distinct possibility of misdiagnosis of the condition or misapplication of its criteria, and the grotesque implications that death can be determined on the basis of neurological dysfunction. As I shall argue next, these weaknesses so severely hobble the concept of “brain death” that its use as a proxy for death is precluded.

The Criterion Is Arbitrary

Even proponents of the whole brain standard admit that the neurological criterion for death and related testing are arbitrary.⁴⁶ This arbitrariness is magnified on a global scale in that guidelines for the neurological determination of death, particularly as regards the legal requirement of technical confirmatory tests, often varies from country to country.⁴⁷ For example, the United States standard is “whole brain death,” including brain stem, whereas the United Kingdom utilizes “brain stem death” as indicative of irreversible coma and as a proxy for clinical death in anticipation of organ procurement.^{48, 49, 50} The United States lacks internal consistency as well, in that special (and in some circumstances exclusionary) criteria must be considered before determination of brain death is rendered in pediatric patients.⁵¹

The arbitrariness of the neurological criterion for death is legally recognized in two states. Because some religious traditions (including some sects of Orthodox Judaism) reject the neurological criterion as a proxy for death, New York regulations require “reasonable accommodation” for those who have religious or moral objections.⁵² New Jersey takes a further step by prohibiting physicians from declaring brain death in patients whose religious traditions do not accept the concept.⁵³ On the basis of such legislation, one might ironically conclude that the distinction between the living and the dead is a simple matter

of geography.

Finally, that "brain death" can be clinically determined necessarily connotes previous "brain life" as well as "brain birth," notoriously difficult concepts.⁵⁴

The "Brain-Dead" Patient Is Not a Corpse

As Capron has observed, "the Ad Hoc Committee equated brain death with irreversible coma, itself a condition of (limited) life, not death."⁵⁵ The assertion by proponents of a neurological criterion for death that "brain-dead" patients will experience biological death in short order, Truog asserts, confuses prognosis with diagnosis.⁵⁶ Indeed, intensive technological support can maintain "brain-dead" patients for weeks after the diagnosis. For example, the literature documents a number of irreversibly brain damaged pregnant women (including those diagnosed as "brain dead") in whom physiological homeostasis was maintained to allow their fetuses to grow to viability.^{57, 58}

Historically, noncardiac signs of death over time included rigor mortis (temporary muscle rigidity), algor mortis (fall in body temperature) and livor mortis (discoloration of the skin).⁵⁹ "Brain-dead" patients do not "look" dead because they display none of these findings. In fact, "brain-dead" patients are very much biologically alive.^{60, 61} Except for unresponsiveness, these patients manifest no evidence of "dis-integration" characteristic of biological death. Integrated cellular and organ system function is maintained in the technologically supported "brain-dead" patient: circulation remains intact and the skin is warm and moist; respiration continues; digestive and renal systems function; hair and nail growth continues.^{62, 63}

As noted above, the UDDA and related legislation requires cessation of brain function in totality. However, several lines of evidence suggest that "brain-dead" patients often retain some degree of neurological function as well. First, most "brain-dead" patients manifest no evidence of diabetes insipidus, suggesting that neurohumeral function (appropriate secretion of arginine vasopressin) remains intact.⁶⁴ Second, although "brain death" can be determined only in the absence of hypothermia, the ability to maintain body temperature is one sign of intact neurologically mediated temperature regulation.^{65, 66} Finally, the disconcerting phenomenon of spontaneous body movements (the so-called "Lazarus sign"), tachycardia, and hypertension has been observed repeatedly in "brain-dead" patients undergoing organ procurement.^{67, 68} In fact, the recommendations by the Intensive Care Society (UK) to administer neuromuscular blocking agents and a volatile anesthetic to prevent muscle contraction and treat hypertension noted under these circumstances⁶⁹ have raised troubling questions for some.⁷⁰ Others suggest that these physiological responses suggest the *possibility of consciousness* at some level in the donor.⁷¹

As Truog has noted, no currently available clinical test other than autopsy can guarantee the certainty of complete brain destruction.⁷²

Brain Death Can Be Misdiagnosed

The critical elements of "brain death" are widely misunderstood and

inconsistently applied (either volitionally or as a result of ignorance) by critical care medical staff and those involved in organ procurement.^{73, 74, 75} Additionally, brain death may be confused with a variety of potentially confounding (and possibly reversible) conditions, including the “locked-in” syndrome, Guillian-Barré syndrome, hypothermia, and drugs and toxins (e.g., neuromuscular blocking agents and sedatives, some of which may not be detected by standard screening tests).⁷⁶

Brain Death’s Slippery Slope

Once the criteria for clinical death include neurological dysfunction, grotesque extrapolations have followed. Because a prominent feature of “brain death” is irreversible impairment of consciousness, some say that neurological criteria for death should be extended to include loss of “higher” brain function (e.g., cognition or sentience) alone.⁷⁷ This formulation begs the question, “How much cognitive ability must be lost for one to be considered dead?” and evokes images of patients with permanent vegetative state (PVS), and, by subsequent logical extension of the premise, others arbitrarily defined as cognitively impaired, classified as “dead.” Such “dead” patients would be not only candidates for organ donation but also candidates suitable for burial. Because burial of a breathing “dead” person is aesthetically unappealing, a “lethal injection” would be required prior to disposal of the “remains.”⁷⁸ Some^{79, 80} replace this horror with another, viz., as regards organ procurement, the definition of death is irrelevant; rather, organ procurement from those who are permanently and irreversibly unconscious (including anencephalic infants and patients in PVS) is a form of justified killing, and existing laws should be amended accordingly.

Interim Conclusion: The “Brain-Dead” Patient Is not Really Dead

As I have argued, several practical difficulties render the concept of “brain death” an unsuitable proxy for death. Furthermore, a strong argument can be made in favor of the presumption that a “brain-dead” patient is not dead but is in fact alive, limitations of the extent of that life notwithstanding. If “brain-dead” patients are alive, removal of vital organs (thereby bringing about the cessation of cardiorespiratory function) constitutes killing. However, there are many, including some Christians,⁸¹ who believe that killing is morally justified under certain circumstances. Innocent “persons” are morally and legally protected from unjustified killing. Therefore, if the personhood of “brain-dead” yet biologically alive patients is successfully called into question, the allegation of killing and the question of the morality of organ procurement would be rendered moot. Next I will turn to this important issue.

The “Brain-Dead” Patient as Person: Personhood and Death

Vautier has observed, “There is a sobering interconnection between definitions of death, the meaning of personhood, and the value of human life.”⁸² Legal importance attaches to this relationship as well, since the Constitution protects

“persons.”⁸³

Lizza⁸⁴ identifies three distinct formulations of “person” and discussed the relationship of each formulation to “death”:

- (1) The “substantive” meaning of “person” is the actual self or unique individual. In Lizza’s view, a necessary condition for a “person” in this sense is the capacity or potential for consciousness. Personhood is lost and personal death (as opposed to biological death) occurs if this capacity or potential is lost. Therefore, personal death in this formulation is distinct from biological death; both can literally occur.
- (2) The “qualitative” meaning of “person” is best conceptualized in terms of the Latin *persona*, viz., a mask or character in a drama. “Death” can only be applied metaphorically in this formulation. Thus, a patient in PVS, although not a “person” in the qualitative sense, cannot be considered “dead” in a literal sense. In this formulation, “personal” death is only metaphorical; biological death is literal.
- (3) The “species” meaning of “person” suggests that membership in *Homo sapiens* confers personhood. The life history of the human organism is identical to that of the human person. Because biological taxonomy remains unchanged after death,⁸⁵ personhood extends beyond biological death. Thus, we speak of “dead persons” to whom (in the Judeo-Christian tradition) we have certain obligations. This formulation of personhood is the context in which contemporary pro-life Christians argue in defense of vulnerable human beings. It is this context I will consider next.

Biological Humankind and Personhood

Nigel Cameron writes, “Man the biological entity and man the creature must be one. The image (of God), with all that implies, must be present wherever this *species* is to be found”⁸⁶ (emphasis added), and speaks of the “radical indivisibility of human dignity”⁸⁷ as well as the concept of humankind without margins.⁸⁸ For Christians, it is the creation of man in God’s image (*imago Dei*, Gen 1:26-27 and Gen 9:5-6) that is the source of the sanctity, dignity, and inestimable moral value of every human life.

The pro-life Christian worldview holds that personhood is grounded in biological considerations⁸⁹ in that the human genotype implies moral status and biological humankind implies personhood.⁹⁰

Because the *imago Dei* is a biological attribute, it inheres in human beings from the moment of conception, as suggested by the doctrine of the Incarnation.⁹¹ As such, although the image is reflected in different human beings to varying degrees, it is nonetheless present in all who are biologically human.

It follows that functional capabilities are irrelevant to human personhood. Every human being, regardless of capabilities, is a person who has a moral claim

to neighbor love. This neighbor love precludes the use of human beings as means to others' ends.⁹² William Cheshire writes, "Human dignity is . . . the exalted moral status which every being of human origin uniquely possesses . . . intrinsic to the human substance and not contingent upon any functional capacities which vary in degree."⁹³ Similarly, Rae and Cox note, "the entire project of defining personhood in functional terms fails because . . . a thing is what it is, not what it does."⁹⁴ These viewpoints reflect the Aristotelian and Thomist metaphysical notion that human persons are substance things rather than property things. Humans, as substance things, possess an internal ordering principle or ontological identity that is maintained despite change and independent of function. A concept of personhood founded on a spectrum of functional capabilities would necessarily suggest a corresponding spectrum of granted rights; and, what can be granted can be taken away. For example, if personhood were founded on degrees of sentience, sleeping persons or patients under general anesthesia would be non-persons. Likewise, the personhood of the patient dependent on life-sustaining medical technology remains intact; otherwise, a patient with a pacemaker⁹⁵ or the diabetic whose life depends on regular injections of insulin would not qualify.

The Christian doctrine of the resurrection of the body (John 26-29; 1 Cor 15:42-44; 2 Cor 5:1-5) is incompatible with not only the dualism of Plato and Descartes in which the body is likened to a disposable piece of machinery⁹⁶ but also a higher brain formulation of personhood that trivializes the moral significance of the body. Judeo-Christian scripture (especially Gen 2:7) and Aristotelian tradition, asserts Vautier,⁹⁷ affirms the human being as a single entity having both a material body and an immaterial soul. Jones writes, "The Christian doctrine of the soul is not dualistic but requires one to believe that where there is a living human individual, there is a spiritual soul."⁹⁸ Cahill adds,

In overview, Western authors writing today . . . are almost unanimously inclined to see dualism as bad and integration as a value, and to affirm that the body's contribution to selfhood is not only essential but is a component of the highest levels of human value and accomplishment such as love, friendship, moral insight, and art.⁹⁹

Defining personhood in terms of cognition artificially separates mind and body.¹⁰⁰

"Brain-dead" patients, as a unity of mind *and* body (in spite of functional limitations), retain their biological taxonomy as *Homo sapiens*. All members of *Homo sapiens* reflect the *imago Dei*. The *imago Dei* confers the sanctity, dignity, and moral worth of human personhood. Therefore, (1) "brain-dead" patients are no less "persons" in the Christian worldview than are human embryos, human fetuses, the cognitively impaired, the aged, or the terminally ill, and (2) no morally relevant difference exists among these vulnerable human beings.

Conclusion: The "Brain-Dead" Patient Is Alive and Is a Person

The pro-life Christian embraces a concept of personhood based on the image of

God borne by all members of the human species, independent of function or change, which reflects the fundamental unity of mind and body. Therefore, in order to remain theologically and philosophically consistent, the pro-life Christian must consider the “brain-dead” patient to be a person, not morally different in a relevant way from other innocent human persons. It follows that the “brain-dead” person ought to be entitled to the rights afforded to any other innocent human person, including the right not to be killed unjustly. The rights of one person create duties in others. Since the “brain-dead” person is alive, as argued above, procurement of vital organs for transplantation (culminating in intentional, iatrogenically mediated cardiac arrest prior to the procurement of the heart) is immoral because (1) it violates the principles of *primum non nocere* and beneficence (2) it violates the covenantal,¹⁰¹ fiduciary relationship between the Christian Hippocratic physician and patient that is characterized by fidelity, steadfastness, a high regard for the patient’s best interests, and charitable justice informed by mercy¹⁰² (3) it unjustly constitutes a utilitarian depersonalization in which a human person is used merely as a means to another’s end (4) by deliberately bringing about permanent cessation of cardiorespiratory function, it constitutes killing of an innocent human person (i.e., overt euthanasia, in view of its utilitarian nature) (5) it violates the autonomy of the patient in that, as euthanasia, truly informed consent for vital organ procurement after a declaration of brain death *a priori* is impossible to give and impossible to obtain.¹⁰³

Recapitulation and Reflections

Literary critic and scholar Harold Bloom has written

One mark of an originality that can win canonical status [authoritative in our culture] for a literary work is a strangeness that we can either never altogether assimilate, or that becomes such a given that we are *blinded to its idiosyncrasies* [italics added].¹⁰⁴

The construct of brain death bears similarity to literary canon as articulated by Bloom: it is clearly authoritative in our culture, a *given*, despite an idiosyncratic strangeness that we have chosen to ignore. Brain death has become medico-legal canon.

However, we risk arrogating to ourselves an omniscient moral certitude in declaring “brain-dead” patients either dead or non-persons if either is not the case. When in moral doubt, we must assume personhood entitlement to neighbor love in every human being that we encounter until it can be proven otherwise.¹⁰⁵

In this paper, on the basis of contemporary pro-life Christian arguments as well as empirical data, I have attempted to demonstrate that “brain-dead” patients are living persons who, though limited in function and with guarded prognoses, are vulnerable human beings entitled to the rights afforded to any other human being, vulnerable or not. Therefore, I conclude that vital organ procurement for utilitarian purposes from “brain-dead” patients constitutes euthanasia, and as such, is immoral. All proximate actions, including counseling in support of the procedure, consenting to the procedure, performing the procedure, or benefiting

from the procedure must be categorically rejected in order for the pro-life Christian who argues from a Christian worldview concept of personhood to be consistent.

Obviously, because organ donation is legally sanctioned, strongly encouraged, and socially laudatory by most in this country, many will not agree with this position. However, lest this position be considered “the pro-life Christian position run amok,” we would do well to consider that the Christian stance places us at odds with secular society on a variety of related fronts: consider abortion and PAS, for example. Each of us must prayerfully examine individual conscience when we confront the issue of organ procurement from “brain-dead” patients. As the individual Christian considers whether or not to give personal or proxy consent for organ donation, ought the desire for perceived altruism win the day? Does the Christian physician who counsels in favor of vital organ donation in cases of “brain death” act ethically? What responsibility is borne in the death of the “brain-dead” patient by the well meaning Christian surgeon who wields the scalpel? Should a dying Christian accept the gift of an organ procured from a “brain-dead” patient? Clearly, the arguments explored in this paper offer hard answers to these difficult questions. We must reject organ procurement from “brain-dead” patients as surely as we reject embryonic stem cell research, use of fetal tissue derived from abortion, PAS, and euthanasia of the ill and disabled. If we do not, we risk losing philosophical consistency and credible witness.

Perhaps this ethic will embolden us to look elsewhere for moral alternatives to the current practice. Although organ donation by “asystolic donors” is problematic on pragmatic¹⁰⁶ and moral grounds,¹⁰⁷ bionics or genetically engineered xenografts may hold promise. Perhaps, against the backdrop of our society’s quest for immortality, this ethic will embolden us to recall that even in our own dying, we must not use others as means to our ends, even with their consent: after all, there are some things worse than death. Perhaps this ethic will cause us to reflect on the truth that as Christian believers, death is not personal annihilation.

Whatever direction we are led, we must remember that the stakes are high. The answer to our question, “Lord, when did we see you . . .?” was, “I tell you the truth, whatever you did not do for one of the least of these, you did not do for me.” **E&M**

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THE OVERLOOKED TEST

WILLIAM P. CHESHIRE, MD

With swift short steps, each one an inch—no more,
No less—crept Mary's withered rigid frame.
Her arms swung not, and as she neared the door,
She paused...then, shuffling, through the entry came.

"Please have a seat," said the neurologist.
"Let's have a scientific look at why
Your trembling fingers oscillate at rest,
Your decremental writing cramps awry."

With reflex hammer, tuning fork and pin,
The doctor tested cranial nerves and strength,
Coordination, plantar signs, and then
Precisely marked and measured each stride's length.

He quantified cogwheel rigidity
And mapped her sensory anatomy,
Then gauged her postural stability
And analyzed her physiognomy.

He raised his brow, then closed his bag and spoke:
" 'Tis insufficient dopamine release
From your substantia nigra (not a stroke).
The diagnosis: Parkinson's disease."

Time stopped. Although the world to Mary froze,
Her thoughts still racing weighed what this might mean.
She thanked the doctor and did not disclose
Strong feelings welling up, her tear unseen.

Reaching for hope she turned from her appall.
"But Sir," she mentioned hesitatingly,
"You've skipped the most important test of all:
The one that shows the part within called *me*."

Convinced the doctor's final word was much
Too limited an explanation for
Her lonely ache within where none can touch,
She challenged him these questions to explore:

"Does individuality reduce
To neural dendrites' cytoplasmic flux?
Can medical analysis deduce
From lacrimation's flow my sorrow's crux?"

Observe cerebral gyri as you will,
Love's memories, life's pains—no ink can draw.
What synapse has the wisdom to distill
Compassion, purpose, wonder, joy, or awe?

What have the basal ganglia to say?
What reason can a squiggly gyrus give,
That I should not let illness have its way?
Today I'll not give up. I choose to live!"

The doctor nodded quite approvingly,
And patting Mary on the back remarked,
"My dear, you pass that test abundantly.
Your courage indicates a special heart."

Mere functional capacities aside,
Test measurements, though accurate, ignore
The essence of the person deep inside,
For science ne'er can grasp the vital core.

Truly the test that science fails to see
Is satisfied by all humanity.
Though worn and weary from infirmity,
All people have immeasurable dignity.

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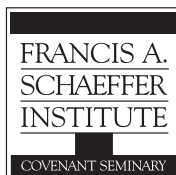
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ETHICAL CONCERNS OF AMERICAN EVANGELICAL CHRISTIANS RELATIVE TO GENETIC INTERVENTIONS AND THE HUMAN GENOME PROJECT, 1974 TO THE PRESENT

JOHN JEFFERSON DAVIS, PHD

The purpose of this brief study is to identify, on the basis of a review of the published periodical literature, the major ethical concerns of Evangelical Protestants in the United States regarding genetic research and the Human Genome Project, from 1974 to the present.¹ It is hoped that the results of this research can assist scientific researchers in the communication and interpretation of the implications of genetic research to the Evangelical Protestant and other religious communities. Better communication is needed, in that many members of religious communities are not adequately informed concerning the nature and significance of genetic research, and some research scientists may not be well informed concerning the nature and strength of the ethical concerns and fears of religious communities.

Evangelical Protestants, the target group in this study, currently represent at least 20 million Americans, based on stated beliefs and practices.¹ Sociological studies have found that Evangelicals are more likely than other religious groups to vote in elections, lobby political officials, and educate themselves about political and social issues.² While this study is focused on the Evangelical Protestant community in the United States, its significance is not limited to this population. Prior sociological studies have shown that attitudes and ethical concerns of Evangelicals are shared in significant degrees with Orthodox Jews, Muslims, Mormons, and traditional Roman Catholics.

For the purposes of this study, the term "Evangelical" is understood to refer to a trans-denominational religious subculture of theologically conservative Protestant Christians found in denominations including, but not limited to, Baptist, Methodist, Presbyterian, Congregational, Lutheran, Episcopalian, Mennonite, Independent, Holiness, and Pentecostal; and which are characterized by (1) a high regard for the authority of the Bible; (2) belief in the deity of Christ and other historical Christian doctrines; (3) an emphasis on individual religious conversion experiences; and (4) concern for the practices of evangelism and missionary activity.³

Citations in the periodical literature in Evangelical publications during the period in question were located through the use of the American Theological Library Association's comprehensive *Religion Database on CD-ROM*. This paper will report on the range of ethical concerns identified, and reflect on the

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significance of the four most frequent of these concerns. Finally, it will give suggestions for researchers and teachers to communicate genetic discoveries to Evangelical and other faith-based communities in ways that can maintain public support and understanding for ongoing work in this area.

The Major Ethical Concerns

In a recent editorial in *Ethics & Medicine* Nigel M. de S. Cameron (2002:3) exemplified the recognition by evangelical scholars of the significance of the emerging genetic technologies when he stated that the “...most challenging questions faced by our civilization in the 21st century will lie just here, in the unfolding biotechnology agenda.” Nothing will “...matter more for the future of the planet,” he stated, and especially for its human inhabitants.

The earliest citation identified in the literature searched was the 1974 article by Harold Kuhn, “Wesleyanism and Genetic Engineering,” published at a time when concerns were beginning to surface in the general public relative to recombinant DNA research.⁴ Some sixteen different types of ethical concerns were identified in the period 1974–present:

- the possibility of discrimination against racial and ethnic groups
- issues of confidentiality and privacy
- impact on the gene pool and/or biodiversity
- political tyranny and “Brave New World” scenarios; procreative rights
- issues of reductionism and human dignity
- impact on family values and parent-child relations
- questions of “Are we wise enough” to manage genetic technologies
- scientific hubris
- threats to the balance of nature
- the safety of recombinant DNA technology
- genetic engineering as an expression of “Playing God”
- concerns relating to abortion and the sanctity of life
- the possible military abuses of genetic technologies
- the possible dangers of germline interventions

The four most frequently mentioned concerns—“family values” (16 citations), “political tyranny” (18), “sanctify of life” and abortion (37), and “reductionism” (38)—will be studied in more focused analysis below.

“Family Values”

Concerns for “family values” or adverse impact upon the parent-child relationship were cited by 16 authors. Faye Angus (1981:27) wondered if new reproductive technologies would weaken the already shaky traditional family.

Allen Verhey (1985:136-37) worried that the possibility of selecting genetically “perfect” children could “drive joy out of parenting and compassion out of children” and promote societal choices for either “a perfect child or a dead child.” Therese Lysaught (1994:342) was concerned that in a society dominated by utilitarian, bottom-line thinking, parents would be less willing to provide financial support for handicapped children and their parents when children are seen as “products” of choice and not chance. Steven Hoogerwerf (1997:104) believed that the new genetic medicine would inevitably shape the way we see and value people, and that it raised the danger of undercutting the unconditional love and acceptance that parents might otherwise have for special-needs children.

Sondra Wheeler (1999:14) was concerned that the new genetic technologies, “that make a child so decisively the project of its parents’ will,” could further weaken the parent-child bond. David Gushee (2002:16) stated that reproductive cloning could represent “an act of despotism that perverts parenthood by turning children into genetically engineered possessions intended to fulfill parental wants.” These concerns for family and parental issues, reflecting a worry that genetic technologies would reshape the ways in which parents perceive their children, were not unrelated to the issues of “reductionism” and the “commodification” of human beings that will be examined below.

Political Tyranny: “Brave New World” Scenarios

Concerns for the possible political misuse of genetic technologies were cited by 18 authors. This set of concerns invoked the specter of “1984” or “Brave New World” scenarios in which scientific elites could manipulate their expertise to the detriment of the general public. Harold B. Kuhn (1974:39) worried that government-mandated programs of genetic testing or screening could be made compulsory for certain ethnic groups and exert dehumanizing influences upon their members. Carl Henry (1975:50) wondered if the new genetic knowledge could produce “an elite cadre, set apart from the masses.” Faye Angus (1981:29) recalled the Nazi era and Auschwitz, in which the “political control of scientific technology has etched its horror across history.” Granberg-Michaelson (1983:22) stated that any ability of genetic engineering to reshape human mental and psychological function could unleash the power for elites to remold society to fit the norms of its rulers. Economic divisions would be reinforced, and a new basis for social discrimination could be established, “based no longer on race or class, but on genetic composition.” Jeremy Rifkin (1983:18) asked, “In whom shall we entrust the authority to decide which are the good genes?” According to Rifkin, Aldous Huxley’s vision of a biologically designed caste system “...with its alphas, betas, gammas, and deltas loomed on the horizon.”

Therese Lysaught (1994:344) expressed concern that in a fragmented culture it seems increasingly difficult to engage in moral discourse, “technological fixes” could become the remedy for social problems. Technology was not neutral, but inherently raised issues of social power and control—“power over those deemed ‘defective,’ power over our children, power over ourselves, power over nature.”

Scorgie and Jones (1997:667), citing C.S. Lewis and *The Abolition of Man*, argued that the general public has little control over the emerging technologies

such as cloning that could reshape human society. It is the “gatekeepers, the technological elite” that understand and control these new technologies, “with only minimal accountability to the general public.”

Sanctity of Life and Abortion

Concerns relating to the *sanctity of life* and abortion were raised in 37 of the citations. Allen Verhey (1985:131) found morally problematic the practice of “fertilizing ova *in vitro*, using the embryos for experiments, and then destroying them before fourteen days,” a permission recommended by the Ethics Advisory Board in a report of 1979. Fay Angus (1981:27), commenting on amniocentesis and other forms of prenatal screening of possibly “substandard” embryos, noted that such practices could further complicate “the already explosive issue of abortion.... Abortion for reasons of depression or gender might be next.”

A different note was struck by Lewis Bird in an article addressing biomedical ethics and gene-splicing. Bird challenged the notion that science, just because it describes phenomena in terms of mechanisms, must inherently be dehumanizing and depersonalizing. “One can celebrate the principle of the sanctity of life as joyfully in the laboratory as in the sanctuary,” insofar as such research reflected attitudes of respect and care (Bird 1989:79).

Scorgie and Jones (1997:666), writing in the wake of the successful cloning of the sheep “Dolly,” noted that those who are convinced that human life begins at the moment of fertilization will have moral objections to human cloning experiments that inevitably would involve many casualties along the way. “True humanness,” they believed, “builds on a recognition of the sanctity, the sacredness, of human life in all its forms and stages” (672).

The controversy regarding cloning and stem cell research in the late 1990s provoked widespread comment. John Kilner (1997:10), troubled by the prospect of “therapeutic” cloning that involved the destruction of human embryos, and writing from a Kantian, deontological ethical standpoint, stated that human beings, “made in the image of God, are not merely *means* for other persons’ benefit.”

In an unsigned editorial of June 12, 2000, *Christianity Today* characterized the discarding of human embryos as “the callous destruction of human life,” and stated that the harvesting of human stem cells “repeats the logic of fascist Germany” (12 June 2000:33). In a later editorial on the same subject, published in May of 2002, *Christianity Today* argued that human cloning research violates the principle of informed consent for experimental subjects, and stated that cloning proponents had offered no assurances that reasonable limits would be enacted to prevent “clone farms, designer children, or eugenics” (21 May 2002:36).

Linda Bevington, writing for The Center for Bioethics and Human Dignity, an evangelical institute near Chicago, stated that embryonic human life, made in the image of God “exists primarily for God’s own pleasure and purpose, not ours” (Bevington 2002). For David Gushee (2002:15) therapeutic cloning was morally odious not only because it involved the intentional destruction of human life, but also because it could surreptitiously lead to reproductive cloning.

Reductionism and the Dignity of Man

The most frequently mentioned ethical concern, cited by some 38 authors, was the issue of *reductionism* or the “dignity of man.” In the minds of many Evangelical scholars the new genetic technologies raised profound and troubling questions about the very basis of human self-understanding and humanity’s special status in the scheme of things. Nancy McCann (1977:26) feared that the new perspectives could reduce human life to “matter alone,” to mere “objects of scientific experimentation.” Paul Schimmel (1978:16) worried that if wrongly understood, genetic engineering could take the mystery out of life and shift thinking about man from the “metaphysical to the physical.” In a similar vein, an editor of *Christianity Today* (19 January 1979:12) wondered, “Will our belief in a spiritual and transcendent reality be shattered with the advent of human engineering?”

The activist Jeremy Rifkin, writing in *Sojourners* (1980:10) raised the question, “Do we want to engineer life in our image rather than maintain it in God’s image?” This question was related to the frequently voiced language of “Playing God.” Three years later Rifkin (1983:16) asked, “When does a repaired or manufactured man stop being a man—and become a robot, an object, an industrial product.... Once we begin the process of human genetic engineering, where is the logical place to stop?” Rifkin feared that human genetic engineering represented a perilous “slippery slope” with no clear stopping points in sight.

Ray Bohlin (1981:19), responding to the perceived genetic determinism of Edward O. Wilson’s *Sociobiology: The New Synthesis* (1975), asked the question, “Can we explain the whole person simply by reducing him to an interaction of heredity and environment.... To reduce our kind to mere molecules is to strip away our humanness.” Such a genetic reductionism would, in Bohlin’s view, deny man’s spiritual nature and erode the moral categories of responsibility and guilt.

Wes Granberg-Michaelson raised concerns about the “commodification” of humanity (1983:18). Life would be further commercialized by understanding it primarily or essentially in terms of its material characteristics. The “vital, sacred, and reverential” qualities of life could evaporate, and the human person could come to be viewed simply as a vast “pool” of genetic material to be manipulated for economic gain.

In their discussions of human cloning Scorgie and Jones (1997:668, 679) expressed concern that in a worst-case scenario “...clones could become marketed by cloning services, function as organ warehouses, or a new slave class,” being subject to insidious strategies of quality control. Human beings could be reduced in the general cultural consciousness to “mere manufactured commodities,” and the very nature of humanness and humaneness could lie in the balance.

Dennis Sansom (1999:501) raised concerns of a meta-ethical nature. Noting that public discussions of biotechnology tended to operate within a utilitarian and pragmatic framework that stressed human freedom and autonomy, he argued that even these utilitarian values could be undermined by a genetic reductionism that saw the essence of human life in terms of physical states of affairs. Such a scientific materialism might argue for the unrestricted freedom of scientific

research, but in the long run undermine the core cultural values of “equality, democracy, and the inherent moral worth of human life.”⁵

C. Ben Mitchell (2001:132) feared that experimentation on human embryos reflected a reductionistic mentality, stating that “Americans should repudiate the commodification of human embryos. They are not crops to be harvested.... Human beings and their parts have become commodities, like sow bellies, corn, and soybeans.” Children should rather be seen as treasured members of the familial covenant, not as commodities to be used for selfish ends (1998:29).

Concluding Reflections

This brief study will be concluded with reflections that may be useful to researchers, journalists, teachers, and policy makers engaged with these issues. In the first place, it should be noted that despite the term “concerns” featured in the title of this article, evangelical reflections on the issues of genetic research are not uniformly negative or alarmist in nature. The aspects of “fears” and “concerns” have been especially prominent during the more recent controversies concerning embryonic stem cell research and therapeutic cloning. Even though this study has focused on the fears and criticisms raised by evangelical scholars, there is a substantial body of evangelical opinion that sees genetic research in a very *favorable* light and as being fully consistent with the teachings of Christian faith. Hessel Bouma (1993:527) is typical in this regard when he states that Christians who embrace the biblical motifs of “Creation-Fall-Redemption should warmly welcome the central theme that genetic engineering may be used cautiously to achieve God’s purposes of redeeming a fallen creation.”

In a similar vein D. Gareth Jones argued that “the Christian’s major task is not that of objecting to scientific developments, but of seeing them as one way in which God is demonstrating his grace through creation” (Jones 2002:99). For James Peterson, genetic engineering should not be seen as an affront to God. Rather, pursuing it rightly “can be part of our mandate to grow and to serve,” to seek to sustain, restore, and improve the creation entrusted to us (Peterson 2000:152). Research workers and policy makers who are aware of this reservoir of good will in the evangelical community could seek to enhance and build upon it in constructive ways.

This study has shown that the four major ethical concerns of American Evangelicals concerning genetic interventions can be summarized as follows: family values, political tyranny, the sanctity of life, and reductionism. Research workers would do well to make it clear, wherever possible, that the new genetic technologies can enhance “family values” rather than undermining them, by promoting human health and well-being. The concerns for the political misuse of genetic technologies by scientific elites can be addressed by recognizing the need for appropriate forms of accountability, transparency, and clear communication on the part of the biotechnology community. Rather than leaving it to the popular press to interpret—or possibly misinterpret—the implications of genetics research, scientists in these fields can advocate for adequately funded programs of education for the general public that are both scientifically accurate and ethically sensitive.

Ethical concerns surrounding the contentious issues of the “sanctity of life,” abortion, and the moral status of the human embryo are not likely to be resolved in the pluralistic context of American culture at any time in the foreseeable future. Researchers working in the sensitive areas of embryonic stem cell research work would do well to make it clear that “respect for human life” is recognized and affirmed as a core cultural value to be respected in all research work, irrespective of differing judgments on when human personhood is fully present.

On the most frequently mentioned concern of *reductionism*, researchers might benefit by considering the value of a philosophical distinction that has been made between *methodological naturalism* and *metaphysical naturalism*.⁶ Scientific research employs a method which is inherently “naturalistic” in that it focuses on the material, chemical, and genetic dimensions of the human person, but this need not imply a commitment to a worldview of *metaphysical naturalism*, i.e., the view that physics, chemistry, and genetics could supply an exhaustive, “reductionistic” description of the human.

A geneticist who employs the scientific method is practicing “methodological naturalism,” but may or may not be a metaphysical naturalist or philosophical materialist; one commitment does not logically entail the other. This distinction, together with the other observations made above, may help scientists and teachers working in the area of genetic research to communicate with religious constituencies in a pluralistic American culture in ways that promote understanding and continuing public support for such work. **E&M**

Appendix:

Figure One: Ethical Concerns

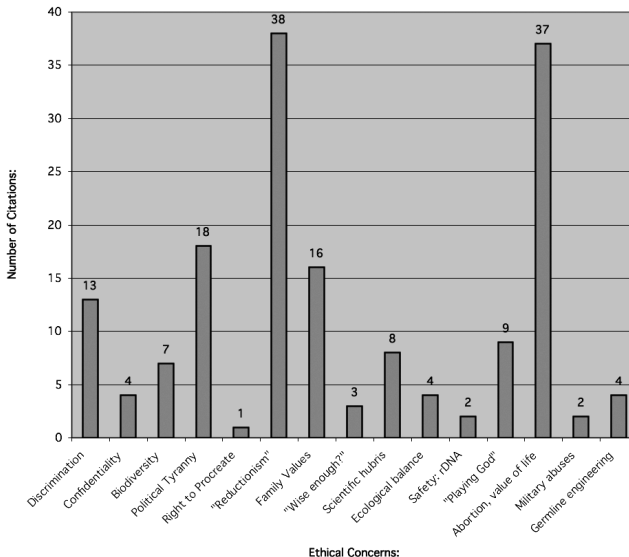
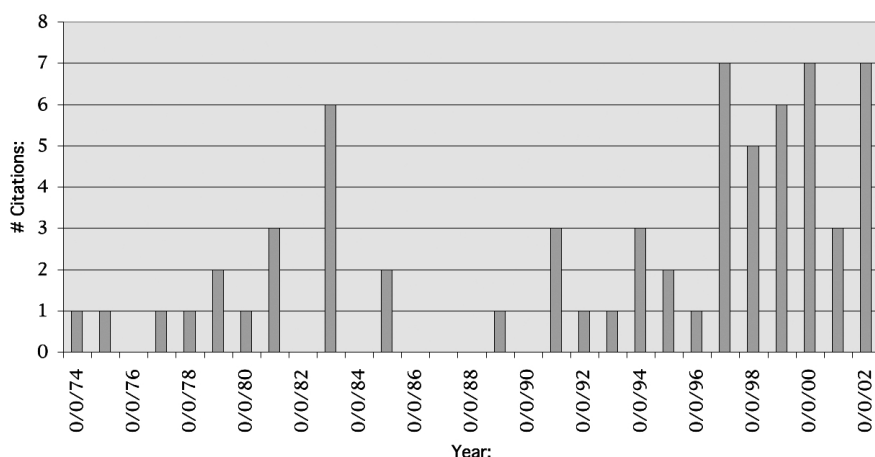


Figure Two: Citations by Year



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- 2 *Ibid.*, p. 39.
- 3 James Davison Hunter, *American Evangelicalism: Conservative Religion and the Quandary of Modernity* (New Brunswick, NJ: Rutgers University Press, 1983), and *Evangelicalism: the Coming Generation* (Chicago: University of Chicago Press, 1987); Mark A. Noll, David W. Bebbington, and George A. Rawlyk, eds., *Evangelicalism: Comparative Studies of Popular Protestantism in North America, the British Isles, and Beyond, 1700-1990* (New York: Oxford University Press, 1994); Leonard I. Sweet, *The Evangelical Tradition in America* (Macon, GA: Mercer University Press, 1984); George M. Marsden, *Understanding Fundamentalism and Evangelicalism* (Grand Rapids, MI: William B. Eerdmans, 1991).
- 4 Harold B. Kuhn, "Wesleyanism and Genetic Engineering," *Wesleyan Theological Journal* 9 (Spring 1974), 38-46.
- 5 Similar concerns have been raised from a secular perspective by Francis Fukuyama, *Our Posthuman Future: Consequences of the Biotechnology Revolution* (New York: Farrar, Straus and Giroux, 2002). A central thesis of the book is that biotechnology, with its potential to alter human nature itself, could undermine core values such as equality that are essential to a democratic form of government. For Fukuyama, genetic engineering raises profound political as well as ethical questions.
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HOLY DYING, ASSISTED DYING?: AN ANGLICAN PERSPECTIVE ON PHYSICIAN-ASSISTED SUICIDE

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Not long ago I was asked by my parish priest to accompany him on a visit to a parishioner who was suffering from advanced cancer and was being maintained on a ventilator. As we entered her hospital room we saw her sitting up in bed, breathing through a tracheotomy tube in her throat. Since the tube rendered her unable to speak, she would write her questions on a legal pad and gave them to us. This woman, a married mother of two, had a number of concerns, including the upcoming first communion of her younger child which would take place in a private family service to be held in a visiting room down the hall from her room. Perhaps foremost among her concerns was whether she would be doing wrong as a Christian to decide at some point to refuse life-prolonging treatments that were available to her and simply let go. As a philosopher who works in biomedical ethics, I was there to help her understand her options. Yet what she sought from me was not any consensus of bioethical scholarship or the latest developments in the writings of philosophers and others in the field, all things I would be prepared to discuss at a moment's notice, but what should *she* do as a faithful Christian. What did God want her to do? Furthermore, she lived her faith in the context of the Episcopal Church, and I perceived her questions to be asking how to determine the ethical and faithful course of action open to her as a particular kind of Christian, an Episcopalian.

What do Episcopalians and other Anglicans have to say on the topic of end-of-life issues including physician-assisted suicide (which I hasten to add was not being considered by my dying fellow parishioner)? What is the Anglican perspective on physician-assisted suicide? Where does one turn as an Anglican or Episcopalian in attempting to develop a perspective on the ethical acceptability of physician-assisted suicide?

Those with any familiarity with the Episcopal Church or the worldwide Anglican Communion will find themselves either baffled or amused by that question. Anglicans are famously or notoriously diverse on many issues not only of morality, but of theology as well. To some extent this is due to the inroads of liberal theological perspectives on a historically orthodox faith, but also it owes to Anglicanism's historic divergences between the three schools of evangelical, broad church or liberal, and Anglo Catholic. In addition, Anglicans tend strongly to value the liberty of individual conscience. We might expect that contemporary Anglicanism does not have a settled doctrine on the ethics of physician-assisted suicide and that Anglicans can be found on all sides of that vexing issue.

Recently the Committee on Medical Ethics of the Episcopal Diocese of Washington issued a report addressing assisted suicide and euthanasia. Reflecting on the report, committee chair Cynthia B. Cohen observed in their group a wide range of perspectives on physician-assisted suicide and euthanasia and reported that “they offer no consensus on the issue at this time.”¹ Again, this is a hardly surprising fruit of the labors of an Episcopalian working group on such topics today.

In light of such facts, isn't it hopeless to attempt to develop the Anglican position on physician-assisted suicide? The Baptismal Covenant of the Episcopal Church asks those receiving the sacrament to “respect the dignity of every human being” (*Book of Common Prayer*, p. 305), but does one respect dignity more by denying euthanasia and physician-assisted suicide and by offering support in the dying process, or by giving those who choose such options the opportunity to die with what they consider “dignity”? In this paper I do not propose to offer a summary of what the Episcopal Church or other Anglican bodies teach on these topics. Rather, I will survey some of the diversity of views on the issue and then attempt to establish my own perspective as an Episcopalian philosopher with some expertise in bioethics, a perspective that will be faithful to important strands of the Anglican heritage and responsive to the current philosophical debate. Anglicans are agreed that the proper method for theological and ethical reflection is to use Scripture, tradition, and reason. I will attempt to apply reason that I hope is enlightened by Scripture and tradition.

The biblical material that seems most relevant to these topics is the command *to do no murder*. Christian tradition in general, and Anglicanism in particular, has overwhelmingly rejected hastening the death of those who are ill or dying. Among classical Anglican divines, Bishop Jeremy Taylor's seventeenth century work, *Holy Dying*, was meant to be a guide to help the Christian to prepare for death. Taylor discussed the commandment *Thou shalt do no murder* and found its duties to include

1. To preserve our own lives, the lives of our relatives, and all with whom we converse, (or who can need us, and we assist,) by prudent, reasonable, and wary defences, advocations, discoveries of snares, etc.
2. To preserve our health, and the integrity of our bodies and minds, and of others.
3. To preserve and follow peace with all men.

It is violated, says Bishop Taylor, by practicing suicide and euthanasia: “They sin against this commandment...that willingly hasten their own or others death.”²

Not all contemporary Anglican opinion necessarily hews to the line that Taylor has drawn. A case could be made that Anglicans are open to very permissive positions on end-of-life issues. On the extreme left of the theological and moral spectrum, Joseph Fletcher, an early and well-known proponent of euthanasia, was at one time an Episcopal priest and seminary professor.³ Two decades before him, Dean W. R. Inge wrote that “I cannot resist the arguments for a modification of the traditional Christian law, which absolutely prohibits suicide in all circumstances.”⁴

One seeking extremely permissive views in the Episcopal Church today need

look no further than the Diocese of Newark and its former bishop, John Shelby Spong. Indeed the Diocese of Newark has turned its attention to this issue and concluded that

Suicide may be a moral choice for a Christian when: a person's condition is terminal or incurable; when pain is persistent and/or progressive; when all other reasonable means of amelioration of pain and suffering have been exhausted; and when the decision to hasten death is a truly informed and voluntary choice free from external coercion. Assisting another in accomplishing voluntary death under these circumstances may be an equally moral choice.⁵

In Bishop Spong's words,

After much internal wrestling, I can now say with conviction that I favor both active and physician-assisted suicide and euthanasia, and I also believe that assisted suicide should be legalized, but only under circumstances that would effectively preclude both self-interest and malevolence.

The Diocese of Washington's report found two main lines of reasoning among those Anglicans who favored physician-assisted suicide. The first is based on a perceived "obligation to respect individual human choice," and the second on "an obligation to relieve suffering, even if this means ending life."⁶ That first line of reasoning is strongly represented in the Newark Report, according to which "our society and church accept the ethical principle of autonomy." Foremost among the conditions for ethically acceptable assisted dying is a "decision to hasten death" that "is a truly informed and voluntary choice." Further, "the plan for voluntary assisted death" that is developed must place "maximum autonomy and command of the process in the hands of the dying person."

Such views can be found among Anglicans not only at the level of resolutions but in the pews. To take but one example, the National Church Life Survey in Australia sought agreement with the statement "people should be able to choose to die if suffering from a terminal illness." It was found that 46% of Anglican Church attenders agree, compared to 86% of those who attend no church.⁷ This however does not necessarily reflect a diversity of authentic Anglican theorizing, but may represent a (lamentable) deficiency in Christian education and spiritual formation.

Notwithstanding this divergence of interpretation and opinion, Anglicanism in general has continued to offer strong resistance to physician-assisted suicide. In the tradition of Bishop Jeremy Taylor these Anglicans have registered principled opposition to euthanasia, and likewise for physician-assisted suicide by major Anglican bodies.

There is no better place to find the mind of the worldwide Anglican church today than in the resolutions of the Lambeth Conference, a gathering every decade of bishops from all corners of the Communion in London's Lambeth Palace. In 1998 the Conference resolved (Resolution 1.14) "that euthanasia, as precisely defined, is neither compatible with the Christian faith nor should be permitted in civil legislation."⁸

Similarly, the mother church of the communion, the Church of England, has issued a statement jointly with a church eminently conservative on bioethical matters, the Roman Catholic Church, in offering a strong condemnation of euthanasia to the House of Lords.

Because human life is a gift from God to be preserved and cherished, the deliberate taking of human life is prohibited except in self-defence or the legitimate defence of others. Therefore, both Churches are resolutely opposed to the legalization of euthanasia even though it may be put forward as a means of relieving suffering, shortening the anguish of families or friends, or saving scarce resources.

Further, they argue that

deliberately to kill a dying person would be to reject them. Our duty is to be with them, to offer appropriate physical, emotional and spiritual help in their anxiety and depression, and to communicate through our presence and care that they are supported by their fellow human beings and the divine presence.⁹

In the Episcopal Church USA, an *End of Life Task Force* was formed on the basis of a 1997 resolution by the 72nd General Convention. This task force, which included bioethicist Cynthia Cohen from the Washington diocesan task force and the Kennedy Institute of Ethics at Georgetown University along with other prominent thinkers including Bruce Jennings of the Hastings Center, David Smith of the Poynter Center at Indiana University, and David Scott and Timothy Sedgwick of Virginia Seminary, among others, published their reflections in a book, *Faithful Living, Faithful Dying: Anglican Reflections on End of Life Care*.¹⁰ The task force concludes

that the Episcopal Church should continue to oppose suicide near the end of life...in addition, members of the task force oppose physician assisted suicide. Such a practice risks making suicide a norm rather than an exceptional act.

They argue that physician-assisted suicide is both a departure from the Christian tradition and unnecessary in view of the capabilities of palliative medicine.

If to make a decision on the ethics of physician-assisted suicide from an Anglican perspective one needed simply to turn to church positions and the statements of task forces, one might conclude that it is morally objectionable, although there are those who demur. I am personally delighted that Anglicans overwhelmingly oppose physician-assisted suicide, but Anglican decision-making is accomplished not simply by consulting church writings, however welcome their conclusions, but by engaging in serious, personal reflection using Scripture, reason, and tradition. Further, for Anglicans, our understanding of doctrine and morals are found in the worship we offer corporately. This fact no doubt scandalizes those Christians who believe that doctrinal reflection must always precede the practice of the faith, but Anglicans are unabashed about *lex orandi lex credendi*. For us, praying indeed shapes our believing.¹¹ The Church

offers liturgical formats for ministering to the sick and attending to a dying person, but not for causing death. The Episcopalian hope for the dying process is beautifully expressed in the collect *For the Sanctification of Illness*:

Sanctify, O Lord, the sickness of your servant *N.*, that the sense of *his* weakness may add strength to *his* faith and seriousness to *his* repentance; and grant that *he* may live with you in everlasting life; through Jesus Christ our Lord, *Amen* (*Book of Common Prayer*, p. 460).

Is the Newark Report correct when it states that “our church accept(s) the ethical principle of autonomy”? The autonomy principle as a support for physician-assisted suicide, as articulated by some of its more extreme champions such as Dr. Jack Kevorkian, is wildly out of step with the communal and covenantal character of Anglicanism as seen in its emphasis on the believing community who gathers for worship on a regular basis. Kevorkian has stated that

In my view the highest principle in medical ethics—in any kind of ethics—is personal autonomy, self determination. What counts is what the patient wants and judges to be a benefit or a value in his or her own life. That’s primary.¹²

Anglicanism does not view autonomy this way. While we recognize an appropriate place for individual choice and responsibility, we offer a strong insistence on our interconnectedness. Anglican liturgical theologians Charles P. Price and Louis Weil put it this way:

The Christian body is composed of separate selves. Yet individuals become who they are not in isolation from their relationship with other individuals but because of those relationships. We are redeemed in the context of our associations. God saves the world; he does not simply rescue individuals from the world.¹³

The corporate nature of Anglican belonging is also emphasized in church historian John Booty’s claim that

Believing is not chiefly assent to propositions, but belonging to a community in which the story of God’s dealing with the people of God...is rehearsed in word and sacrament. The story is the story of a community, the story to which we belong.¹⁴

Anglicans should not accept the exaltation of autonomy found in the Newark Report and more widely in secular, post-Christian culture. We recognize that we are in community with others, members of “the household of God” (*Book of Common Prayer*, p. 308) and “the blessed company of all faithful people” (*Book of Common Prayer*, p. 339). The Newark Report and other Anglicans who favor such conclusions strike me as more in tune with current secular thinking than reflection centered in the life of worship, prayer, and Christian reflection.

The exaltation of autonomy found in Newark Report is very much in line with the thinking of many contemporary philosophers and ethicists who have

openly declared that some lives are not worth living, and that individual autonomy rather than respect for the sanctity of life should prevail in moral and legal contexts.¹⁵ In addition to Kevorkian mentioned earlier, it was alarming when Dr. Marcia Agnell, then editor of the prestigious *New England Journal of Medicine*, took the historic step of writing an editorial in favor of physician-assisted suicide in which she justified her position in terms of the principles of autonomy and beneficence. Dr. Agnell wrote,

I begin with the generally accepted premise that one of the most important ethical principles in medicine is respect for each patient's autonomy, and that when this principle conflicts with others, it should almost always take precedence.¹⁶

Recently several of the most prominent figures in contemporary ethics made the historic move of offering *amicus curiae* testimony before the United States Supreme Court as that body faced euthanasia decisions in 1997.¹⁷ The document, *Assisted Suicide: The Philosophers' Brief*, was submitted to the Supreme Court and was also published in the *New York Review of Books*.¹⁸ The *Brief* is an unambiguous statement in support of the right to assisted suicide. It claims that the right to assisted suicide derives clearly from autonomy, the right of "every competent person...to make momentous personal decisions which involve fundamental religious or philosophical convictions about life's value for himself." Expanding on this,

certain decisions are momentous in their impact on the character of a person's life-decisions about religious faith, political and moral allegiance, marriage, procreation, and death, for example. Such deeply personal decisions pose controversial questions about how and why human life has value. In a free society, individuals must be allowed to make those decisions for themselves, out of their own faith, conscience and convictions.

Should an Anglican regard the findings of such eminent philosophers as evidence that "reason," if not Scripture and tradition, favors physician-assisted suicide? Happily, reason does not lead to such a conclusion and offers reasons to challenge such an exaltation of individualist autonomy. It is, according to ethicist Aaron Ridley, "the principle that one should attempt to give due weight to the goals, preferences, and interests of others."¹⁹ As used by Tom Beauchamp and James Childress, it is the acknowledgement of "person's right to hold views, to make choices, and to take actions based on personal values and beliefs.... Autonomous actions should not be subjected to controlling constraints by others." Yet, they argue that "respect for autonomy has only *prima facie* standing and can be overridden by competing moral considerations."²⁰

A similar limitation on autonomy is offered by philosopher Ronald Munson, author of the leading textbook in bioethics, who argues that while "to act autonomously is to decide for oneself what to do," it must be remembered that "of course, decisions are never made outside of a context, and the world and the people in it exert influence, impose constraint, and restrict opportunities." He goes on to state that "autonomy is not an absolute or unconditional value," and argues that it may be restricted by the harm principle (to prevent harm to others),

the principle of paternalism (to prevent harm to self), the principle of legal moralism (to enforce society's important moral convictions), and the welfare principle (to provide benefits to others).²¹

In the context of the principle approach, then, autonomy is only one of a set of competing principles, any one of which might have to yield to another in a particular circumstance. Yet in practice it is getting considerably more difficult to mount a principled challenge to any argument that can appeal to the principle of autonomy. In fact, many contemporary philosophers seem to be defending a view that could be called "Promethean autonomy," the view that an individual's decision alone determines what is right. Happily, a number of prominent thinkers have expressed their rejection of Promethean autonomy. Such founding fathers of bioethics as Richard A. McCormick, S. J.; Daniel Callahan, co-founder of the Hastings Center; Leon Kass; and others have weighed in recently to challenge the preeminence of autonomy in contemporary bioethical deliberation. Fr. McCormick objects to what he calls "absolutizing autonomy," and has argued that

Absolutizing autonomy represents a failure to wrestle with those dimensions of conduct that make choices right or wrong—in brief, a moral vacuum....[Daniel] Callahan recently referred to this as "autonomy run amok."...

Since absolutizing autonomy prescind from the goods and values that define human well-being by reducing them to one (namely choice), it is not surprising that it produces an unreal and distorted picture of the human person...when contemporary bioethics talks about patients as autonomous persons, it is talking mostly of a dream world.²²

This is a judgment with which Anglicans can concur, as is Fr. McCormick's judgment that the concept has to be used carefully, since taken out of context autonomy presumes a false anthropology, a view that people are primarily to be understood as individuals, individuals who are capable of acting in ways that are quite free and self-determining. This is false empirically, since many people, particularly the ill, are limited in their capacity for self-expression and self-determination. It is also very incautious in the present intellectual climate to assert that people are primarily autonomous individuals, and only secondarily members of communities and groups. The wealth of contemporary challenge to liberalism by those who call themselves communitarians suggests that we need to be very circumspect about asserting the absoluteness of individualism.²³

The parishioner of whom I spoke at the beginning of this article was not interested in practicing Promethean autonomy. She was interested in finding a way to manage her pain and suffering in a way that was faithful to Christ and which showed love and care for her two children and her husband. Her dying was an extension of her life, and I found myself awed by her faith and her compassion for her loved ones at the end of her life. I am comforted by my faith and hers, that God will "grant her an entrance into the land of light and joy, in the fellowship of [his] saints." (*Book of Common Prayer*, p. 493). That is Holy Dying in the Anglican tradition. **E&M**

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- 5 News release: "Diocese of Newark Convention Affirms that Suicide and Assisted Suicide May be a Moral Choice for Christians," January 29, 1996. *Report of the Task force on Assisted Suicide to the 122nd Convention of the Episcopal Diocese of Newark*, January 27, 1996.
- 6 Cohen, "Christian Perspectives," p. 372.
- 7 "Life Ethics Divide Anglicans." *The Melbourne Anglican*, March 2001; http://www.media.anglican.com.au/tma/2001/2001_03/lifeethics.html.
- 8 *The Official Report of the Lambeth Conference*, 1998, 104. (<http://www.episcopalchurch.org/hawaii/workshop/lambeth/resolutions/sept1.html>—accessed Jan 17, 2004.)
- 9 "The Church's view on Medical Ethics and Issues of Life and Death." See also General Synod Board for Social Responsibility, *On Dying Well: An Anglican Contribution To The Debate On Euthanasia* (London: Church Information Office, 1975).
- 10 Cynthia B. Cohen et al., *Faithful Living, Faithful Dying: Anglican Reflections on End of Life Care* (Harrisburg, PA: Morehouse Publishing, 2000). The copyright on this book is held by the General Convention of the Episcopal Church.
- 11 Leonel L. Mitchell, *Praying Shapes Believing: A Theological Commentary on the Book of Common Prayer* (Harrisburg, PA: Morehouse Publishing, 1985).
- 12 Jack Kevorkian, M.D., *Free Inquiry*, Fall 1991.
- 13 Charles P. Price and Louis Weil, *Liturgy for Living*, The Church's Teaching Series (New York: Seabury Press, 1979), p. 298.
- 14 John Booty, *The Episcopal Church in Crisis* (Cambridge MA: Cowley, 1988), p. 139.
- 15 Grant Gillett has argued that "the arguments of philosophers are almost uniformly for" euthanasia. "Euthanasia, Letting Die, and the Pause," *Journal of Medical Ethics*, 14 (1988):61-68.
- 16 Dr. Marcia Agnell, editorial. *New England Journal of Medicine*, 336, no. 1 (January 2, 1997).
- 17 The authors of the brief are some of the most prominent social philosophers of the latter part of the twentieth century: Ronald Dworkin of the University of Oxford, Thomas Nagel of New York University, Thomas Scanlon, Robert Nozick, and John Rawls (now late), all of Harvard University, and Judith Jarvis Thomson of the Massachusetts Institute of Technology.
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BIOTECHNOLOGY UPDATE: NEWS AND VIEWS

The Bio Prospect for 2004

NIGEL M. DE S. CAMERON, PHD

As we move further into the uncharted territory of the Biotech Century, some facts seem very clear. Biotechnology is set to dominate the questions facing global culture, as our new powers over our own selves are increasingly liberated by technology from the realm of sci-fi and confront the human community with the most fateful decisions of our long history. At the same time, it holds the seeds of extraordinary powers of healing. The extent to which we shall be able to draw a line between therapy and enhancement/control will determine the future of *Homo sapiens*. Nothing less is at stake.

From a global perspective, the picture is mixed and the prospect unclear. In the US, the state of New Jersey has passed the worst biotech bill in the world, not only encouraging cloning of embryos for stem-cells, but prohibiting only the actual birth of cloned babies – that is, developing what would seem to be the first formal policy regime on the planet in which cloned embryos may be implanted and cloned fetuses used for organ production and experimentation, provided they are killed before birth. This terrible law has been supported by BIO, the trade group that claims to speak for the biotechnology industry – their chief lobbyist, to whom with a twist of irony hard to equal they recently gave the title “Vice-President of Bioethics.” Governor McGreevey, in his fateful decision to sign, has ensured New Jersey’s place in the history books.

Of course, BIO also decided to oppose, with some vigor, the patent amendment proposed by Congressman Dave Weldon, the intent of which was merely to provide legal support for the practice of the Patent and Trademark Office in refusing to issue patents on human organisms. Their position – that a human who is the result of some kind of technological intervention is a “manufacture” and not a “product of nature,” and may therefore be patented, will long remain a stain on the face of the US biotech industry. As pro-choice feminist and leading legal authority Professor Lori Andrews commented, this suggests that the industry sees in the birth of every American child the prospect of royalties.

Having encouraged CAMR, their campaigning sibling group, to call on their supporters to jam the congressional switchboard with calls to members and senators since this modest amendment would undermine “cures” for sick patients, they have now backed off. It seems they realized that they would not succeed. They say they are satisfied with clarifications of what the amendment means. If this means that BIO now supports a ban on cloning human organisms, so much the better. If it means they still favor the manufacture of a slave class of gestational humans but are biding their time, we need to be on our guard.

But both these developments raise a fundamental question: when will the growing, energetic, and very largely ethical American biotech industry decide to tell the leaders of BIO to take a walk? The US has 75% of global biotech revenues, so how we act has vast implications for the future of this entire technology. Why do responsible biotech companies and the venture capitalists who stand behind many of them – and, for that matter, the big Pharma companies who are increasingly linked with Bio enterprise – not decide to tell their so-called leaders that they want to listen to the ethical voice of their markets and hire some new guys to speak for them?

Around the world, the situation is encouraging. Many nations are now putting laws in place that ban human cloning in all its guises, France and Mexico being among the most recent. At the United Nations, the cynical attempt of the small minority of pro-cloning states to defer the discussion for two years was recently overturned, and in the fall of this year the General Assembly will return to the theme. By then, we trust, there will be such a groundswell of international support that the apologists for those few rogue states that want untrammelled biotech (of which, to its great shame, the UK is the leading western example) will be thoroughly isolated. Germany, which initiated the “partial ban” approach two years ago even though its own domestic law entirely outlaws cloning, has been forced out of leadership and indeed into a position of neutrality by unprecedented domestic pressure on the federal government of Chancellor Schroeder. France, who joined Germany in its initial resolution, must contend with the fact that it has in the meantime outlawed all cloning at home. Belgium, which has now taken the lead, is a bioethics bad boy; the only nation to have jumped on the Dutch euthanasia bandwagon. But many of the states that either supported the Belgian partial-ban position (which included the three Baltic states, who may be under pressure, perceived or actual, from the European Union that they will be joining in a few months) or the two-year delay (including many of the Muslim states) should be encouraged to swing around, and they have good reason to. Leading Islamic authorities have now come out against all human cloning, and that will weigh heavily with all 57 members of the Organization of the Islamic Conference.

In the US, of course, we still need to pass a federal ban. The fact that this is an election year will help. Americans need to put irresistible pressure on their elected representatives, not least through the passing of state-level bans.

In all these developments, we need to remember that the cloning debate is a surrogate for all the unfolding issues of the Biotech Century. That underlines its historic significance for the human community. And we need also to continue to note that these are questions that unite conservatives, progressives, and many who would avoid either label – all those human beings who seek to preserve human nature in the face of the unique onslaught it faces.

To that end, let us re-commit ourselves to the task of a comprehensive global cloning ban.

BIOTECHNOLOGY NEWS UPDATE

Cloning Vote to Come Back to UN; US Pushing for Total Ban

Despite a recent setback in the United Nations' General Assembly for the development of a treaty to completely ban human cloning and the motion to postpone any action for two years, the United States is now leading a push for the ban, which will be discussed later this year. Joined by Costa Rica, Spain, and a coalition of other nations, the United States will be working to encourage European and Islamic countries, who had wanted a partial ban, to reconsider allowing a comprehensive ban on human cloning.

<http://www.washingtonpost.com/wp-dyn/articles/A39943-2003Dec5.html>

<http://www.reuters.com/newsArticle.jhtml?type=scienceNews&storyID=3965951>

Fetal Cell Grafts Not Effective Parkinson's Treatment

A new study reported before the Society for Neuroscience recently concluded that fetal stem cell grafts were ineffective in treating patients with Parkinson's disease. The patients, whose Parkinson's could no longer be treated with medication, tended to develop dyskinesia and their motor scores on standardized tests for Parkinson's patients decreased at rates similar to those who were in the control group.

<http://www.docguide.com/news/content.nsf/news/8525697700573E1885256DDD0064B02F>

Adult Stem Cells in Mice May Provide Diabetes Cure

In a major advance using adult stem cells, researchers believe they have cured Type I diabetes in mice using the mice's own spleen cells, which then become insulin-producing cells. This technique holds promise for human studies, but the researchers in Massachusetts say they need more funding in order to conduct such clinical trials. The current study was funded by the Iacocca Foundation.

<http://www.hon.ch/News/HSN/516027.html>

http://www.guardian.co.uk/uk_news/story/0,3604,1084838,00.html

<http://www.news.scotsman.com/latest.cfm?id=2175391>

http://www.boston.com/news/nation/articles/2003/11/14/juvenile_diabetes_cured_in_lab_mice?mode=PF

Congress Addresses Human Patent Issue

The US House decided recently to ban the US Patent and Trademark Office from issuing patents on any "human organism," including embryos, fetuses, and clones. This codifies current PTO practice and ensures for now that human beings will remain unpatentable, and thereby less likely to become the legal products of

corporations. The Biotechnology Industry Organization, which worked to have the language excluded from the bill, accepted that it simply maintained the status quo and did not reject patents on embryonic stem cell lines.

<http://www.washingtonpost.com/wp-dyn/articles/A49678-2003Nov16.html>

<http://www.washtimes.com/national/20031208-123624-3763r.htm>

Adult Stem Cell Advances

Numerous advances utilizing adult stem cells in medical applications have been reported recently, including the use of blood stem cells to allow paralysis sufferers to regain feeling and the creation of bone and cartilage from stem cells to form jaw joints in rats. In another study, the stretching of stem cells was found to produce bone instead of fat cells, which may have long term applications for the understanding of the effects of exercise. A variety of other researchers have found that adult stem cells can be useful in treating muscle damage, heart disease, Parkinson's disease, and skin problems.

Other advances in the field of adult stem cell research have shown to be promising in their effects on patient care and treatment, including using bone marrow cells to restore cardiac function in rats, other adult cells to become nervous system cells to treat Parkinson's, yet others to become effective skin replacements, eye blood vessels, and lung tissue. In each of these cases, adult stem cells have proven equally or more effective in treatment than similar procedures with embryonic stem cells, yet without the complications of rejection of foreign tissue or the ethical issues of using embryonic tissue.

Still other research findings using adult stem cells have shown that rats who have been burned heal more quickly when they are treated with stem cells from their own bone marrow than with embryonic stem cells. Rats were also tested with stem cells from other rats' bone marrow, which was less effective than the rats' own marrow, but still more so than the embryonic cells. Other studies on bone marrow cells have shown that they can fuse with brain, heart, and liver cells to foster regrowth. Scientists are also working to activate stem cells from people's eyes in order to regrow cells that have caused blindness in those people.

<http://www.biomedcentral.com/news/20031013/02/>

<http://www.betterhumans.com/Errors/index.aspx?aspxerrorpath=/searchEngineLink.article.2003-10-10-4.aspx>

<http://www.biomedcentral.com/news/20030811/01>

http://www.eurekalert.org/pub_releases/2003-08/uom-amb081803.php

<http://www.betterhumans.com/News/news.aspx?articleID=2003-10-10-4>

<http://www.betterhumans.com/News/news.aspx?articleID=2003-09-24-4>

<http://www.betterhumans.com/News/news.aspx?articleID=2003-09-01-3>

<http://www.betterhumans.com/News/news.aspx?articleID=2003-11-17-7>

<http://www.nidcr.nih.gov/news/12012003.asp>

<http://www.nature.com/nsu/031208/031208-16.html>

<http://www.washtimes.com/national/20031228-114541-5034r.htm>

<http://www.theage.com.au/articles/2003/10/11/1065676206311.html>

Nanotechnology Update

The United States Congress has created a new home for emerging nanotechnologies in a bill signed by President Bush on December 3, 2003. Along with a \$3.7 billion research and development budget, the 21st Century Nanotechnology Research and Development Act formalizes and coordinates planning between a number of different agencies and departments all working on nanoscale projects. In other nanotech research, issues of toxicity of otherwise harmless materials at the nanoscale are now being published by scientists in Britain.

<http://www.smh.com.au/articles/2003/11/14/1068674378878.html>

<http://www.i-sis.org.uk/nanotubestoxic.php>

<http://www.i-sis.org.uk/Nanotox.php>

http://www.smalltimes.com/document_display.cfm?document_id=6973

http://www.smalltimes.com/document_display.cfm?document_id=7035

European Parliament Allows Limited ESC Research

The European Parliament voted on a compromise position this week regarding the use of human tissues in research, including safety protocols for tissues and allowing member states to retain their individual positions regarding the use of cloned and embryonic stem cells. This compromise came about because of a lack of agreement between member states for a ban on cloned and hybrid tissues in transplantation. The vote disallowed the sale of human tissues for profit, though allows payment for expenses in cases such as sperm and egg donations.

<http://www.biomedcentral.com/news/20031204/05>

<http://www.biomedcentral.com/news/20031217/03>

<http://www.alertnet.org/thenews/newsdesk/L16613790.htm>

New Jersey Approves Cloning Bill

Governor Jim McGreevy of New Jersey signed into law on January 5, 2004 a bill that proponents claim allows stem cell research in the state. Opponents of the bill have stated that it actually legalizes human cloning, as long as the fetus is not

born. The bill specifically allows somatic cell nuclear transfer (the process that results in cloning) and the growth and development of a cloned fetus. Both sides agree that the bill sets a significant precedent for state laws around the nation.

<http://www.suntimes.com/output/novak/cst-edt-novak15.html>

http://www.dioceseoftrenton.org/department/news_detail.asp?newsid = 850

<http://www.nytimes.com/aponline/science/AP-Stem-Cell-Law.html>

<http://www.betterhumans.com/News/news.aspx?articleID = 2004-01-05-7>

Problems with Safety of Human Cloning

A new report in *Nature* looks at the major problems involved in animal cloning and wonder if human cloning could ever be made into a safe process. Genetic abnormalities, the early deaths of clones, and other problems associated with the technique have led researchers to seek answers in order to succeed in human cloning. Human cloning opponents disagree and point to the many problems associated with cloning as even more reason to ban the procedure.

http://www.nature.com/cgi-taf/DynaPage.taf?file = /nrg/journal/v4/n11/full/nrg1205_fs.html

<http://www.newscientist.com/news/news.jsp?id = ns99994334>

Canadian Study on IVF Risks to Children

A new Canadian research report on in vitro fertilization and similar fertility treatments indicated that such treatments are more likely to result in multiple births, birth defects, and prematurity. Many couples receiving treatment for infertility are allowing the implantation of multiple embryos, which increases the likelihood of a live birth but also significantly increases the risks for the mother and the children born in the process.

http://mediresource.sympatico.ca/health_news_detail.asp?channel_id = 0&news_id = 2847

UK Rules Against Women Using Frozen Embryos

The British High Court recently ruled that two women who sought to implant embryos they had previously frozen would not be allowed to do so because of the objections of their former partners who be the biological fathers of the children. Both women were disappointed by the rulings that stated that the embryos must be destroyed rather than used, claiming that if they had become pregnant by their partners without the use of IVF, the men would not have had a say in their decisions to keep the babies, a claim with which the judge agreed.

<http://news.bbc.co.uk/1/hi/health/3151762.stm>

Senate Passes Genetic Nondiscrimination Act

The Senate recently passed a bill 95-0 to require insurers and employers to refrain from gathering or using genetic data to discriminate against people in determining employment and insurance eligibility and rates. The law is a needed civil rights measure in an environment of increasing potential for the abuse of genetic information, and is expected to be considered by the House early in 2004.

<http://www.washingtonpost.com/wp-dyn/articles/A26767-2003Oct14.html>

UN Sixth Committee Fails to Pass Cloning Ban

The Sixth Committee of the United Nations failed to set a ban on human cloning in a close and heavily divided vote between developing and developed nations. Instead, the issue will be taken up again in two years, leaving no protections regarding cloning in place in the mean time. For more information on this critical issue, see this section's lead article.

<http://www.un.org/law/cloning/>

Eugenics Rears Its Head with New Test for "Race"

A new genetic test is available for "race" by a company called DNA Print Genomics. Like other firms that offer consumer-based genetic testing, this test is currently used to indulge people's curiosities about their heritage and has led to some surprising results. It also has begun a new chapter in the broader discussion of race as an idea, eugenics and desirability in "race", and the possibility of similar tests being used more broadly or for discriminatory purposes.

<http://alternet.org/story.html?StoryID=16917>

<http://www.dnaprint.com>

<http://www.cbsnews.com/stories/2003/03/04/sunday/printable542739.shtml>

Fertility Technique Similar to Cloning Results in Failed Pregnancy

Chinese researchers reported that they were able to achieve pregnancies (though not live births) in women by removing the nucleus from the mothers' eggs and transplanting them to other women's denucleated eggs in order to give the resulting embryos a better chance at survival. This procedure greatly resembles the procedure needed to achieve cloning, though in this case, the DNA used to create the embryos was from a standard fertilized egg. In the wake of controversies regarding the new fertility technique, the Chinese government has moved to tighten regulations for biotechnological research, including banning human cloning.

http://www1.chinadaily.com.cn/en/doc/2003-10/14/content_271876.htm

<http://www.theage.com.au/articles/2003/10/14/1065917410965.html?from=storyrhs>

International Declaration on Human Genetic Data Soon

There may soon be an international standard developed regarding the use of genetic data, according to UNESCO. Standards for privacy, confidentiality, storage, and dissemination are included in the draft of the declaration.

http://portal.unesco.org/en/ev.php@URL_ID=16443&URL_DO=DO_TOPIC&URL_SECTION=201.html

President's Council on Bioethics – LATEST REPORT

Read the latest report from the President's Council on Bioethics regarding a look ahead at future biotechnological advances and their ethical implications. The topics included are: Better Children, Superior Performance, Ageless Bodies, and Happy Souls.

<http://bioethics.gov/reports/beyondtherapy/index.html>

Canadian House Passes Anti-Cloning Bill; Not Likely to Pass Senate This Term

In a divided vote, the Canadian House of Commons voted to ban human cloning in Canada and regulate in vitro fertilization. The bill specifically allows for and regulates embryonic research and also prohibits commercial surrogate pregnancies. It is not likely to pass the Senate this term.

http://mediresource.sympatico.ca/health_news_detail.asp?channel_id=16&news_id=2584

FDA Declares Cloned Animals Safe as Food

The FDA has reported that they find animals who are clones or products that are derived from clones to be safe as human food products and allowable in American agribusiness. There had previously been a voluntary moratorium on the use of clones as food, though that will soon change based on the report. This has prompted controversy, both among animal rights and consumer groups as well as from those who see the widespread use of animal cloning in farming as a precursor to the use of human cloning.

<http://www.washingtonpost.com/wp-dyn/articles/A44602-2003Oct30.html>

Horse Gives Birth to Its Own Clone

Following quickly on the heels of a recent successful attempt to clone a mule, researchers in Italy have now cloned a horse and had the mare that was cloned give birth to the clone. This is both the first successful cloning of a horse and the first animal to be born from the animal from which it was cloned.

<http://www.wired.com/news/medtech/0,1286,59924,00.html>

http://www.economist.com/agenda/displayStory.cfm?story_id=1174648

Rats Cloned in France

Researchers in France have become the first to successfully clone rats, adding to the now-lengthy list of cloned mammals. Rats have been notoriously difficult to clone, yet many scientists want to use the techniques to introduce specific genetic modifications into the rats to study their development and responses.

<http://www.betterhumans.com/News/news.aspx?articleID=2003-09-26-2>

<http://www.nature.com/nsu/030922/030922-16.html>

First Cloned Deer

Researchers at Texas A&M University have cloned the first deer, a white-tailed deer named Dewey. Dewey was developed from the skin cells of another deer and was gestated in a surrogate mother. The deer is the fifth species cloned first at the University.

<http://www.washingtonpost.com/wp-dyn/articles/A23182-2003Dec22.html>

http://www.cvm.tamu.edu/news/releases/deer_clone.shtml

Researchers Give Clone Health Warning

As more types of animals are successfully cloned by researchers today, many scientists studying the health of these animals are concerned about abnormalities that regularly appear in clones. Most clones die before ever reaching birth, and those that are born do not live past middle age, regardless of species. Not only are the animals cloned harmed by this process of experimentation, but any attempts at human cloning would likely suffer the same fate.

<http://news.bbc.co.uk/go/pr/fr/-/2/hi/science/nature/3131255.stm>

Chinese Researchers Create Human-Rabbit Hybrid

The first beings developed as human-rabbit hybrids have been fertilized as embryos in China. While no one knows what such chimeras would look like if brought to term, many in the scientific and ethical communities have expressed outrage over the combining of human and animal DNA. This may prompt greater support for a full ban on this type of cloning research.

<http://www.washingtonpost.com/wp-dyn/articles/A55911-2003Aug13.html>

Effective Treatment Discovered as an Alternative to IVF

For women who have unexplained infertility, a new, less invasive, less expensive treatment alternative to in vitro fertilization (IVF) has been shown to be highly effective. Particularly in cases of mild endometriosis, women who had lipiodol flushed through their fallopian tubes and uerti were four and a half times more likely to become pregnant than women in the control group. Lipiodol has been used for some time in x-ray dye tests, but this is the first instance of it being used to aid in fertility, so the specific function of the fluid in aiding fertility is unknown.

<http://www.cnsnews.com/ViewForeignBureaus.asp?Page=/ForeignBureaus/archive/200309/FOR20030923b.html>

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BOOK REVIEWS

Culture of Life, Culture of Death: Proceedings of The Linacre Center Conference of The Great Jubilee and the Culture of Life

Luke Gormally, Editor

London: The Linacre Centre, 2001

ISBN 0-906561-24-8, 352 PP., PAPERBACK, \$17.95, \$25.00

As Luke Gormally explains in his introduction, only two of the six presentations given at the Conference by medical practitioners are included in these Proceedings. This is because doctors usually lecture by presenting slide shows with commentary (in medicine, visual aids are essential to get a complex message across simply); a picture is worth a thousand words, they say. Such medical talks would need reformatting for reproduction in a book that is text only, and the task may not even be possible. This seemed to be the case with medical papers given at the Conference, and it led to two difficulties for me: there are few articles in the book in the discipline, medicine, with which I am most familiar; and I found the information in most of the articles difficult digest, with its use of unfamiliar words and ideas and given in long blocks of solid prose, and not in the format of medical articles with diagrams and sub-headings. This led me to three conclusions: that a clinical practitioner is not going to find it an easy read at the end of a long day, even less, light reading for a holiday; thus clinical practitioners are not going to benefit from the Conference Proceedings as they should; and that maybe philosophers and theologians could make their material a little more accessible to people not in their specialties by putting their ideas across in simple terms, or using explanatory notes, and breaking text up with sub-headings, utilizing diagrams if possible, instead of presenting hardly penetrable prose. Doctors, after all, have to simplify things when explaining medical conditions to their patients, so why should theologians and philosophers, and for good measure lawyers and historians for they also contributed, get away with talking shop!

Having made these comments about its presentation and accessibility, therefore, I found the material put forward in the book to be heavy going but excellent. That is to say one had to work hard at it to reach the good things herein.

From the Introduction we learn that the theme of the Conference is taken from 'Evangelium Vitae', the encyclical letter of John Paul II. The book is divided into three sections. The first is an analysis of the mind-set and philosophies that result in the Culture of Death. The second is an analysis of why Christian Revelation points to life and how this faith may be put into practice in a Culture of Life. The third part consists of supplementary papers.

Analysis of the Culture of Death. There are four contributors. *John Finnis* considers secularism, the interest only in worldly, temporal matters, as the root cause of the culture of death because with loss of the sense of God and eternity, man loses sight of himself. He points out that long ago, Plato observed and condemned the attitudes, now found in modern society, which are engendered by three premises concerning God: there is no God; God takes no interest in human affairs; God is easily placated and does not require reform of human vice. The parable of the Sower is cited to warn against secularism by default. The impact of God's word on us can be lost through lack of understanding (stony ground), lack of endurance (shallow roots), and

allowing the brambles of the world to choke it. *Dermot Fenlon* next considers the impact of John Stewart Mill and his friend Harriet Taylor, later to marry Mill after the death of her husband, on the de-Christianising of England. He points out that religion in ancient times assisted social control. It is no less the case now with secularism, religion's substitute. Look up 'Deism' – the existence of God can be established by reason but He has made no Revelation of Himself, 'Deus otiosus', – God free from public duties (and no interest in human affairs), and 'Latitudinarianism' – broad and liberal standards of religious belief and conduct, specifically freedom of doctrine and practice within the Church of England, to begin to understand how Christianity has been undermined in England since the Reformation and the link with present day secularism. *Robert P. George* demonstrates contemporary liberalism to be the political theory of the culture of death. The right of every human life to protection by the law, no matter how vulnerable or damaged it is, cannot logically be refuted. So how does political liberalism counter this to promote abortion and euthanasia? By side-stepping. These are choices that must be allowed in a multicultural society, where not everyone is agreed on what is moral, or what constitutes 'private immorality' in which the state cannot interfere. The answer to political liberalism is Natural Law theory. *Kateryna Cuddeback* (straightforward stuff here and no problems with presentation) discusses worldwide population control – 'family planning', as it is euphemistically called by its protagonists. She traces how Malthusian population theory and Darwinism came together to produce the pseudo science of eugenics, or the necessity of exterminating the poor; and how 'family planning' masquerades as 'women's rights' – when in fact enforced contraception and abortion are gross violations of women; and the rights of third world countries; and how multiple agencies are involved in these abuses. Ultimately population control is a counsel of despair for the Godless, who know nothing of Providence. We should take as our motto the 'Be not afraid' of John Paul II.

(I shall stop making comments on presentation now, although that is not to say that there are none that could be made.)

The Culture of Life. There are ten contributors in this section, which is divided into four parts: Theology and the Culture of Life; Promoting the Culture of Life; Politics and the Culture of Life; and Medicine, the Developing World and the Culture of Life.

In the first section, *Livio Melina* comments on the urgent need for bioethics to regulate the interventions of medical science. The Incarnation of the Son of God points to the kind of good that human life is. A false idea of democracy, that the worth of anything can be decided by vote, denies the absolute right of every human being to life. Human life is an absolute, not an evaluable good. An authentic culture, which should fulfill the human need for truth, value, and purpose in life, is fostered by faith in the Incarnation, Death, and Resurrection of Christ. *Carlo Lorenzo Rossetti* reflects on how to be in the world but not of it. The Christian must love the world and every man in it because they are God's creation and God has willed the redemption of the universe and divinization of the human being. He ponders on the mystery of evil and the mystery of the Cross. *Bishop Donal Murray* proposes the Church as a community of hope in the face of the culture of death.

In the second section there are three contributions covering the roles of the bishop, the priest, and the family in promoting the culture of life. *Archbishop George Pell* commences with statistics on the serious worldwide decline in birthrate. In many countries the population is increasingly elderly, with insufficient young people to look after them. How does the bishop influence public opinion on sexual morality? He discusses strategies for the struggle. He believes that a large number of people muddled by moral relativism and a false idea of freedom, would respond to the truth, which must be preached. *Father Richard Hogan* outlines the arguments by

which dissenters justified their opposition to the teaching of the Church, particularly the encyclicals 'Casti Connubii' and 'Humanae Vitae', so that priests failed and still fail, in their responsibility to preach on life issues. Failing to speak out is false compassion, because, assisting denial, it deprives of repentance and healing those spiritually and psychologically harmed by abortion. *Laura Garcia* points out that the grace of the Sacrament of Matrimony is for the good of society, as well as for the spouses to enable them to follow their vocation in marriage. Love is the fundamental vocation of every human being. Christian marriage with its total, permanent, unconditional commitment of the spouses provides the school where children learn how to love. She discusses the undermining of families and family life, and how to counteract this, and reflects on Christ's 'This is my body, given up for you', which must apply particularly to mothers who shelter life in their own bodies, but also to all Christians who would give their lives in service to God and their fellows.

In the third section, *Anthony Fisher* discusses the difficulties of pro-life politicians, who are frequently vilified by their own side, as well as by pro-abortionists. May, for example, changes that ameliorate but not abolish the laws on abortion be voted for by them? He gives extensive footnotes on the teachings of the Church, particularly the contents of 'Evangelium Vitae', which assist in guidance on this kind of problem. *Jorge Garcia* deals with the morality of violence in defending life.

In the fourth section, two major topics covering help for the poor of the third world are presented. *R. L. Walley* details the frightful complications of pregnancy endured by mothers in the third world and the shocking statistics on maternal death and infant mortality in these countries. The developed world's answer to this is 'reproductive health', that is abortion and contraception. An international group of obstetricians and gynaecologists in 1995 founded MaterCare International (visit their website www.matercare.org to make a free daily donation via sponsors and advertisers). This organization, formed by pro-life obstetricians who have been hounded out of their jobs in the West, provides essential obstetric care to mothers in poor countries. *Sr Dr Miriam Duggan* presents an initiative for preventing AIDS in Africa. This programme, involving education in chastity, started in Uganda, which has now seen a fall in the prevalence of AIDS from 28.9% to 9.8%, and is now showing signs of success in Kenya, Zambia, Zimbabwe, Tanzania, South Africa, and Botswana.

Supplementary Papers. There are six papers on a variety of topics in this section, all good stuff, but I think my favourite has to be the contribution of *Scott FitzGibbon*. His subject is the loss of solidarity amongst humankind. It has a rather long title: 'Wojtylan Insight into Love and Friendship: Shared Consciousness and the Breakdown of Solidarity'. How man forms a community was a major interest of Professor Karol Wojtyla. His insights are revealed in his philosophical writings, plays, and poetry. Wojtyla's metaphor of a mirror for consciousness, also used by Saint John of the Cross and Saint Teresa of Avila, gives so much food for thought. It comes out in his poem on the young lovers, Teresa and Andrew, gazing into the jeweller's shop for a ring, and seeing themselves reflected together in the shop window, an image of their shared consciousness of each other.

Altogether *Culture of Life, Culture of Death* is thoroughly to be recommended; but if you are a mere clinical practitioner you have some hard work ahead of you.

Margaret Sealey is an anaesthetist from Birmingham, UNITED KINGDOM.

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War Against the Weak: Eugenics and America's Campaign to Create a Master Race

Edwin Black

New York: Four Wall Eight Windows, 2003

ISBN 1-56858-258-7, 550 PP., HARDCOVER, \$27

In *War Against the Weak*, Edwin Black outlines the history of American eugenics from the beginning of the 20th century through World War II and beyond. This includes the stories of influential individuals, organizations, and foundations responsible for developing the ideology and policies necessary to create an America in which those who are deemed "unfit" are sterilized and those who are desirable are encouraged to procreate with one another. Black also explains the policy history that accompanied this pseudo-scientific quest and how it resulted in the sterilization of thousands of Americans, as well as its influence on international public policy. He gives a brief overview of post-WWII policies and events, but this serves mostly as a wrapping-up of earlier stories.

The story begins with the initial confluence of late 19th century events and ideas, including social Darwinism, Mendelian genetics, theories of breeding, and racist ideologies that led to the development of *eugenics*, Francis Galton's term using the Greek words for "good birth," meaning an attempt at the scientific development of a better race of human beings through carefully breeding the best with the best and discouraging reproduction among those deemed unfit. This led to two separate but complementary tracks of eugenics: positive eugenics, which encouraged mass procreation of the "best" people, and negative eugenics, which sought to eliminate reproduction among the unfit by means of sterilization, segregation, and similar coercive methods.

Eugenics began in Britain but quickly moved to the United States, where the ideology is picked up by a number of influential scientists and foundations, including the Rockefellers and the Carnegies. This well-heeled movement did not gain popularity among the masses, but it did influence public policy in many states, which proceeded to allow forced sterilization for the "feebleminded" and others whom eugenicists felt should not reproduce. Black traces the stories of people involved with the eugenics movement through the early 20th century, including leaders Charles Davenport and Harry H. Laughlin, as well as the influence of eugenical ideas on other movements of the time, such as Margaret Sanger's birth control movement and the campaign to fight hereditary blindness.

American concepts of eugenics, infused as they were with racism and prejudice against the poor and disabled, were taken up by other nations and influenced international public policy. This influence on international policy, including the German "race hygiene" movement and the horrors of the concentration camps, comes to dominate the book. It is critically important to understand how American ideas, funding, and research contributed to the Nazi atrocities. Black tells the stories of Nazis such as Edwin Katzen-Ellenbogen and Josef Mengele and, in sad and awful detail, discusses the experiments conducted on innocent people, all in the name of eugenics. This becomes the central focus of the book, however, and the American story is derailed and never fully recovered.

The final section of the book briefly looks at what happened to eugenics after the events of World War II, including the stories of Americans who had been involved in the movement. Black describes the move as one from eugenics to genetics, from a racist and pseudo-scientific campaign to an actual science free from destructive ideologies. He does not fail to point out, though, that even as a genuine science, genetics is not free from the possibilities of its discriminatory past. *War Against the Weak* is a sobering account of what can happen and has happened even in a free country like the United States, and is an important historical witness as we move into a new genetic age. It will surprise many readers to know what has happened in just the past century, but Black's account is fair and well documented throughout. It is, at times, very difficult to read, particularly in the sections regarding the Nazi experiments, but it is a valuable book for anyone interested in the history of eugenics and genetic discrimination and is a much-needed resource for those seeking to prevent such discrimination in the future.

Amy Michelle DeBaets is a Master of Divinity student at Princeton Theological Seminary in Princeton, New Jersey, USA, and Editor of the Biotech Update for the Council on Biotechnology Policy for The Wilberforce Forum.

challenged to

care

a christian perspective to nursing

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Challenged to Care, NCFI's 16th Quadrennial Conference to be held in Seoul, South Korea, will offer a number of opportunities for delegates to broaden nursing horizons. Delegates will be able to meet fellow nursing colleagues from around the world and participate in key sessions based on Christian values within their nursing environments. As well as active participation in sessions, they will be able to visit the exhibition, the "cultural fair" and participate in social gatherings.

Key Speakers

Dr. Mo Im Kim, PhD, RN (keynote speaker).

Dean, Red Cross College of Nursing.

Former President of the International Council of Nurses (ICN),
Minister of Health and Welfare, Republic of Korea.

Dr. Susie Kim, DNSc, RN, FAAN.

Professor and former Dean of College of Nursing Science,
Ewha Womans University, Seoul, Korea; chairperson of
Psychiatric-Mental Health Nursing Division.

Prof. Barbara Parfitt, PhD, MSc, McommH, RGN, RM.

Professor of Nursing, Dean of School of

Nursing, Midwifery and Community

Health Glasgow Caledonian University.

Dr. Judith Shelly, DMin, RN.

Nurses Christian Fellowship USA

Resource Director, Editor of

the Journal of Christian Nursing.

Registration

To register online, complete
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www.global-meeting.co.uk/ncfi.

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